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Behavioral Health

Standards Manual

carf INTERNATIONAL

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INTRODUCTION

CARF International is a private, nonprofit organization that is financed by fees from accreditation surveys, workshops, and conferences; sales of publications; and grants from public entities.

The CARF International family of organizations includes:

■ CARF

■ CARF Canada

■ CARF–CCAC (The Continuing Care Accreditation Commission)

Since its inception in 1966, CARF has benefited from national organizations joining together in support of the goals of accreditation. These organizations, representing a broad range of expertise, sponsor CARF by providing input on standards and other related matters through membership in CARF's International Advisory Council (IAC). A list of current IAC members is available on the CARF website, **www.carf.org/members.**

Mission

The mission of CARF is to promote the quality, value, and optimal outcomes of services through a consultative accreditation process and continuous improvement services that center on enhancing the lives of the persons served.

Vision

Through responsiveness to a dynamic and diverse environment, CARF serves as a catalyst for improving the quality of life of the persons served.

Moral Ownership

The CARF Board of Directors has identified that the persons served, as defined below, shall be the moral owners of CARF.

Persons served are the primary consumers of services. When these persons are unable to exercise self-representation at any point in the decision-making process, *persons served* is interpreted to also refer to those persons willing, able, and legally authorized to make decisions on behalf of the primary consumer.

Values

CARF believes in the following core values:

■ All people have the right to be treated with dignity and respect.

■ All people should have access to needed services that achieve optimal outcomes.

■ All people should be empowered to exercise informed choice.

CARF's accreditation, research, continuous improvement services, and educational activities are conducted in accordance with these core values and with the utmost integrity.

In addition, CARF is committed to:

■ The continuous improvement of both organizational management and service delivery.

■ Diversity and cultural competence in all CARF activities and associations.

■ Enhancing the involvement of persons served in all of CARF's activities.

■ Persons served being active participants in the development and application of standards of accreditation.

■ Enhancing the meaning, value, and relevance of accreditation to persons served.

Purposes

In support of our mission, vision, and values, CARF's purposes are:

■ To develop and maintain current, field-driven standards that improve the value and responsiveness of the programs and services delivered to people in need of life enhancement services.

■ To recognize organizations that achieve accreditation through a consultative peer-review process and demonstrate their commitment to the continuous improvement of their programs and services with a focus on the needs and outcomes of the persons served.

■ To conduct accreditation research emphasizing outcomes measurement and management and to provide information on common program strengths as well as areas needing improvement.

■ To provide consultation, education, training, and publications that support organizations in achieving and maintaining accreditation of their programs and services.

■ To provide information and education to persons served and other stakeholders on the value of accreditation.

■ To seek input and to be responsive to persons served and other stakeholders.

■ To provide continuous improvement services to improve the outcomes for organizations and the persons served and their community of influence.

Development of the Standards

The CARF standards have evolved and been refined over more than 45 years with the active support and involvement of providers, consumers, and purchasers of services. The standards are maintained as international consensus standards. The standards define the expected input, processes, and outcomes of programs for persons served. CARF recognizes and accepts its responsibility to assess and review the continuing applicability and relevance of its standards. CARF convenes its International Advisory Council; advisory committees; and regional, national, and international focus groups to systematically review and revise CARF's standards and develop standards for new accreditation opportunities. Composed of individuals with acknowledged expertise and experience, these committees and groups, including persons served, make recommendations to CARF concerning the adequacy and appropriateness of the standards.

This work is viewed as a starting point in the process of standards development and revision. Recommendations from this input are used to develop proposed new and revised standards, which are then made available for review by the public, persons served, organizations, surveyors, national professional groups, advocacy groups, third-party purchasers, and other stakeholders. This input from the field is carefully scrutinized by CARF and results in changes to the standards.

Applying the Standards

The organization is expected to demonstrate conformance to the **applicable standards** during the site survey so that the survey team can determine the organization's overall level of conformance and, ultimately, allow CARF to determine the accreditation decision. Some sections of the standards, such as those relating to the overall business practices of the organization, are applicable regardless of the programs or services for which the organization is seeking accreditation. The standards in other sections

are applicable in accordance with instructions in those sections.

Throughout this manual the following icons are used to denote content that is related to a specific country and standards that must be met by programs in specific countries:

★ (star icon) United States only

🍁 (maple leaf icon) Canada only

❉ (pinwheel icon) Sweden only

➤ (arrow icon) all other programs

When none of these icons appear, the standard is applicable to any program seeking accreditation.

Some standards have **intent statements** that help to explain, clarify, and provide additional information about the standard. When there is an intent statement, it immediately follows the standard to which it relates.

Some intent statements are followed by **examples** that illustrate potential ways an organization may demonstrate conformance to the standard.

Some standards may suggest **resources** that an organization may find helpful in implementing or conforming to the standard(s). Resources may include references to websites, organizations, or publications that provide information or assistance relevant to topics or areas included in the standard.

NOTE: *Before initiating the self-evaluation process or the request for a survey, an organization should contact CARF to discuss the programs and services it intends to include in the accreditation process. This step helps determine which standards will be applicable. If an organization provides a program or service that is not listed in this manual, the organization should also contact CARF to obtain more information.*

Blended Surveys

Some organizations may want to become accredited for programs or services included in different standards manuals. This is possible using what CARF terms a "blended" survey. Blending allows an organization to seek accreditation through one survey for programs or services with applicable standards in more than one manual. For example, services found in the *Employment and Community Services Standards*

Manual can be blended into a survey using the *Medical Rehabilitation Standards Manual.* The primary manual (i.e., the one into which other standards are blended) is determined by the predominant focus of the programs or services for which the organization is seeking accreditation. Factors that CARF considers when blending programs include the integrity of the programs and services and whether to incorporate standards from a related program or service section, such as the rehabilitation process or quality services for the persons served.

For more information, contact CARF, as specific guidelines are used for blended surveys. It is important to make this contact early in the accreditation preparation process.

CARF Publications

CARF offers publications and products through the online store at **www.carf.org/catalog**. Publications are available in alternative formats to accommodate persons with disabilities. Please contact CARF's Publications department at (888) 281-6531 (voice/TTY) for assistance.

Organizations are encouraged to call CARF toll free for clarification of any questions regarding which manual to use, which standards apply, interpretation of the standards, and clarification of the survey process. It is important to access CARF resources throughout the preparation process.

Following is a list of the customer service units and the standards manuals related to each.

Customer Service Unit	Standards Manuals
Aging Services	Aging Services CARF–CCAC
Behavioral Health	Behavioral Health Opioid Treatment Program Business and Services Management Network
Child and Youth Services	Child and Youth Services

Customer Service Unit	Standards Manuals
Durable Medical Equipment Prosthetics, Orthotics, and Supplies	DMEPOS
Employment and Community Services	Employment and Community Services One-Stop Career Center Business and Services Management Network
Medical Rehabilitation	Medical Rehabilitation
Vision Rehabilitation Services	Vision Rehabilitation Services

NOTE: *Standards manuals become effective on July 1, 2013, to allow organizations sufficient time to incorporate changes into their operations.*

Survey Preparation Workbooks

CARF recommends that you use the companion survey preparation workbook for your standards manual. The workbook assists organizations in conducting a self-evaluation in preparation for the accreditation survey.

NOTE: *The survey preparation workbook is incorporated into the standards manuals for Business and Services Management Network, DMEPOS, One-Stop Career Center, and Vision Rehabilitation Services.*

ACCREDITATION POLICIES AND PROCEDURES

The accreditation policies and procedures relate to the site survey, accreditation process, and continuation of accreditation. Because all aspects of the accreditation process are reviewed regularly for appropriateness, these policies and procedures may be changed between standards manual publication dates. Notification of changes, additional information, and clarification can be obtained from the CARF website, **www.carf.org**, or by contacting CARF. Organizations that are currently accredited or have begun the process of becoming accredited and have obtained Customer Connect access can obtain current accreditation policies and procedures at the Customer Connect website (**customerconnect.carf.org**).

NOTE: *Customer Connect is CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. To increase efficiency and support CARF's commitment to the environment, Customer Connect has been implemented as the primary means of transmitting certain documents such as the survey fee invoice and quality improvement plan. Rather than sending these documents through the mail, they are posted to Customer Connect and an email is sent to the individual identified as the organization's Survey Key Contact. Organizations should use Customer Connect regularly to view accreditation- and survey-related documents and to keep CARF informed of any changes in the name or email address of the key contact person.*

The submission of an Intent to Survey constitutes the organization's agreement to adhere to the CARF policies and procedures that are in effect on the date on which the Intent to Survey is submitted to CARF and to all subsequent changes as they become effective. The review and appeal process set forth in these policies and procedures, as amended from time to time, shall be the organization's sole remedy with respect to the survey, accreditation decision, and continuation or termination of accreditation.

By submitting the Intent to Survey, the organization expressly waives and releases CARF from any and all claims, demands, actions, lawsuits, and damages that may arise from or relate to, directly or indirectly, the survey, accreditation decision, and continuation or termination of accreditation.

Accreditation Conditions

The following Accreditation Conditions must be satisfied in order for an organization to achieve or maintain accreditation by CARF:

1. **For a minimum of six months prior to the site survey, each service for which the organization is seeking accreditation must demonstrate:**
   a. **The use and implementation of CARF's organizational and service standards applicable to the service.**
   b. **The direct provision of services to the persons served.**

Intent Statements

This time frame is required to ensure that the CARF survey process is not merely a paper review, but that the service seeking accreditation is actually having an impact on the persons served. In addition, this time frame allows for the collection of sufficient historical data, information, and documentation to assess the organization's conformance to the standards.

It is also expected that services will have been provided for at least six months prior to the site survey. This condition applies to organizations that have newly initiated services and to those that have ongoing services that are provided sporadically. Therefore, in the six months prior to the survey, the organization should have served at least one person in each service seeking accreditation.

In a business or services management network, direct services are provided by the members or under service contracts.

2. **The organization must provide such records, reports, and other information as requested by CARF.**

Intent Statements

It is the responsibility of the organization to provide evidence to the survey team to demonstrate conformance to the standards.

This condition also applies to information requested by CARF prior to, during, and after the site survey. The intent of this condition is for CARF to have access to all information deemed necessary to assess conformance to the standards. Access to stakeholders, including persons served, is also covered by this condition, as is access to all documents, including but not limited to files of persons served (active and closed), human resource files, strategic plans and reports, and financial statements. In certain circumstances, unavailability of key organizational staff necessary to demonstrate conformance to standards at the on-site survey may be grounds for Nonaccreditation.

3. **A Quality Improvement Plan (QIP) must be submitted within 90 days following notice of accreditation. This plan shall address all areas for improvement identified in the report.**

Intent Statements

CARF will provide the organization with the format to use for this plan with its notification of the accreditation decision.

If consultation in completing the QIP is needed, the organization is encouraged to contact CARF.

If an organization requests a review of a Non-accreditation decision and the outcome of that review is a One-Year, Provisional, or Three-Year Accreditation decision, the QIP must be submitted to CARF within 45 days of notice of the outcome of that review or appeal.

4. **An organization that achieves a Three-Year Accreditation must submit a signed Annual Conformance to Quality Report (ACQR). The report is submitted in each of the two years following the Three-Year Accreditation award.**

Intent Statements

In order to maintain accreditation, organizations are expected to operate in conformance to CARF's standards and comply with CARF's policies and procedures on an ongoing basis. They must incorporate changes to the standards, accreditation conditions, and policies and procedures as they are published and made effective by CARF.

CARF will provide the organization with the format for this report, which must be completed and returned.

NOTE: *If any of these conditions are not met, CARF will determine the appropriate course of action, which may include denial or withdrawal of an accreditation award.*

Accreditation Decisions

To be accredited by CARF, an organization must satisfy each of the CARF Accreditation Conditions and demonstrate through a site survey that it meets the standards established by CARF. While an organization may not be in full conformance to every applicable standard, the accreditation decision will be based on the balance of its strengths with those areas in which it needs improvement.

CARF uses the following guidelines to determine each accreditation decision:

Three-Year Accreditation

The organization satisfies each of the CARF Accreditation Conditions and demonstrates substantial conformance to the standards. It is designed and operated to benefit the persons served. Its current method of operation appears likely to be maintained and/or improved in the foreseeable future. The organization demonstrates ongoing quality improvement and continuous conformance from any previous period of CARF accreditation.

One-Year Accreditation

The organization satisfies each of the CARF Accreditation Conditions and demonstrates conformance to many of the standards. Although there are significant areas of deficiency in relation to the standards, there is evidence of the organization's capability to correct the deficiencies and commitment to progress toward their correction. On balance, the services benefit those served, and the organization appears to protect their health, welfare, and safety.

An organization may be functioning between the level of a Three-Year Accreditation and that of a One-Year Accreditation. In this instance, accreditation will be awarded for one year. An organization will not be awarded a second consecutive One-Year Accreditation.

Provisional Accreditation

Following the expiration of a One-Year Accreditation, Provisional Accreditation is awarded to an organization that is still functioning at the level of a One-Year Accreditation. A Provisional Accreditation is awarded for a period of one year. An organization with a Provisional Accreditation must be functioning at the level of a Three-Year Accreditation at its next survey or it will receive an accreditation decision of Nonaccreditation.

Nonaccreditation

The organization has major deficiencies in several areas of the standards; there are serious questions as to the benefits of services or the health, welfare, or safety of those served; the organization has failed over time to bring itself into substantial conformance to the standards; or the organization has failed to satisfy one or more of the CARF Accreditation Conditions.

Preliminary Accreditation

Prior to the direct provision of services to persons served, the organization demonstrates substantial conformance to applicable standards. There is evidence of processes and systems for service and program delivery designed to provide a reasonable likelihood that the services and programs will benefit the persons served. A Preliminary Accreditation is awarded to allow new organizations to establish demonstrated use and implementation of standards.

A full follow-up survey is conducted approximately six months following the initiation of services to persons served, at which time a Three-Year Accreditation, One-Year Accreditation, or Nonaccreditation decision is issued. If this follow-up survey has not been applied for and scheduled within six months of the first survey, this Preliminary Accreditation will expire.

NOTE: *Some of the accreditation policies and procedures are supplemented, revised, or not applicable for organizations seeking Preliminary Accreditation. Please contact CARF for details.*

Overview of the Steps to Accreditation

The table below provides an overview of the steps to accreditation. These steps are explained in more detail in the sections following the table.

STEP 1 **Consult with a designated CARF Resource Specialist.**	An organization contacts CARF, and a resource specialist is designated to provide guidance and technical assistance. ■ For an organization preparing for its first survey, it is important to make this contact early in the process. The resource specialist is available to answer questions in preparation for a survey and throughout the tenure of the accreditation. ■ For an organization preparing for a resurvey, the designated resource specialist may already be known. It is suggested that contact still be made early in the reaccreditation process to verify relevant organizational or program information. ■ The resource specialist provides the organization access to Customer Connect (**customerconnect.carf.org**), CARF's secure website for transmitting documents and maintaining ongoing communication with accredited organizations and organizations seeking accreditation. ■ The organization orders the standards manual in which its programs and services best fit. Visit **www.carf.org/catalog**. ■ The *CARF Accreditation Sourcebook*, which explains the accreditation process, and other publications are also available to assist the organization in the preparation process. ■ The organization maintains ongoing contact with CARF for assistance.
STEP 2 **Conduct a self-evaluation.**	The organization conducts a self-study and evaluation of its conformance to the standards using the standards manual and its companion publication, the survey preparation workbook. The self-evaluation is part of the organization's internal preparation process and is not submitted to CARF.

STEP 3	
Submit the Intent to Survey.	The organization submits the Intent to Survey via Customer Connect, **customerconnect.carf.org**. ■ The Intent to Survey requests detailed information about leadership, programs, and services that the organization is seeking to accredit and the service delivery location(s). ■ The organization submits the completed Intent to Survey, required supporting documents, and a nonrefundable Intent fee at least three full calendar months before the two-month time frame in which it is requesting a survey. Organizations undergoing resurvey submit their Intent to Survey on the date that corresponds with their accreditation expiration month (see page 13). ■ The submission of the completed Intent to Survey indicates the organization's desire for the survey and its agreement to all terms and conditions contained therein. ■ If any information in the Intent to Survey changes after submission, CARF should be notified immediately.
STEP 4	
CARF invoices for the survey fee.	After reviewing all information contained in the Intent to Survey, CARF invoices the organization for the survey fee. The survey fee invoice is posted to the Customer Connect website and an email notification is sent to the organization's key contact person. ■ The fee is based on the number of surveyors and days needed to complete the survey. ■ Scheduling of the survey begins immediately upon invoicing. Any changes in problem dates must be communicated in writing to CARF by this time.
STEP 5	
CARF selects the survey team.	CARF selects a survey team with the appropriate expertise. ■ Surveyors are selected by matching their program or administrative expertise and relevant field experience with the organization's unique requirements. ■ CARF notifies the organization of the names of team members and the dates of the survey at least 30 days before the survey.

STEP 6 **The survey team conducts the survey.**	The survey team determines the organization's conformance to all applicable standards on site through the observation of services, interviews with persons served and other stakeholders, and review of documentation. ■ Surveyors also provide consultation to organization personnel. ■ The organization is informed of the survey team's findings related to the standards at an exit conference before the team leaves the site. The survey team submits its findings to CARF, but the team does not determine the accreditation decision.
STEP 7 **CARF renders the accreditation decision.**	CARF reviews the survey findings and renders one of the following accreditation decisions: ■ Three-Year Accreditation ■ One-Year Accreditation ■ Provisional Accreditation ■ Nonaccreditation Approximately six to eight weeks after the survey, the organization is notified of the accreditation decision and receives a written report. The organization is also awarded a certificate of accreditation that lists the programs and services included in the accreditation award.
STEP 8 **Submit a Quality Improvement Plan.**	Within 90 days after notification of an accreditation award, the organization fulfills an accreditation condition by submitting to CARF a Quality Improvement Plan (QIP) outlining the actions that have been or will be taken in response to the areas identified in the report.
STEP 9 **Submit the Annual Conformance to Quality Reports.**	An organization that achieves a Three-Year Accreditation award submits a signed Annual Conformance to Quality Report (ACQR) to CARF on the accreditation anniversary date in each of the two years following the award. This is a condition of accreditation. ■ CARF sends the organization the form for this report approximately ten weeks before it is due. ■ The ACQR reaffirms the organization's ongoing conformance to the CARF standards.

STEP 10	
CARF maintains contact with the organization.	CARF maintains contact with the organization during the tenure of accreditation. Organizations are also encouraged to contact CARF as needed to help maintain conformance to the CARF standards.
	■ CARF offers publications to help organizations provide quality programs and services.
	■ CARF's public website, **www.carf.org**, and its secure customer website, Customer Connect (**customerconnect.carf.org**), provide news, information, and resources.
	■ CARF seminars and conferences are excellent ways to receive updates and other information about the accreditation process and the standards.

CARF Events

CARF sponsors a series of educational and training sessions to assist organizations to prepare for CARF accreditation, help them remain current with changes in the standards, present new standards, and discuss field practices. CARF also offers web-based educational events. To obtain the dates and locations of all events, visit **www.carf.org/events** or contact the Education and Training Department at (888) 281-6531, ext. 7114 (voice/TTY).

Steps to Accreditation

Step 1. Consult with a designated CARF Resource Specialist

The first step in the accreditation process is to contact CARF. When an organization contacts CARF, a dedicated resource specialist is assigned to provide guidance and technical assistance regarding the appropriate standards manual, programs to be accredited, interpretation and application of standards, and accreditation process. The resource specialist is available to answer questions both in preparation for a survey and throughout the entire term of accreditation.

After initial contact with a resource specialist, the organization orders the standards manual in which its programs and services best fit. The *CARF Accreditation Sourcebook*, which explains the accreditation process in detail, and other publications are also available to assist the organization in the preparation process. The manual and other publications can be ordered at **www.carf.org/catalog**.

Step 2. Conduct a self-evaluation

To earn accreditation, an organization must meet Accreditation Conditions 1 and 2 and demonstrate that it meets the applicable CARF standards. The starting point is an assessment by the organization of its current practices against the applicable standards set forth in the appropriate standards manual. The organization conducts a self-study and evaluation of its conformance to the standards using the appropriate standards manual and its companion publication, the survey preparation workbook. Depending on the level at which the organization initially assesses its conformance, a number of successive assessments may be appropriate. The organization's designated resource specialist is available to provide free technical assistance during the self-evaluation process.

The self-evaluation is part of the organization's internal preparation process, and there is no requirement for it to be submitted to CARF or shared with the surveyors. However, some organizations find it useful to share the self-evaluation with the survey team during the on-site survey.

Step 3. Submit the Intent to Survey

The Intent to Survey is the accreditation application that is completed and submitted online via Customer Connect. After preparing under the appropriate standards manual, an organization seeking accreditation for the first time requests access to the Intent to Survey for completion and submission to CARF. Resurvey organizations are notified of the Intent to Survey automatically.

The Intent to Survey is submitted with the nonrefundable Intent fee when the organization is ready for survey dates to be established in accordance with the accompanying chart. It generally takes two to three months for a survey to be scheduled after the Intent to Survey has been received.

Survey Time Frame At a Glance

An organization seeking accreditation for the first time uses the due date corresponding to its preferred time frame.

Resurvey organizations use the due date corresponding to expiration month, not preferred time frame. This lead time is needed for timely scheduling and rendering of a new decision before expiration of the current accreditation.

Preferred Time Frame	Intent Due to CARF no later than	*Expiration Month
*Jul/Aug	Feb. 28	Aug
*Jul/Aug	Mar 31	Sep
Aug/Sep	Apr 30	Oct
Sep/Oct	May 31	Nov
Oct/Nov	Jun 30	Dec
Nov/Dec	Jul 31	Jan
Dec/Jan	Aug 31	Feb
Jan/Feb	Sep 30	Mar
Feb/Mar	Oct 31	Apr
Mar/Apr	Nov 30	May
Apr/May May/Jun	Dec 31	Jun

*CARF does not award July expirations since the standards manuals become effective on July 1 of each year.

NOTE: *Actual survey time frames are assigned by CARF based upon surveyor availability.*

Please note that an Intent to Survey received after the due date is at risk for a delay in survey time frame. Organizations are encouraged to submit their Intent to Survey at least ten business days before the indicated due date to ensure timely receipt. Submission of the completed Intent to Survey confirms the organization's agreement to all terms and conditions contained therein. If any information in the Intent to Survey changes after submission, CARF should be notified in writing immediately.

Selection of Programs and Services to be Surveyed

In the Intent to Survey, the organization identifies the programs and services it desires to have surveyed by CARF and the site(s) where they are provided, including administrative locations. The number and expertise of surveyors and the length of survey required are based on information in the Intent to Survey and will be determined at CARF's sole discretion. Additional information, such as the organization's budget, brochures, and other materials, must be sent to CARF when the Intent to Survey is submitted.

An organization has the right and responsibility to choose the programs or services to be accredited. However, all locations that offer any of the programs or services must be included in the accreditation. CARF will not accredit a program or service if only a portion of it is submitted for accreditation.

CARF does not consider the funding or referral entities as differentiating a program so as to exclude portions of it from being included in the accreditation. If the organization needs assistance in interpreting or applying this policy, it should contact CARF.

CARF may change the size and/or scope of any accreditation survey or decision as it deems appropriate.

Organizations with Multiple Programs and Services

If one survey includes multiple programs and services or sites for accreditation, and any one program or service or site is operating at a lower level of conformance to the standards than the others, the level of accreditation awarded for that survey will be the level at which the weakest program, service, or site is functioning.

An organization may submit more than one Intent to Survey if it wishes to have separate surveys for different programs or sites that it operates. In separate surveys, each accreditation decision is independent and based solely on the individual survey and the level of conformance demonstrated by the organization and the programs and services that are part of that survey. In this case, different decisions may be awarded as appropriate.

Step 4. CARF invoices for the survey fee

After reviewing the Intent to Survey and other materials to determine the number of surveyors and days needed to conduct the survey, CARF invoices the organization for the survey fee.

CARF's survey fee applies to any type of site survey conducted by CARF—an initial survey, resurvey, or special visit (e.g., a supplemental survey or a One-Year, Provisional, or Nonaccreditation review). Any part of a day that a surveyor spends at any site of the organization, including the last day, is billed as a whole day.

The survey fee must be paid in full within 30 calendar days of the invoice date. Any public agency for which advance payment of the survey fee is not legally permissible must submit, before the survey, a binding purchase order for the full amount of the survey fee.

CARF reserves the right to cancel any scheduled survey if the fee is not paid sufficiently in advance of the survey.

Once the surveyors are in transit to a survey site, the survey fee is not refundable in whole or in part. Thus, if a survey is terminated on site or is shortened for any reason, no portion of the survey fee will be refunded.

Please contact CARF for current fees.

Outstanding Debt

All survey and other fees referenced in this manual shall be paid when due. CARF will not accept an Intent to Survey from any organization that has an outstanding past due debt to CARF until that debt has been paid. CARF also reserves the right to withhold an accreditation decision or issue a Nonaccreditation if an outstanding debt remains. CARF may modify an organization's existing accreditation, up to and including termination of accreditation, in the event any fees are not paid in a timely manner.

Step 5. CARF selects the survey team

Surveyors are assigned to surveys based on a number of factors, the most important of which is the surveyors' knowledge of the types of services being surveyed. Other considerations include the availability of surveyors, language, and the need to avoid conflicts of interest.

The organization may request a change of any surveyor assigned to conduct the survey in the event of a bona fide conflict of interest. CARF must receive the request for a surveyor change in writing within 14 calendar days of the date on which CARF transmits notification of surveyor assignment. A change in surveyor assignment is made when just cause, as determined by CARF, has been presented.

Subject to surveyor availability, the organization may be required to provide language interpreters at its expense to assist the surveyors; please contact CARF for details.

Scheduling the Survey Dates

Survey dates are established by CARF based on the Intent to Survey and in consultation with surveyors. A time frame of no fewer than four weeks within a specific period of two consecutive months is required for scheduling. CARF must be advised at the time of submission of the Intent to Survey if there are days during the designated time frame that will pose problems for the organization. Examples of such days may include community events, religious holidays, and vacation plans. A survey is scheduled during the organization's workweek and hours of operation. The use of Saturdays and Sundays as survey days is limited to organizations that operate on those days and only with prior approval from the organization.

Cancellation and Rescheduling

The organization is notified of the specific survey dates at least 30 calendar days prior to the survey. An organization is considered scheduled for a site visit on the date the notification is sent. The dates established by CARF are final. A cancellation/rescheduling fee, plus all related nonrefundable travel cancellation expenses, will be assessed if an organization requests any change affecting the scheduled dates or configuration of its survey, whether cancellation, postponement, or other date change, or if the survey is cancelled by CARF due to survey fees not paid sufficiently in advance of the survey.

It should be noted that CARF does not wait for receipt of the survey fee to schedule the survey. Therefore, to avoid a cancellation/rescheduling

fee, the organization must notify CARF in writing of any changes in available survey dates prior to CARF's notice of established dates.

When CARF is unable to schedule a survey in the designated time frame, the organization's current accreditation will not lapse but will be extended until notification of the next survey decision.

Step 6. The survey team conducts the survey

Involvement of the Persons Served

CARF considers the involvement of the persons served vital to the survey process. As such, persons served are involved in a variety of ways prior to, during, and after the survey.

Before the survey, persons served are notified of the pending survey and may submit comments about the organization's performance and their satisfaction with services. During the survey, the organization identifies persons served for interview by the survey team; however, the surveyors may also select additional persons served in each program or service area for interviews.

Some of the persons interviewed may be those who contacted CARF prior to the survey. The surveyors may conduct some of the interviews in a focus group forum or via telephone. After the survey, the persons served are encouraged to continue to provide CARF with feedback about the services provided at any organization with accredited programs.

A person served is the preferred person to be interviewed. A family member, guardian, or significant other may, as appropriate, be interviewed instead of or in addition to a person served during the survey process. Community members, employers, and others may also be interviewed. All interviews are confidential.

Before the Survey

Preparation

In conjunction with the appropriate standards manual, the organization should use CARF's other publications to adequately prepare for the site survey. Many of these publications have been written to help an organization prepare for a survey. CARF may be contacted by telephone or email to answer questions that the organization

may have regarding the survey process or interpretation of the standards. Inquiries about the standards or survey process can be made as frequently as needed by an organization seeking accreditation, and there is no charge for this support.

The survey poster

At least 30 days prior to the survey, the organization must display a poster announcing the pending survey and the survey dates. This poster can be downloaded in English, Spanish, or French from the Resources section of Customer Connect (**customerconnect.carf.org**). This poster must remain conspicuously posted at all locations until the survey concludes. Information on the poster includes a description of CARF as a review organization and instructions for interested persons to contact CARF to submit comments about the organization's performance and their satisfaction with services. These comments can be submitted through a toll-free phone number or via email, fax, or letter. Information received by CARF may be sent to the surveyors. The survey team may interview persons who have submitted comments or contacted CARF prior to the survey when on site. All interviews are confidential.

Pre-survey contact

Approximately two to three weeks before the visit, the survey team coordinator will contact the organization to discuss logistics and answer questions the organization may have regarding scheduling interviews and other items. The survey team may request that additional information that is not confidential be made available at the hotel the night before the survey or otherwise in advance.

Assemble or arrange access to records

Records needed to substantiate conformance to the CARF standards should be assembled in one room of the organization to be available for surveyor use throughout the survey, or arrangements should be made for surveyor access to electronic records. Many of these items are listed as documentation examples in the survey preparation workbook.

Third-party representatives

Each organization is required to have at least one representative of a major purchaser or user of its services available, either in person or by phone, to be interviewed by the survey team. CARF also routinely requests information prior to the survey about an organization from the state, provincial, or other governmental oversight agency and funding or referral sources. Although the organization generally chooses the individuals to be interviewed during the survey, the survey team may select other stake-holders to interview. An organization has the option of inviting third-party representatives to observe the orientation and exit conferences. Observations of interviews and survey team meetings, however, are prohibited because of the confidential nature of the matters discussed.

The Survey

NOTE: *The daily schedule of a survey will vary for each organization. The following is only a sample.*

First Day

Opening of business

The survey team arrives at the organization and conducts an orientation conference with the leadership, personnel, and others invited by the organization. The orientation conference provides the opportunity for the surveyors to clarify the purpose of the site survey, how the team will conduct the survey, and verify the programs, services, and sites to be surveyed. The organization should be prepared to provide the team with a brief overview of its operations, including the population served, the services provided, the programmatic objectives of the organization, and other important areas.

After the orientation conference

The survey team is given a brief tour of the physical facilities. Some team members may proceed directly to community sites that are a part of the survey rather than participate in the tour.

Mid-morning

The survey team meets to coordinate efforts and to identify the personnel whom the team will interview during the site survey. The organization is asked to schedule interviews with these individuals based on their availability. Every effort is made to minimize disruption to ongoing operations. If the organization has any question about the scheduling of interviews, these should be addressed with the survey team coordinator.

Late Morning to Late Afternoon

With a short lunch break, the team spends the rest of the day observing the programs and services being surveyed; interviewing various personnel, persons served, leadership, funding source representatives, community members, and others; and reviewing documents such as records of the persons served, fiscal reports, administrative records, and other materials. Records for review shall be selected by the survey team. A responsible person from the organization should be on the premises at all times to facilitate the process and answer questions for the team; however, this person should not attend individual interviews or survey team meetings.

Evening

The survey team reviews findings relative to conformance to the standards. The surveyors may request permission to remove nonconfidential documents from the survey site for review in the evening. Approval of this is at the discretion of the organization. If the organization offers residential programs, community housing, or supported living services, evening hours may also be used to visit sites.

The work that the survey team must do in the evenings prior to the last day of the survey is quite extensive. Therefore, the organization should never schedule any social activity that would involve surveyors.

Second or Last Day

If the survey involves more than two days, the following schedule applies to the last survey day. The other day(s) will be used for further observation, interviews, and documentation

review. It should be noted that the last day of the survey typically ends not later than 3:00 pm.

Opening of business

The survey team returns to the organization to obtain additional information, continue its interviews, review documents, and perform other survey activities. The organization's personnel may be asked for assistance in locating information to show conformance in specific areas.

Late Morning

The survey team meets to compile its findings and prepare for the exit conference. A pre-exit meeting may be requested with or by the personnel in charge to summarize the findings and/or discuss any questionable areas.

Early Afternoon

The exit conference, which is approximately one hour in length, is conducted by the survey team with those invited by the organization. The organization may record the exit conference. The purpose of the conference is for the survey team to provide feedback concerning the strengths of the programs and operations in relation to the standards, identify areas for improvement, and offer suggestions and consultation.

The organization may question any areas identified for improvement by the survey team at the exit conference and present further evidence of conformance to the standards before the surveyors leave the site. Once the survey team has left the site, the organization may not contribute any further information to demonstrate conformance to the standards.

NOTE: *If any issues or questions arise before or during the survey that the organization cannot resolve with the surveyors, the organization is encouraged to call CARF for guidance and resolution.*

After the Survey

After the survey has ended, all questions or concerns should be directed to the CARF office rather than to members of the survey team.

Step 7. CARF renders the accreditation decision

The survey team reports its findings to CARF. After the accreditation decision has been made, a written report is sent to the organization. The length of time from the site survey to the organization's notification of the decision is approximately six to eight weeks.

The report contains the accreditation decision and standards that were not met. When the organization is resurveyed, it is held accountable for follow up on areas identified in the previous report and for conformance to all applicable standards in the current standards manual.

NOTE: *CARF personnel, acting during the course and within the scope of their employment, are the only persons authorized to officially represent CARF in interpreting its policies, procedures, standards, and accreditation conditions.*

Step 8. Submit a Quality Improvement Plan

Within 90 days of notification of the accreditation decision, the organization submits to CARF a Quality Improvement Plan (QIP) in which it outlines the actions that have been or will be taken in response to the areas identified in the report. The QIP form with instructions is posted on Customer Connect (**customerconnect.carf.org**) at the time of the accreditation decision. CARF may be contacted for assistance if any areas for improvement require further explanation or if the organization needs assistance in determining whether its planned action is adequate to demonstrate conformance to the CARF standards. Submission of the completed QIP is required by Accreditation Condition 3 in order to maintain accreditation.

If an organization requests a review of a One-Year or Provisional Accreditation decision, the QIP must be submitted to CARF within 45 days following notice of the outcome of the review.

If an organization requests a review of a Non-accreditation decision and the outcome of that review is a Provisional, One-Year, or Three-Year Accreditation decision, the QIP must be submitted to CARF within 45 days of notice of the outcome of that review or appeal.

Step 9. Submit the Annual Conformance to Quality Reports

As part of the commitment to ongoing performance excellence that all CARF-accredited organizations are expected to demonstrate, each organization that achieves a Three-Year Accreditation must submit an Annual Conformance to Quality Report (ACQR) in a format supplied by CARF for each year of its accreditation. The report is due on the first and second anniversary dates. Through the ACQR, the organization certifies that it at all times conforms to the standards, satisfies the Accreditation Conditions, and complies with CARF's policies and procedures as changes are published and made effective from time to time.

Submission of the completed ACQR is required by Accreditation Condition 4 in order to maintain accreditation.

Step 10. CARF maintains contact with the organization

Communication Regarding Administrative Items

During the term of accreditation, the organization must provide CARF with information on situations that may affect the continuation of accreditation status. Some situations may require further actions to be taken. (See the "Supplemental Surveys" section.) The following types of administrative items must be communicated to CARF within 30 calendar days of their occurrence:

1. A change in the leadership
2. A change in the ownership
3. Relocation of an accredited program or service or the organization itself
4. A change in mail and/or email addresses
5. Significant reorganization of the personnel associated with the accredited program or service
6. Expansion, reduction, or elimination of an accredited program or service or site
7. Severe financial distress
8. Acquisition, merger, consolidation, or joint venture affecting an accredited program

Changes in ownership and/or leadership, the addition of a site to an existing accreditation, mergers, consolidations, joint ventures, and acquisitions involving accredited programs may require the payment of an administrative fee or a supplemental survey. A form for reporting administrative items is available online from the Resources section of Customer Connect (**customerconnect.carf.org**). Please contact CARF for more details.

Communication Regarding Significant Events

During the term of accreditation, the organization must provide CARF with information on significant events that occur within the organization and its accredited programs and services. Some situations may require further actions to be taken by CARF, including alleged incidents concerning conformance to the standards. Significant events that involve or may affect accredited programs and the organization's response to those events must be communicated to CARF within 30 days of their occurrence. Significant events are:

1. Investigations
2. Material litigation
3. Catastrophes
4. Sentinel events
5. Governmental sanctions, bans on admissions, fines, penalties, or loss of programs (e.g., sanctions imposed by U.S. Centers for Medicare and Medicaid Services)

A form for reporting significant events is available online from the Resources section of Customer Connect (**customerconnect.carf.org**). Please contact CARF for more details.

Falsification of Documents

The information provided by an organization seeking CARF accreditation is a critical element in the accreditation process and in determining the organization's conformance to the standards. Such information may be obtained via interviews or direct observation by surveyors or may be provided through documents reviewed by the survey team or submitted to CARF.

CARF presumes that each organization seeking accreditation is doing so in good faith and that all information is accurate, truthful, and complete. Failure to participate in good faith, including CARF's reasonable belief that any information used to determine conformance to CARF's standards during or subsequent to the survey has been falsified, may be grounds for Non-accreditation or a decision to modify or withdraw the existing accreditation.

In the event that an organization loses accreditation or is not accredited because of CARF's reasonable belief of falsification of documents or information, CARF will not accept an Intent to Survey from the organization for a period of at least twelve months. CARF may also notify the appropriate state, provincial, and federal agencies.

Public Information

Identification of Accreditation by the Organization

CARF accreditation is awarded to an organization for identified programs and services. An organization that has been awarded accreditation should identify this achievement publicly. Use of the CARF logo by an accredited organization for this purpose is encouraged. The CARF logo is available online in the Resources section of Customer Connect (**customerconnect.carf.org**) and at **www.carf.org/logo**. All references to CARF accreditation by the organization must clearly identify the accredited programs and services, unless all programs and services offered by the organization are accredited by CARF.

CARF personnel and surveyors may not be referred to or quoted in any public release involving accreditation without prior approval from CARF. An organization may, however, disseminate or quote from the report.

Certificate of Accreditation

An organization is provided, at no charge, one certificate of accreditation. Additional certificates are available for purchase. This free certificate, which is suitable for framing, identifies the organization that submitted the Intent to Survey, the level of accreditation, the programs and services for which the organization is accredited, and the month and year in which the accreditation expires. It also contains areas to place annual seals to demonstrate ongoing conformance to standards as attested through the ACQR.

An organization may use or display its certificate of accreditation to demonstrate conformance to the CARF standards, but it may not use or display the certificate in any manner that is inconsistent with the purposes of CARF and its accreditation function or that misrepresents the availability or quality of the services offered by the organization. The certificate should never be used either explicitly or implicitly as a claim, promise, or guarantee of successful service. Accreditation indicates an organization's demonstrated use of professionally approved standards and practices in connection with particular programs and services, and the certificate is regarded as providing information and guidance for the public at large and for persons considering services.

An accreditation award applies only to the organization's specific programs and services surveyed by CARF. The certificate may be displayed only by that organization. If an organization closes one or more of its accredited programs and other programs remain accredited, the certificate should be returned to CARF and a revised certificate will be issued free of charge.

Each unexpired certificate must be returned upon dissolution of the organization or loss of accreditation for any reason and the organization must refrain from representing itself or its programs and services as accredited and must cease to use or display the certificate or the CARF logo in any manner. Similarly, if accreditation is suspended, the organization must not represent itself or its programs and services as accredited or use or display the certificate or the CARF logo until and unless accreditation is restored.

Release of Information by CARF

To enhance the value of accreditation to persons served and other stakeholders, CARF may release information related to an organization and its accreditation to the extent not confidential or protected by law, including, but not limited to:

1. Whether CARF has received an Intent to Survey from a specific organization.

2. Scheduled survey dates for a specific organization.

3. Whether a survey has been completed.

4. The date of expiration of accreditation of a particular organization.

5. An organization's accredited programs and services.

6. An organization's accreditation decision and status.

7. Whether an organization has requested review of a One-Year Accreditation, Provisional Accreditation, or Nonaccreditation decision.

8. Whether an organization is involved in appealing or may still appeal a Nonaccreditation decision.

9. A summary and/or other general information (all organizations surveyed by CARF are required to provide information concerning their accreditation, services, and programs directly to the public).

10. As required by law or contract.

For convenient access to information, CARF includes on its web site a searchable list of organizations with accredited programs, including identifying information such as name, address, and telephone number. This posting allows the public to review the accreditation status of an organization's accredited programs at any time.

Subsequent Surveys

Depending on the circumstances, CARF may conduct three types of surveys of the organization's programs following the initial survey. These survey types are described below.

Resurveys

To maintain accreditation beyond the expiration date of its current accreditation, an organization's programs must be resurveyed or be in the process of a resurvey by the expiration date. CARF notifies an organization of the need for a resurvey approximately seven months before expiration of its accreditation.

The resurvey process is the same as the initial survey process in that a completed Intent to Survey is required and all applicable standards are applied. During a resurvey, however, the organization is expected to be able to demonstrate conformance during the entire period since its last survey. Also, special attention is given to implementation of changes made in response to the Quality Improvement Plan from the previous survey.

If new programs and services are being added or the mission and focus of the organization or its programs have changed since the previous survey, it is suggested that the organization contact its CARF resource specialist.

Supplemental Surveys

The main objective of a supplemental survey is to recognize the dynamic status of organizations and permit changes in accreditation between surveys. Supplemental surveys may be required under two circumstances:

1. **When an organization changes its leadership or ownership or engages in a merger, consolidation, joint venture, or acquisition transaction.**

When an organization's leadership or ownership changes after the survey is conducted, it may be necessary to conduct a supplemental survey of conformance to the standards applicable to the organization's administration and programs. For the same reasons, a supplemental survey may also be required when an organization is party to a merger, consolidation, joint venture, or acquisition involving accredited programs.

2. When an organization wishes to add a new program, service, or location to an existing accreditation.

An organization with currently accredited programs and services may be required to have a supplemental survey for the purpose of adding a new location to its existing accreditation. CARF will determine the need for a supplemental survey once the organization notifies CARF, in writing, of the changes in the organization. CARF will contact a representative of the organization to get more details, if required.

A supplemental survey is always required if an organization wants to add a new program or service that is not currently accredited.

If a supplemental survey is required by CARF, the organization must submit a completed Intent to Survey to CARF with a nonrefundable Intent fee. A survey fee for a supplemental survey is assessed for the number of days and surveyors required.

The maximum tenure of the accreditation of the new program, service, or location added will be the remaining tenure of the current accreditation. If during the supplemental survey the program, service, or new location is found to be functioning at a lower level of accreditation than the programs and services currently accredited, the result will be a reduction in the level and tenure of the entire accreditation decision.

A supplemental survey focuses on the program, service, or location being added. The standards that are applied may vary in accordance with the length of time since the previous survey. Organizations seeking to add a program, service, or location to their current accreditation should contact CARF for instructions regarding the applicable standards.

Monitoring Visits

CARF may from time to time conduct announced or unannounced monitoring visits of organizations with accredited programs. A monitoring visit may be conducted any time CARF receives information that an organization may no longer be conforming to the standards. The organization's accreditation award may be modified as a result of a monitoring visit and

submission of a new Quality Improvement Plan may be required.

Extension of Accreditation Awards

Extensions of up to three months for extenuating circumstances may be granted by CARF, at its sole discretion, for an organization with a current Three-Year Accreditation. The organization must request this extension in writing when submitting the completed Intent to Survey at least five months before its expiration date. CARF will review the request and determine whether the extension will be approved. Although the request for extension will not be approved prior to the submission of the Intent to Survey, an organization may contact CARF to seek prior authorization to request an extension.

An extension will not be considered or granted for an organization with a One-Year, Provisional, or Preliminary Accreditation.

If an organization with a Three-Year Accreditation intends to request an extension greater than three months, additional information must be submitted for consideration. The organization must submit written information with the completed Intent to Survey and Intent fee that details demographic and program changes since the last survey and an update on the performance of each accredited program. The organization should also send the following items and/or information to CARF at least five months prior to the expiration month:

- A letter from the organization's leadership explaining the reasons that the extension is being requested.

- A copy of the most recent performance analysis, as specified in Standard 1.N.1. in this manual.

- An update of the Quality Improvement Plan completed after the last survey.

- Information pertaining to any area previously identified in these policies and procedures under the heading "Step 10. CARF maintains contact with the organization."

■ If the organization is required to be accredited by any funding or referral entity, then a letter of support for consideration of the extension from that entity.

All information will be reviewed before CARF renders a decision on the extension request. In no case will an organization be granted more than a six-month extension.

If an organization is granted an extension, the survey will be conducted using the standards manual that is current on the date of the survey. After the survey, the expiration date will revert to the original month of expiration.

If an extension is granted, only those programs and services that are currently accredited and that the organization intends to have resurveyed will be included in the extension.

Organizations that submit their Intent to Survey and request for an extension after the date the Intent was due risk a lapse in their accredited status.

Allegations, Suspensions, and Stipulations

Upon being informed by any source of a change in an organization's conformance to the CARF Accreditation Conditions, standards, or policies and procedures, CARF, at its sole discretion, may review and modify the organization's accreditation status up to and including revocation of accreditation. CARF may also suspend or place stipulations on continued accreditation. During suspension, the organization is not accredited and may not communicate to third parties that it is CARF accredited.

CARF's review may involve a request for an immediate response from the organization, the submission of documents and other information, solicitation of information from external organizations and individuals, and/or the undertaking of an announced or unannounced monitoring visit to the site at the discretion and expense of CARF. Refusal to respond or unsatisfactory response to a CARF inquiry concerning an allegation may result in modification of accreditation status. When a change in status is deemed warranted, CARF will notify the organization of this action.

If an allegation is received after a survey but before the report and the accreditation decision are released, CARF may withhold the release of the report and decision until an investigation of the allegation has been completed and the matter resolved.

Disputed Decisions

Review of One-Year or Provisional Accreditation Decisions

When a One-Year or Provisional Accreditation is awarded, the organization may submit a written request for an on-site review of the findings of the first survey team to determine whether, in light of this on-site review, the One-Year or Provisional Accreditation decision is appropriate. In connection with this review, the following procedures apply:

1. The organization must submit a written request for a review of the accreditation decision, to be received by CARF within 30 calendar days of the date of the accreditation letter. In the written request for review, the organization must identify in detail its specific disputes regarding items cited in the report and why it believes they are not appropriate.

2. Upon receipt of the written request for review, CARF determines the number of surveyors and days needed to conduct the review and then contacts the organization to establish the dates of the review. In the interest of timeliness, every effort is made to conduct the review within 60 calendar days of receipt of the written request.

3. A letter of confirmation will be sent to the organization with the dates of the review and the names of the surveyors who will conduct the review. Also enclosed will be an invoice for the nonrefundable review fee, which must be paid at least 21 calendar days prior to the review. This fee will be based on CARF's current survey fee.

4. The survey team conducts the review at the organization using the same standards manual used by the first survey team. During the review, the organization must provide evidence of conformance in those areas where it disputes items cited in the report. The CARF surveyor(s) conducts interviews and reviews documentation to the extent necessary to determine whether at this point in time any revisions to previous findings should be made.

5. Following the review, the findings of the surveyor(s) are submitted to CARF for reconsideration of the accreditation decision.

6. Following the accreditation decision-making process, the organization is provided with the final decision and is informed as to whether sufficient evidence of conformance has been presented to warrant a change in the accreditation decision. The organization is informed of its accreditation status and new expiration date, as appropriate.

7. If the organization does not submit a sufficient written request for review or payment within the required time frames, it waives the right to a review of its One-Year or Provisional Accreditation.

Review and Appeal of Nonaccreditation Decisions

CARF has established a review and appeal procedure for organizations that receive a Nonaccreditation decision. This procedure offers an organization the opportunity to sequentially challenge such a decision at two levels: an on-site review and an appeal hearing.

The organization is informed of the Nonaccreditation decision and has 30 calendar days in which to submit a written request for an on-site review.

If the outcome of this on-site review is Nonaccreditation, the organization may appeal this decision. This final appeal shall only be based on questions of whether the survey was conducted in a manner consistent with CARF's survey policy and procedures.

NOTE: *If the Nonaccreditation decision is based on failure to satisfy one or more of the CARF*

Accreditation Conditions or unavailability of key organizational staff at the on-site survey, review and appeal of the decision are not available.

Request for Review

An organization whose programs and services receive a Nonaccreditation decision may initiate a review by submitting a written request for review to CARF. The written request must be received by CARF no later than 30 calendar days following the date of CARF's letter notifying the organization of the decision.

Within seven calendar days of receipt of the written notification, CARF will send the organization written confirmation of its receipt and an invoice for the on-site review. The invoice for a review will be based upon CARF's current survey fee structure. The organization is required to submit payment in full for the review within ten calendar days of the invoice date. CARF will schedule the review and notify the organization of the date(s) and the surveyors within 30 calendar days after payment is received.

NOTE: *If the organization does not submit a written request for review or appropriate payment within the required time frame, it waives the right to a review of its Nonaccreditation decision.*

On-Site Review

The number of surveyors and days needed to conduct the on-site review and the surveyors assigned will be determined at CARF's sole discretion. They will be selected based on their expertise in the service or program areas surveyed. The format of the review will be to conduct a completely new, full survey. The survey team will:

■ Arrive on site at the time agreed upon in the presurvey call from the team coordinator.

■ Conduct an orientation meeting with individuals invited by the organization to explain the process and on-site review.

■ Observe program and service delivery and review documentation to determine conformance to the standards. The organization must present information to demonstrate conformance to all applicable standards.

- Conduct interviews, as appropriate and necessary for any survey, with personnel, board members of the organization, persons served, funders, and other stakeholders.

- Conduct an exit conference on the last day and share information with the organization about areas of conformance and nonconformance to the CARF standards.

Within 35 calendar days after the site review has ended, CARF will determine if the Nonaccreditation decision should be upheld or revised. CARF may:

a. Affirm the Nonaccreditation decision. This action is final unless the organization notifies CARF in writing of its decision to appeal, pursuant to the following section.

   or

b. Reject the Nonaccreditation decision. CARF may award a Provisional, One-Year, or Three-Year Accreditation. CARF may also establish specific stipulations that the organization must meet. This decision is final.

Appeal Hearing

If the result of the review is to reaffirm the Nonaccreditation decision, the organization, upon written notice to CARF, is entitled to a hearing before a designated appeal panel. The organization's notice of appeal must be received by CARF within 14 calendar days of the date of the letter that communicates the decision from the review survey. This final appeal shall only be based on questions of whether the review survey was conducted in a manner consistent with CARF's survey policies and procedures. The appeal panel will not consider the organization's conformance to the standards.

Review at this final level is accomplished by submitting materials supporting the organization's appeal, which are presented verbally to the appeal panel via conference call or an in-person presentation. The written materials supporting the organization's appeal and notice as to whether the organization wishes to present via conference call or in person must be received by CARF within 30 calendar days of the organization's notification to CARF of its decision to appeal. CARF will schedule the hearing within 60 calendar days of receipt of the organization's materials, if practical.

The appeal panel may review the written information submitted by the organization, the report, and any other information, including comments from the original survey team, that it considers relevant. Within seven calendar days after completion of the hearing, CARF renders one of the following decisions, which is final:

a. Affirm the Nonaccreditation decision.

   or

b. Reject the Nonaccreditation decision and issue another decision. This may be a Provisional, One-Year, or Three-Year Accreditation. CARF may also attach specific stipulations to the accreditation.

Other Provisions

1. The organization is responsible for the cost of the on-site review survey, including payment of the current survey fee. All costs incurred by the organization or by CARF in connection with the appeal will be the responsibility of the party incurring the expenses. Fees and expenses incurred by the organization are not refundable in whole or in part.

2. Time notification requirements may be waived or modified only if agreed to in writing by CARF.

3. Failure by an organization to adhere to any of the terms of any review or appeal procedures will constitute a waiver and relinquishment of its right to review or appeal the Nonaccreditation decision.

4. The organization has no right to review CARF's books or records.

CHANGES IN THE 2013 MANUAL

Section 1. ASPIRE to Excellence®

1.G. Risk Management

- In Standard 1.G.3., elements a. and b. are new to include *media relations* and *social media* in written procedures for communications.

1.H. Health and Safety

- In Standard 1.H.4., previous element c. has been deleted and the stem of the standard modified to include the requirement for *documented* competency-based training.

- Standard 1.H.5.c.(10) has been modified slightly and the word *signage* has been deleted. Signage is not required as long as evacuation routes are accessible and apparent.

- In Standard 1.H.6., element c. has expanded to include specific items to be analyzed for performance improvement.

- In Standard 1.H.8., element c. is new to include the requirement that critical incident procedures include *documentation*.

1.I. Human Resources

- In Standard 1.I.5., the stem has been modified to add *documented*.

- In Standard 1.I.6., previous elements b. and c. have been deleted from this standard and are now incorporated into Standard 1.I.8. Previous elements d. and e. are now b. and c.

- Standard 1.I.8. has been restructured and modified. Elements b.(1)(b) *Disciplinary action,* and b.(1)(c) *Termination* are new; elements b.(2)(a) *Promotions* and b.(2)(b) *Job postings* were previously in Standard 1.I.6. as elements b. and c. Note that this change also changes the requirement for "guidelines" to requiring inclusion of these elements in written personnel policies. Previous element c. was deleted; other parts of this standard have been reorganized and renumbered.

1.K. Rights of Persons Served

- In Standard 1.K.3., the term *legal status* has been changed to *legal decision-making authority*.

- Standard 1.K.4., element c. is new to include the requirement that formal complaints are *documented*.

- Standard 1.K.5. has been modified to require an annual *written analysis* of all formal complaints.

1.M. Performance Measurement and Management

- In Standard 1.M.1., elements 1.a.–d. are new to include the minimum components expected in the written description of a performance management system.

- Previous Standard I.M.6. has been expanded and modified, and it was moved to Standard 1.M.3. as new elements 3.d.(1)–(2). Subsequent standards were renumbered.

- Standard 1.M.7. was Standard 8. in the 2012 manual. In element d. the word *goal* has been changed to *target*.

1.N. Performance Improvement

- In Standard 1.N.1.b. the word *goals* has been changed to *targets*.

Section 2. General Program Standards

2.A. Program/Service Structure

- Standard 10. is new and requires all programs identified as treatment programs to identify treatment modalities used and credentials of staff qualified to provide identified treatment modalities. Subsequent standards have been renumbered.

- Standard 24. was previously Standard 23. and has been revised.

2.B. Screening and Access to Services

- In Standard 14., element m.(7) is new and adds *living situation* to the required information to be gathered in the assessment process.

2.E. Medication Use

- In Standard 1., element b.(1) is new.

Section 3. Behavioral Health Core Program Standards

Behavioral Health Field Categories

- A new field category for Comprehensive Care has been added. This category applies to Health Home programs and may also be applicable for Integrated Behavioral Health/ Primary Care programs.

3.D. Community Housing (CH)

- In Standard 9., element d. is new and requires the program to address needs for separate sleeping areas based on age, gender, and developmental needs of persons served; previous element d. is now e.

3.N. Health Home (HH)

- This section is new in the 2013 manual; subsequent sections have been renumbered.

3.R. Intensive Outpatient Treatment (IOP)

- This was Section 3.Q. in the 2012 manual. Standard 1. has been changed to require a varying number of direct contact hours per week depending on the age of the person served.

3.U. Partial Hospitalization (PH)

- Standard 8. has been modified to specify that the requirement for availability of a psychiatrist 24 hours a day 7 days a week is based on the needs of persons served, when applicable.
- In Standard 11. the term *primary* assessment has been changed to *initial* assessment to improve clarity.

3.W. Residential Treatment (RT)

- This was Section 3.V. in the 2012 manual. Standard 2. has been modified slightly to clarify that the term "team" refers to the *treatment* team.

Section 4. Behavioral Health Specific Population Designation Standards

- Section 4.G. Eating Disorders is new.

Section 5. Community and Employment Services

- Previous Section 5.J. Home and Community Services has been deleted; subsequent sections have been renumbered accordingly.
- Section 5.O. Employment Skills Training is new.

5.A. Program/Service Structure

- In Standard 12., element b. is new and adds a requirement that *positive behavior interventions continue to be used in conjunction with any restrictive interventions.*
- Standard 13. has been expanded and restructured to add elements a. and b., which require personnel to be trained in the use of positive behavior interventions initially and annually.
- Standard 14. has been restructured and element d.2., which requires *monitoring of the effectiveness of any restrictive procedures used to reduce rights restrictions,* is new.

5.J. Personal Supports Services (PSS)

- The program description and the standards in the Personal Supports Services portion of this section have been revised based on input from the field. A thorough review is suggested. Changes include:
  - Standard 1. is new.
  - Standard 2. was previously Standard 1. and it has been modified.
  - Previous Standard 2. has been combined with and incorporated into what was previously Standard 1.
  - Standard 3. has been modified and restructured.

– Standards 4. and 5. were not changed.

– Previous Standard 6. has been deleted.

– Standards 6. and 7. are new.

■ The standards in the Short-Term Immigration Support Services portion of this section were renumbered and now begin with Standard 9.; the standards in this area were not changed.

Appendix C. Required Training

This Appendix is new and lists standards that require training to be provided by the organization.

Glossary

The following new term has been added:

■ Performance target

SECTION 1

ASPIRE to Excellence®

ASPIRE to Excellence®

Input Process

Change Process

a — Assess the Environment

s — Set Strategy

p — Persons Served and Other Stakeholders — Obtain Input

i — Implement the Plan

r — Review Results

e — Effect Change
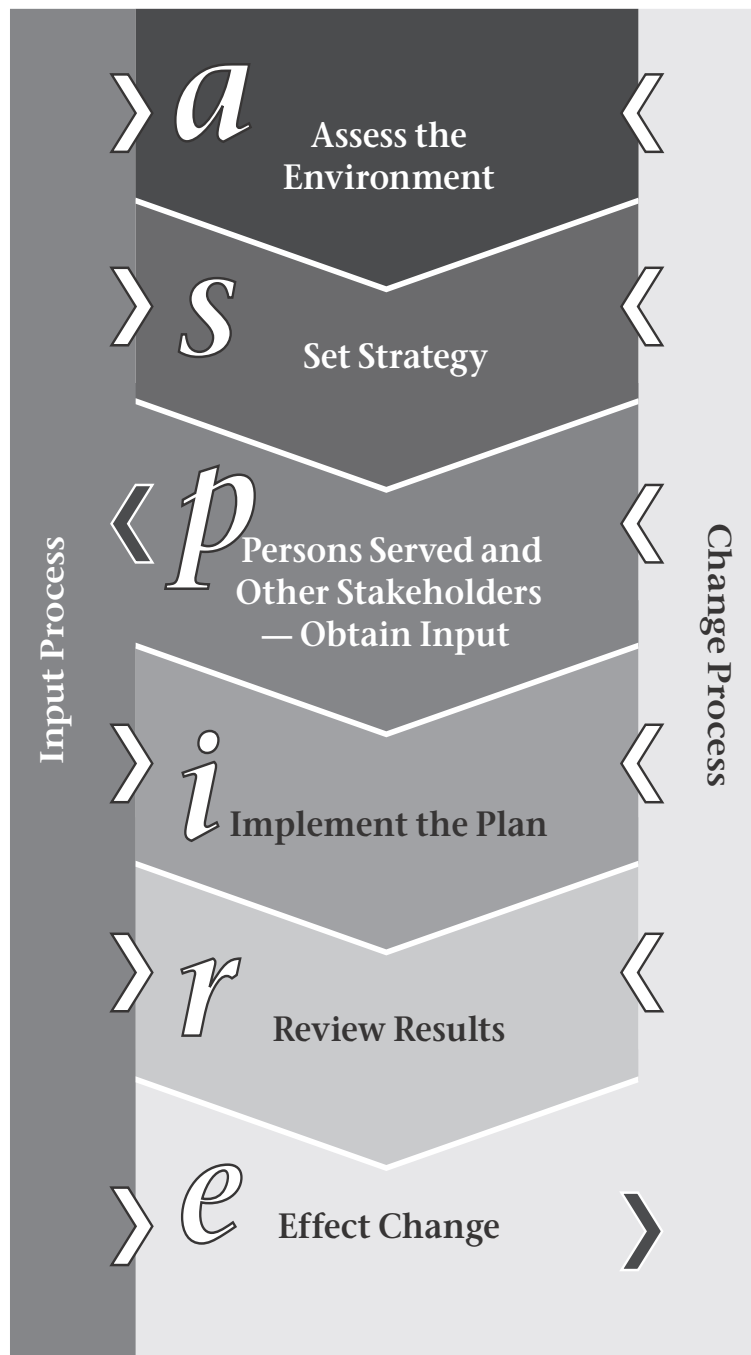
Assess the Environment

To be relevant and responsive in a rapidly changing environment, the organization must be vigilant of the context in which it conducts its business affairs. Environmental assessments provide the foundation for development and implementation of organizational strategy. Assessments should be conducted within the context of the organization's purpose, location, and sphere of influence, and relate to the vision and mission of the organization and how both fit into the social, economic, competitive, legal, regulatory, and political environments in which the organization operates. Collection and analysis of information regarding these factors provide the basis for the creative thought necessary to guide all organizational planning and action toward a future of service and business excellence. The role of leadership is critical to environmental assessment.

A. Leadership

Description

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

1.A. **1. The organization identifies:**
   a. **Its leadership structure.**
   b. **The responsibilities of each level of leadership.**

Examples

The leadership structure can be documented in the form of an organizational chart, table of organization, or narrative description of the positions and lines of authority within the organization. For very small organizations it is common to see a narrative description of positions, responsibilities, and lines of authority since there are typically so few staff members covering all areas of responsibility.

The survey team verifies that whoever is identified fulfills the responsibilities of leadership.

1.A. **2. A person-centered philosophy:**
   a. **Is demonstrated by:**
      (1) **Leadership.**
      (2) **Personnel.**
   b. **Guides the service delivery.**
   c. **Is communicated to stakeholders in an understandable manner.**

Intent Statements

The organization's person-centered philosophy should be evident in the development and delivery of services, systems, approaches, and interventions. Implementation of this philosophy from the unique perspectives of the leadership,

personnel, and persons served is addressed during the survey process.

1.A. **3. The identified leadership guides the following:**
   a. **Establishment of the:**
      (1) **Mission of the organization.**
      (2) **Direction of the organization.**
   b. **Promotion of value in the programs and services offered.**
   c. **Achievement of outcomes in the programs and services offered.**
   d. **Balancing the expectations of the persons served and other stakeholders.**
   e. **Financial solvency.**
   f. **Risk management.**
   g. **Ongoing performance improvement.**
   h. **Development of corporate responsibilities.**
   i. **Implementation of corporate responsibilities.**
   j. **Compliance with:**
      (1) **All legal requirements.**
      (2) **All regulatory requirements.**
   k. **Annual review of the organization's policies.**

Intent Statements

3.k. Annual review of the organization's policies addresses all policies specific to the program(s) seeking accreditation and policies that directly relate to or impact the program(s).

Examples

As the mission impacts service delivery, the achievement of outcomes, and strategic planning activities, a regular review of the mission statement assesses and reinforces the values of personnel and board members (when applicable) regarding the persons served and ensures that everyone is in agreement regarding the direction of the organization.

Input from the persons served and other stakeholders can influence the mission, as their needs, desired outcomes, and other factors change over time. The leadership ensures that specific activities are conducted to enhance its ability to guide the organization ethically, effectively, and efficiently.

3.c. The leadership works together to achieve and improve identified outcomes. Information on outcomes is used to guide performance improvement efforts such as strategic planning. These efforts and achievements are documented.

The organization is responsive to its environment and conducts planning to position itself strategically. In strategic planning, the organization may begin by doing an environmental scan and asking all of its stakeholders for input.

3.h.–i. These standard elements establish the organization's responsibility to be prepared to respond to questions from the public regarding its accredited services. Questions that might be expected include, but are not limited to, those about its CARF survey results and the survey report, the quality and effectiveness of services, descriptions of services and persons served, performance outcomes of the services, consumer and customer satisfaction with services, and other information that persons may use to make informed choices about services and service providers.

The organization informs the public of its policy and procedure for responding to requests for information through such means as a brochure, newsletter, public service announcement, newspaper article, or information posted on its website.

The organization demonstrates its knowledge and implementation of applicable federal, state/provincial/territorial, and local laws and regulations.

The organization has a system that ensures that it stays informed of changes and remains current.

1.A. **4. The leadership of the organization is accessible to:**
   a. **The persons served.**
   b. **Personnel.**

1.A. **5.** **The organization implements a cultural competency and diversity plan that:**

   a. **Addresses:**

     (1) **Persons served.**

     (2) **Personnel.**

     (3) **Other stakeholders.**

   b. **Is based on the consideration of the following areas:**

     (1) **Culture.**

     (2) **Age.**

     (3) **Gender.**

     (4) **Sexual orientation.**

     (5) **Spiritual beliefs.**

     (6) **Socioeconomic status.**

     (7) **Language.**

   c. **Is reviewed at least annually for relevance.**

   d. **Is updated as needed.**

Intent Statements

The organization demonstrates an awareness of, respect for, and attention to the diversity of the people with whom it interacts (persons served, personnel, families/caregivers, and other stakeholders) that are reflected in attitudes, organizational structures, policies, and services.

The organization's cultural competency and diversity plan addresses how it will respond to the diversity of its stakeholders as well as how the knowledge, skills, and behaviors will enable personnel to work effectively cross culturally by understanding, appreciating, and respecting differences and similarities in beliefs, values, and practices within and between cultures.

Examples

The organization assesses and has awareness and knowledge of the diversity of a variety of stakeholders. Examples of diversity awareness and knowledge include areas such as spiritual beliefs, holidays, dietary regulations or preferences, clothing, attitudes toward impairments, language, and how and when to use interpreters. The organization should be prepared to discuss what has resulted from the knowledge gained, e.g., modified service delivery, consideration of diversity in treatment plans, personnel training, increased satisfaction of stakeholders.

Cultural competency can be demonstrated by hiring persons who are representative of the persons served, by designing and delivering service in a manner that will be most effective given the cultures served, and by providing settings that promote comfort, trust, and familiarity.

Training and education in diversity and cultural competency may be offered directly by the organization or by community resources. Diversity in terms of culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, and language would be addressed. Training might focus on the cultures and spiritual beliefs of the countries of origin, especially their views of health, wellness, disability and its causes, and the influence of culture on the choice of service outcomes and methods.

Training related to cultural competency is directed toward personnel working with ethnically or otherwise diverse populations. It is suggested that the training attended by each employee be documented, generally in the personnel file and/or training records.

Resources

The Society of Human Resource Management has information about diversity training on its website at **www.shrm.org** that might be helpful, including views of disability and its causes, and the influence of culture on service delivery and predicted outcomes.

Many professional, educational and advocacy organization websites provide information related to diversity and cultural competency. These include:

- The Society of Human Resource Management **www.shrm.org**
- National Center for Cultural Competence **nccc.georgetown.edu**
- U.S. Department of Health and Human Services **www.hrsa.gov/culturalcompetence/index.html**
- Office of Minority Health, U.S. Department of Health and Human Services **www.thinkculturalhealth.hhs.gov**
- Human Rights Campaign **www.hrc.org/resources/entry/lgbt-cultural-competence**

1.A. **6. Corporate responsibility efforts include, at a minimum, the following:**

    a. Written ethical codes of conduct in at least the following areas:

        (1) Business.

        (2) Marketing.

        (3) Contractual relationships.

        (4) Service delivery, including:

            (a) Conflicts of interest.

            (b) Exchange of:

                (i) Gifts.

                (ii) Money.

                (iii) Gratuities.

            (c) Personal fund raising.

            (d) Personal property.

            (e) Setting boundaries.

            (f) Witnessing of documents.

        (5) Professional responsibilities.

        (6) Human resources.

        (7) Prohibition of:

            (a) Waste.

            (b) Fraud.

            (c) Abuse.

            (d) Other wrongdoing.

    b. Written procedures to deal with allegations of violations of ethical codes, including:

        (1) A no-reprisal approach for personnel reporting.

        (2) Time frames that:

            (a) Are adequate for prompt consideration.

            (b) Result in timely decisions.

    c. Education on ethical codes of conduct for:

        (1) Personnel.

        (2) Other stakeholders.

    d. Advocacy efforts for the persons served.

    e. Corporate citizenship.

Intent Statements

Corporate responsibility demonstrates what an organization stands for including its ethical, social, and environmental values. It involves creating, communicating, and balancing value for all stakeholders.

Corporate responsibility assists in:

- Advocating for the persons served.
- Promoting ethical business practices.
- Developing efficiency as an organization.
- Considering the impact of organizational activities on persons served, personnel, other stakeholders, and the environment.

Examples

The organization identifies, develops, and documents its required ethical practices and values. Although these codes may be found in various written materials such as personnel policies and operations manuals, many organizations find it helpful to include this information in one set of documents, which makes it easier to use in staff and board member training. An organization might find information from professional organizations and associations useful as a reference in developing its codes of ethical conduct.

Values are the core beliefs that guide attitudes and actions. A written ethics code states the major philosophical beliefs, principles, and values of an organization. Codes should be designed to promote the kind of relationship within which services can best be carried out and to give guidance in decision-making situations.

The policies concerning ethical conduct could be developed using information from such sources as state practice acts for the various disciplines/professions involved in services; the ethical codes of professional associations for the various disciplines/professions involved in services; the ethical codes of business, marketing, and human resource management associations; and the organization's own mission and core values statements.

The staff and members of the governance authority are knowledgeable of and follow the organization's required codes of ethical practices and values. This is evident in its daily operations. The organization has a mechanism in place to follow up and address all allegations of violations of its ethical codes. An organization could use a mechanism such as an ethics committee to investigate and act on allegations of violations

of ethical conduct. It could also use the same or a similar mechanism to address both allegations of violations of ethical conduct and allegations of infringements of the rights of the persons served.

A no reprisal system is developed for use by the staff in reporting suspected incidents of waste, fraud, abuse, and other questionable activities and practices. Written procedures for investigating allegations of wrongdoing are available for guidance. In addition, there should be some evidence that employees are aware that the system exists and know how to use it.

Examples of advocacy and corporate citizenship efforts could be:

- Positions on local boards that address accessibility, housing, leisure pursuits, and employment for persons in need of human services.
- Educational events for communities on caregiver issues.
- Educational events for schools on safety issues, such as wearing helmets while riding bikes.
- Drug and alcohol programs.
- Education on health issues.
- Employment opportunities.
- Active involvement in community organizations and service groups, such as chambers of commerce, rotary clubs, governor councils, provincial advisory committees, and meals on wheels.
- Providing reasonable accommodations to promote equal opportunities for participation throughout all levels of the organization.
- Providing access or referral to social, legal, or economic advocacy resources.
- Involvement in projects and programs to inform, educate, protect and promote a healthy environment such as recycling, use of environmentally friendly products, reduction of consumptions in the areas of water and energy, or reduction of greenhouse gas emissions.

6.a. The codes of ethical conduct could be developed using information from such sources as state practice acts for the various disciplines/ professions involved in services; the ethical codes of professional associations for the various disciplines/professions involved in services; the ethical codes of business, marketing, and human resource management associations; and the organization's own mission and core values statements and corporate compliance programs.

6.a.(4)(c) Examples of personal fund raising that may be addressed in an organization's written code of ethical conduct include personnel soliciting funds on behalf of a personal cause, selling cookies for a daughter in girl scouts, selling candy or wrapping paper for a child's school, having persons served selling items on behalf of the organization, and allowing persons served to raise funds by appeals to personnel or other persons served.

6.a.(4)(d) Ethical conduct might include respect for and safeguarding of the personal property of the persons served, visitors, and personnel and property owned by the organization.

6.a.(4)(e) The code of ethical conduct might address relationship issues such as personnel dating other personnel at the organization or persons served, sexuality, and boundaries in the relationships between providers and the persons served.

6.a.(4)(f) Examples of documents that personnel may be asked to witness include powers of attorney, guardianship, and advance directives.

6.d. Advocacy efforts for the person served could include the organization conducting or participating in public education or activities that promote the elimination of discrimination and stigma for the persons served.

Activities that demonstrate promotion of the reduction of stigma could include participation in a variety of public education efforts, community boards and committees, newspaper articles, and radio and television presentations. The organization can directly provide these sessions or actively participate in them. Maintaining a log or file of the activities in which the organization is involved can be helpful in demonstrating conformance. A method of demonstrating internal conformance to this standard would be the use of "people first" language in its publications, operations, and activities.

1.A. ★ **7. An organization in the United States receiving federal funding demonstrates corporate compliance through:**

   a. A policy on corporate compliance that has been adopted by the organization's leadership, including a document that authorizes establishment of the compliance program.

   b. Written designation of a staff member to serve as the organization's primary point of contact for:

      (1) Monitoring matters pertaining to corporate compliance.

      (2) Reporting on matters pertaining to corporate compliance.

Intent Statements

The acceptance of federal funding requires acceptance of the responsibility and accountability for tracking the funds and determining and overseeing how funds are being used and reported. Receiving federal funding not only relates to direct federal funding but also indirect funding, such as that funneled through state Medicaid or vocational rehabilitation systems.

The receipt of federal funding may occur in a variety of ways including the direct receipt of Medicaid or Medicare funding, funding through another entity (such as a block grant or funds received through a vocational rehabilitation or other state agency contract), or funding through being a federally funded network.

Examples

Under corporate compliance systems, organizations develop and implement processes to assess compliance issues, take corrective measures, and continually monitor compliance in all areas including administration and service provision.

Generally speaking, the term "compliance" is used to describe the act of complying with or acting in accordance with a set of standards or expectations mandated by an outside entity and is frequently used in conjunction with regulatory reviews, licensing audits, etc.

The organization, by assigning an individual to ensure that these business practices are followed, demonstrates that it can be a responsible agent.

With these responsibilities, the organization is committed to protecting its personnel when actions of the organization are being put under scrutiny. Personnel will be given assistance during any investigative process.

A corporate compliance program must be "effective" as defined by the U.S. sentencing guidelines and be "...reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal conduct." Perhaps the most practical benefit of having an effective corporate compliance program in place is the mandatory reduction in any monetary fines and penalties ordered by a judge who imposes a sentence on an organization. The implementation of a corporate compliance program establishes an atmosphere that prompts early detection of any wrongdoing before it becomes too serious and/or before it is detected through a regulatory or governmental audit or survey. Additional benefits of an effective corporate compliance program are:

- Reducing the likelihood of a violation occurring;

- Reducing the likelihood of civil liability, which comes chiefly in the form of demands for return of overpayments, civil money penalties, and whistle-blower lawsuits;

- Providing management with a different and generally more accurate view of the organization.

- Establishing a structure of information relevant to the compliance program;

- Establishing a structure to maximize the right of confidentiality under the attorney-client privilege.

1.A. **8. Leadership provides resources and education for personnel to stay current in the field in order to demonstrate program strategies and interventions that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**

Intent Statements

Leadership support is critical to the ability of personnel to learn and implement current strategies and interventions.

Examples

Examples of resources that leadership might provide include journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, in-service programs, journal clubs, collaborative resource or education efforts with other area providers of services, financial support and/or time off to participate in special interest groups or to attend conferences.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Organizational chart

■ Policy on corporate compliance

■ Written ethical codes of conduct

■ Mission and values statements

■ Minutes from governance meetings, if applicable

■ Surveys, assessments, or reports of input gathered from the persons served, personnel, and stakeholders

■ A budget

■ A strategic plan

■ Program outcomes

■ Current information on file pertaining to applicable legal and regulatory requirements

■ A file of information related to advocacy activities

■ A written plan for obtaining input from the persons served

■ A written plan on cultural competency and diversity

■ Written procedures to deal with allegations of violations of ethical codes

B. Governance (Optional)

Description

The governing board should provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability. The board is responsible for ensuring that the organization is managed effectively, efficiently, and ethically by the organization's executive leadership through defined governance accountability mechanisms. These mechanisms include, but are not limited to, an adopted governance framework defined by written governance policies and demonstrated practices; active and timely review of organizational performance and that of the executive leadership; and the demarcation of duties between the board and executive leadership to ensure that organizational strategies, plans, decisions, and actions are delegated to the resource that would best advance the interests and performance of the organization over the long term and manage the organization's inherent risks. The board has additional responsibilities under the domain of public trust, and as such, it understands its corporate responsibility to the organization's employees, providers, suppliers, and the communities it serves.

Applicable Standards

These governance standards may be applied, at the option of the organization, if the organization has a corporate governing board. The organization must indicate on its Intent to Survey that it wishes to have the governance standards applied.

When elected, these standards apply only to the board vested with legal authority to direct the business and affairs of the organization's corporate entity. These standards may not be applied to bodies lacking governance authority granted by state or provincial corporation laws, such as advisory and community relations boards and management committees. For example, if a hospital is seeking accreditation

at the level of its brain injury program, and the hospital requested that these standards be applied as an effort to review the governance practices in the organization, the standards would be applied to the hospital's governing board and not to the program's leadership (unless the program is separately incorporated, in which case they would apply to the program's board if it has the vested authority).

For more information, please contact your customer service unit.

1.B. **1. The board has governance policies that:**

    a. **Facilitate ethical governance practices.**

    b. **Assure stakeholders that governance is:**

        (1) **Active in the organization.**

        (2) **Accountable in the organization.**

    c. **Meet the legal requirements of governance.**

Intent Statements

The board should clearly document its approach and duties related to governance including its compliance with applicable statutes and provisions of articles of incorporation and bylaws. Board members are subject to three basic legal duties in performing their responsibilities: duty of care, duty of loyalty, and duty of obedience. Accountability requires that oversight mechanisms be in place, such as meetings, reports, and timely reviews of corporate performance.

Examples

Examples could include:

- Documented governance policies.
- Annual review of bylaws (legal requirements).
- Delegation of authority to executive leadership with defined limits, such as financial limits.
- Assurance that internal control and risk management systems, delegated to executive leadership, are in place.
- Timely reviews of corporate performance (e.g., quarterly).
- Annual reports to stakeholders.
- Input meetings with stakeholders.

1.B. **2. Governance policies address:**

    a. **The selection of the board, including:**

        (1) **Board membership criteria.**

        (2) **Selection process.**

        (3) **Exit process.**

    b. **Board member orientation.**

    c. **Board development.**

    d. **Board education.**

    e. **Board leadership, including selection of:**

        (1) **Board chair.**

        (2) **Committee chairs.**

    f. **Board structure, including:**

        (1) **Board size.**

        (2) **Board composition.**

        (3) **Definition of independent, unrelated board representation.**

        (4) **Duration of board membership.**

    g. **Board performance, including:**

        (1) **Financial matters, if any, between the organization and individual board members, including:**

            (a) **Compensation.**

            (b) **Loans.**

            (c) **Expense reimbursement.**

            (d) **Stock ownership.**

            (e) **Other matters of financial interest.**

        (2) **Use of external resources, including, as applicable:**

            (a) **External auditors.**

            (b) **Executive compensation advisors.**

            (c) **Other advisors, as needed.**

        (3) **Annual self-assessment of the entire board.**

        (4) **Periodic self-assessment of individual members.**

        (5) **Annual written and signed conflict of interest declaration.**

        (6) **Annual written and signed ethical code of conduct declaration.**

        (7) **External interactions.**

Intent Statements

2.a. The board has sole responsibility to determine appropriate skills and characteristics required for a competent and contributing board member. Each organization and its board must consider and identify its own member criteria (such as skills, diversity, representation of person served) and follow a selection process that accounts for the perceived needs of the board at the time of selection, attracting board members who have the time to devote to board activities to advance the organization's purpose. Establishing membership criteria and defining a selection process should attract board members with the necessary skills and knowledge to do their job well.

The board should also manage its own governance performance by reviewing the collective board and individual members. In the event that performance issues arise with any specific board member (such as not attending meetings or lack of meaningful participation) the board must clearly identify its protocol to discharge a board member in a defined exit process.

2.b. Board member orientation usually requires that both the board and executive leadership conduct a comprehensive orientation process to ensure the board member becomes familiar with the organization's vision—mission, strategic direction, values, ethics, financial matters, governance practice, and policies in keeping with legal and/or other reporting requirements (e.g., annual tax filings).

2.c.–d. The organization should continually make efforts to build governance capacity through ongoing education. Rather than specifically relying on the individual expertise of a particular board member, the organization should make a concerted effort to advance the skills of the entire board, as the whole board is ultimately accountable, speaking with one voice.

2.e. The board should act freely to select a chair who is best for the board and organization at a given time. With respect to selecting the board chair or specific committee chairs, the organization should identify those criteria and selection processes.

2.f.(1)–(4) Good governance means performing effectively in clearly defined roles and functions. The structure of governance—board size, mix, and terms—are all decisions unique and specific to each organization.

Each organization should assess the optimum number of board members it needs with the requisite skills to thoroughly exercise governance oversight. It is the board's responsibility to decide how it should strike a balance between the broad-based skills and experiences necessary for the board, with the pragmatic consideration of managing the structure and process of a larger board. Although larger boards may bring diverse skills, they do not necessarily bring better governance.

The approach an organization takes regarding the term of board membership is also subject to board deliberation and decision. No term limits, with acceptable board performance, ensures continuity in knowledge and community relationships. Natural attrition and term limits bring renewal and new vigilance by virtue of new skills and experiences of new members. Boards that frequently turn over tend to create organizational instability as both knowledge and experience is lost to the organization. The board must determine its approach in the context of the organization.

Board member independence and unrelatedness to executive leadership allows the board to act without undue influence from management. Further, when selecting a qualified candidate for board membership, a mix of members who have no ties or relationships to the organization is one way of ensuring independence. This effort can be satisfied through *at-large* members who can balance the varied interests of board members. Independent and unrelated board members may sometimes lead the governance management or executive compensation committees to enhance accountability.

2.g.(1) The board must set the ethical tone in the organization and model integrity in its conduct. In the case of publicly traded or other for-profit organizations, the board may receive compensation and other forms of financial incentives. In not-for-profit organizations, there may be other financial links not directly apparent. Board policy should address these issues, supported by signed conflict of interest and ethical code of conduct declarations.

2.g.(2) Many governance decisions are complex and significant; therefore, the board should seek expert advice. Although expert advice can be provided through the organization's internal experts, the board should seek external professional advice on complex legal and financial issues as necessary. Access to external expert advice can be coordinated and supported by the organization's executive leadership.

2.g.(3)–(4) The board as a whole should continuously assess its performance in an effort to determine its effectiveness in governing the organization. This assessment ensures that the board is fulfilling its duties and evolving within the context of challenges the organization may face. Assessing board achievement and opportunity to improve will facilitate an evolving governance model to ensure that its activities remain relevant and effective on behalf of owners/stakeholders. This concept also applies to individual board members.

2.g.(7) Outside parties may include advisors, regulators, investors, press, consumers, and customers.

Examples

2.e. A selection criterion for the finance/audit committee chair could ideally be a board member with a finance background.

2.g.(2) Examples of situations in which the use of external advisors or resources would be appropriate could include:

- Seeking financial or legal advice on a merger or acquisition.
- Getting advice from an expert on corporate risk management.
- Getting advice from a financial expert on organization investment policies.

2.g.(3) Whole board assessment strategies can include:

- Completing meeting questionnaires (e.g., questions rated *strongly agree, agree, neutral, disagree,* or *strongly disagree*).
  - *We (the board) spent our time on the most important governance topics.*
  - *We used our time effectively.*
  - *The meeting was chaired effectively.*

- Discussing the board's effectiveness at the conclusion of each board meeting, rolled into a year-end review documented in board minutes.
- Completing a year-end questionnaire tallied for board discussion. The following are sample questions, which can be rated by board members as *Excellent, Good, Fair, Poor,* or *N/A*:
  - Legal Frameworks:
    - *Statements in the governing documents (e.g., bylaws, policies) setting forth the board's function and duties are:*
  - Board Structure:
    - *The board's size in relation to the organization's needs is:*
    - *The board's spread and balance in regard to expertise, age, diversity, interest, and points of view are:*
  - Board Comprehension:
    - *The board's comprehension of the interests of various constituencies (funders, persons served, and advocates) with which the organization deals is:*
  - Board Practices:
    - *The board's orientation to the organization is:*
    - *The frequency of board meetings in relation to organizational needs is:*
    - *The board's practices with regard to amendments of bylaws are:*
    - *The board's practices with regard to election of officers are:*
    - *The board's practices with regard to establishing committees and their mandates are:*
  - Board Performance:
    - *The board's performance in formulating the organization's long-term goals is:*
    - *The board's ability to monitor its own accomplishments and progress is:*
    - *Performance standards expected by the board for attending all regularly scheduled meetings are:*

- *Performance standards expected by the board for committee participation are:*
- *Performance standards expected by the board for referral of prospective board members are:*
– Relations with Executive Leadership:
  - *The board's working relationship with the chief executive officer is:*
  - *The definitions of the roles of the chief executive officer and board are:*

2.g.(4) Individual board self-assessment can include:

■ A yearly self-assessment questionnaire and resulting discussion with the board chair. The following are sample questions, which can be rated by board members as *Excellent, Good, Fair, Poor,* or *N/A*:

– *My understanding of the organization's mission, vision, and core values is:*

– *My understanding of the legal requirements and stipulations under which the board acts is:*

– *When outside auditors present the financial statements, my understanding of those documents is:*

– *My attendance at board meetings is:*

– *My preparedness for board and committee meetings is:*

– *My working relationship with other board members is:*

1.B. **3.** **The board's relationship with executive leadership includes:**

   a. **Delegation of:**
      (1) **Authority to executive leadership.**
      (2) **Responsibility to executive leadership.**
   b. **As appropriate, access to personnel.**
   c. **Support of governance by the organization.**

Intent Statements

See the Glossary for the definition of *executive leadership*.

3.a. Determining the relationship between the board and the organization's executive leadership requires significant thoughtfulness and diligence to be clear about the functions of governance versus the duties delegated appropriately to the organization's management. Although each organization determines appropriate roles, generally boards ensure that the organization has a vision for its future via goals, aims, missions, or ends and that management work is conducted legally, ethically, and with integrity to achieve those goals. The board's accountability to its stakeholders is achieved by holding the organization's management accountable for performance. The board delegates authority to management to conduct business via resource use (e.g., money, people, technology) and ensures that executive leadership develops plans and acts to achieve organizational goals. This delegation and review process is a continuous oversight mechanism, culminating in an annual review of the organization's (and therefore, the executive leadership's) success.

This delegation of authority differentiates between the authority of the executive leadership and the authority of the board.

3.b. From time to time, the board may need access to varied management and staff in carrying out its governing duties. So as not to cross into management authority, the board should be clear on when and how it may consult with other management/staff to enhance its governance duties. This relationship is established between the board and executive leadership so that managerial operations are maintained as a priority for those assigned to that responsibility. The organization should ensure that the board has appropriate administrative support.

Examples

3.c. The organization may show support of the governing body by how it shares information with members of the governing body; how time and space are provided in support of governance-related work; the types of resources made available to the board for educational purposes such as orientation to the organization, memberships in professional associations in the field, or membership in an organization such as Boardsource (**www.boardsource.org**) which promotes effective governance practices.

1.B. **4.** **Board processes include:**

    a. **Agenda planning.**

    b. **Developing meeting materials.**

    c. **Distributing meeting materials.**

    d. **Overseeing the following committee work, as applicable:**

        (1) **Governance development.**

        (2) **Governance management.**

        (3) **Financial audit.**

        (4) **Executive compensation.**

        (5) **Other pertinent activities, as defined by the board.**

1.B. **5.** **Governance policies address executive leadership development and evaluation, including:**

    a. **Formal annual written review of executive leadership performance in relation to:**

        (1) **Overall corporate performance versus target.**

        (2) **Individual performance versus target, if applicable.**

        (3) **Professional development.**

        (4) **Professional accomplishments.**

        (5) **Professional opportunities.**

    b. **An annually reviewed executive leadership succession plan.**

Intent Statements

Evaluation of executive leadership is an essential part of performance management and should include opportunities for continued growth and development.

5.b. Succession planning for executive leadership ensures continuity of leadership due to the planned or unplanned departure of the chief executive. To manage associated risks of unplanned leadership vacancies, the board should have a plan for this. Details of such a plan vary by organization and often the current executive leadership is charged with providing this plan to the board annually.

Examples

5.b. The succession plan for review may include an annual letter from the executive leadership to the board identifying two internal candidates who can fill the position on a temporary or permanent basis. Often, this leads the board into a joint discussion with executive leadership on the skills, capacity, and depth of leadership potential in the organization.

A complex and thorough competency-based succession program should assess competencies necessary for organizational leadership positions, match against annual 360 review of potential internal candidates, and identify promotion or development opportunities.

1.B. **6.** **Governance policies address executive compensation, including:**

    a. **A written statement of total executive compensation philosophy.**

    b. **Review by an authorized board committee comprised of independent, unrelated board members.**

    c. **Defined total compensation mix, up to and including, as warranted:**

        (1) **Base pay.**

        (2) **Incentive plans.**

        (3) **Benefit plans.**

        (4) **Perquisites.**

    d. **Total compensation references to:**

        (1) **Market comparator data.**

        (2) **Functionally comparable positions.**

    e. **A documented process that outlines:**

        (1) **Terms of compensation arrangements.**

        (2) **Approval date.**

        (3) **Names of board members on the committee who approved the compensation decision.**

        (4) **Data used in the compensation decision.**

        (5) **Disclosures of conflict of interest, if any.**

        (6) **Annual review of executive compensation records.**

(7) Authority of board members to exercise executive compensation actions.

Intent Statements

The board's role in determining executive compensation remains a high-profile task for the governing board whether organizations are for-profit or not-for-profit. A board-endorsed compensation philosophy is intended to provide a broad-based foundation for designing an effective compensation and performance management plan for executive leadership. It should be broad enough to provide an enduring foundation, yet be specific enough for the board to make annual compensation decisions on an informed and reasonable basis. A compensation plan must attract and retain leadership talent, yet respond to market trends, reflecting the value of the functional demands of executive work and rewarding performance results. Further, tests of reasonableness regarding executive pay also place board members at potential personal risk. That risk is minimized by ensuring that executive compensation decisions are independently approved by the governing board or committee acting on behalf of the board in a non-conflict-of-interest position. Further, appropriate practice would also involve using comparability data before approving a compensation arrangement, followed by documenting the process that supports that decision.

Examples

As a general guide, publicly traded for-profit companies have models of executive compensation programs/approaches or protocols that detail the principles and philosophies of various compensation models. These, with modification, could be used by not-for-profit organizations.

Comparison to or benchmarking of total compensation plans can include many sources: salary surveys (regional/national), profit versus non-profit, functional responsibility of leadership regardless of tax status, and comparators or comparator mixes that can establish a policy line for executive leadership pay.

Resources

★ For U.S. nonprofits, Section 53.4958-6 of the Treasury Regulations also outlines a process that a board of a tax-exempt entity should follow to reduce exposure to penalties in relation to unreasonable compensation.

❀ The Canadian Society of Association Executives may be a useful resource for information on executive compensation.

1.B. **7. The governing board annually reviews its governance policies.**

Examples

Examples of how to conduct this annual review may include a review of policies by a board committee with the review documented in meeting minutes, or a staff liaison to the board may help to facilitate this review with the board.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Board organizational chart
- Ethical practices policy
- Board selection and composition policies
- Board leadership policies
- Board structure and performance policies
- Board annual self-assessment documentation
- Individual board member self-assessment documentation
- Annual signed conflict of interest declarations
- Annual signed ethical code of conduct declarations
- Sample board meeting agendas
- Sample meeting materials
- Executive leadership development and evaluation policies
- Executive compensation policies
- Annually reviewed executive leadership succession plan
- Formal annual written review of executive leadership performance

Set Strategy

Each organization has at its core a purpose developed through environmental assessment. Setting strategy is the activity of understanding the environment and organizational competencies, identifying opportunities and threats, and articulating a high-level map of the direction to take in order to achieve, sustain, and advance organizational purpose in a competitive environment. Strategy translates the salient environmental factors into tangible planning assumptions, sets goals and priorities, and globally aligns resources to achieve performance targets.

C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

1.C. **1. The ongoing strategic planning of the organization considers:**
   a. **Expectations of persons served.**
   b. **Expectations of other stakeholders.**
   c. **The competitive environment.**
   d. **Financial opportunities.**
   e. **Financial threats.**
   f. **The organization's capabilities.**
   g. **Service area needs.**
   h. **Demographics of the service area.**
   i. **The organization's relationships with external stakeholders.**
   j. **The regulatory environment.**
   k. **The legislative environment.**
   l. **The use of technology to support:**
      (1) **Efficient operations.**
      (2) **Effective service delivery.**
      (3) **Performance improvement.**
   m. **Information from the analysis of performance.**

Intent Statements

1.l.(1)–(3) Technology has an ever increasing role and presence in today's human services environment. While the use of technology and the sophistication of that technology will vary among organizations, each organization considers current literature and professional consensus in determining its current and future technology needs and identifies the resources needed to advance its use of technology to support

operations, effective service delivery, and performance improvement.

This standard relates to Standard 1.J.1.

Examples

1.f. Capabilities may include areas such as human resources, research and development, integration with or development of new segments of the continuum, and technology.

1.g. Consideration of service area needs may include waiting list and information regarding persons served found ineligible for, or excluded from, services.

1.h. Consider an organization that is 30 years old and was once in a very rural area. The demographics of the area have dramatically changed as the area has become more industrial. This information affects many areas including expectations, financials, and demographics.

1.i. External stakeholders may include educational institutions.

1.k. An organization evaluates changes in public funding from legislation such as the prescription drug bill and Medicaid waivers and integrates the information into the planning process.

1.l.(1)–(2) Some organizations have found that providing community-based staff with personal digital assistants (PDAs) increases the amount of time they can spend in services as it relieves the travel-time associated with having to go to an administrative site to complete notes and reports.

Resources

1.l.(1)–(2) There are numerous web-based resources that may be used, including:

- **www.techsoup.org**
- **www.nonprofit.about.com**

1.C. **2. A written strategic plan:**
    a. **Is developed with input from:**
        (1) **Persons served.**
        (2) **Personnel.**
        (3) **Other stakeholders.**

    b. **Reflects the organization's financial position:**
        (1) **At the time the plan is written.**
        (2) **At projected point(s) in the future.**
        (3) **With respect to allocating resources necessary to support accomplishment of the plan.**
    c. **Sets:**
        (1) **Goals.**
        (2) **Priorities.**
    d. **Is implemented.**
    e. **Is reviewed at least annually for relevance.**
    f. **Is updated as needed.**

Intent Statements

The strategic plan sets forth an organizational roadmap for the future in consideration of relevant business, environmental, and other factors. Because sound business practice demands that the plan be used as a dynamic tool, it should be reviewed at least annually and modified as appropriate.

Examples

2.e. An organization determines the method of review and update. Since environmental factors play an important role, if there are significant changes, this could prompt leadership to consider updating more often than annually to maintain the relevance of the plan to current conditions.

Resources

A helpful planning resource is the CARF monograph *Strategic Positioning and Planning in the 21st Century*. An electronic copy may be requested by contacting your CARF resource specialist.

1.C. **3. The strategic plan is shared, as relevant to the needs of the specific group, with:**
    a. **Persons served.**
    b. **Personnel.**
    c. **Other stakeholders.**

Examples

An annual report might include information on the strategic direction and achievement of an organization's strategic objectives. It is not expected that an organization share information it considers confidential and critical to its positioning.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Strategic plan
- Strategic planning documents
- Financial reports
- Input received from persons served, personnel, and other stakeholders
- Leadership or management meeting minutes, where strategic planning was discussed

Persons Served and Other Stakeholders—Obtain Input

In a service environment, organizational success cannot be achieved or sustained without success for the persons served. Actively engaging the persons served as part of the planning and service processes has been demonstrated to result in better outcomes. In fact, the more the organization obtains feedback from persons served and other stakeholders relative to all appropriate organizational functions, the better the outcomes reported. The important role of input from persons served and other stakeholders is recognized by its prominent position in the ASPIRE to Excellence framework. This input process engages all parties in a sense of shared future that promotes long-term organizational excellence and optimal outcomes.

D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

1.D. **1. The organization demonstrates that it obtains input:**
   a. **On an ongoing basis.**
   b. **From:**
      (1) **Persons served.**
      (2) **Personnel.**
      (3) **Other stakeholders.**
   c. **Using a variety of mechanisms.**

Intent Statements

Input is requested and collected to help determine the expectations and preferences of the organization's stakeholders and to better understand how the organization is performing from the perspective of its stakeholders. The input obtained relates to the organization's services, persons served, and business practices. The organization identifies the relevant stakeholders, besides the persons served, from whom it solicits input.

Examples

There are a variety of mechanisms to solicit and collect information. They range from the informal to the formal. Some examples include written surveys, advisory groups, face-to-face

meetings, conferences, focus groups, telephone conversations, listservs/chat rooms, consumer boards/councils, presentations to stakeholders, suggestion boxes, complaints, and communication logs. Input can also be obtained by having board members or an advisory committee who are representative of the populations and cultures served.

It is important to not only use a variety of mechanisms, but also collect information throughout the year. For example, simply having an annual public forum would not meet the intent of this standard.

1.c. Mechanisms may include:

- Input forums.
- Surveys.
- Complaint, grievance, or incident summaries.
- Performance improvement activities.
- Strategic planning, including:
  - Finance.
  - Human resources.
  - Environmental scans.
- Program/service development.

Please see the Glossary for the definition of *strategic planning.*

1.D. **2. The leadership:**
  a. Analyzes the input obtained.
  b. Uses the input in:
    (1) Program planning.
    (2) Performance improvement.
    (3) Strategic planning.
    (4) Organizational advocacy.
    (5) Financial planning.
    (6) Resource planning.

Intent Statements

The input is continually analyzed, and the analysis is integrated into the business practices of the organization. The input is analyzed to help determine if the organization is:

- Meeting the current needs of the persons served and other stakeholders.
- Offering services/products that are relevant to the persons served and other stakeholders.
- Identifying potential new opportunities for the growth and development of programs and services.

Examples

Input can be used in various ways: developing or revising individual service plans; changing service delivery designs; developing, improving, or eliminating services; making short- and long-range planning; and prioritizing staff training needs.

The organization uses stakeholder input to direct its ongoing process for quality improvement. This process is a continuous cycle of quality improvement in which the organization seeks and uses the input it gets from its stakeholders.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Leadership and other meeting minutes
- Written surveys and results
- Strategic planning documents
- Satisfaction surveys from consumers and other stakeholders, such as board members, funder and referral sources, parents and guardians, staff persons, and other community members

Implement the Plan

The strategic plan, based on a thorough assessment of environmental factors, provides a roadmap to achieving organizational purpose. To actually achieve its purpose, the organization must translate strategic goals into tangible action. Implementation is the development and enactment of tactical steps designed to achieve strategic goals. Sound implementation requires a solid foundation of service delivery and business practices operationalized via organizational resources, including personnel, technology, and assets. Excellence is attained through the translation of strategy into practices that, when performed by a competent workforce and enhanced by the effective use of available resources, achieves the desired outcomes.

E. Legal Requirements

Description

CARF-accredited organizations comply with all legal and regulatory requirements.

1.E. **1. The organization demonstrates a process to comply with the following obligations:**
   a. **Legal.**
   b. **Regulatory.**
   c. **Confidentiality.**
   d. **Reporting.**
   e. **Licensing.**
   f. **Contractual.**
   g. **Debt covenants.**
   h. **Corporate status.**
   i. **Rights of the persons served.**
   j. **Privacy of the persons served.**
   k. **Employment practices.**
   l. **Mandatory employee testing.**

Intent Statements

The organization should engage in activities designed to promote awareness, understanding, and satisfaction of its various obligations at all times. Satisfaction of obligations is necessary for the organization's success, sustained existence, and ability to positively affect the lives of persons served. Failure to satisfy obligations may result in monetary or other penalties, potentially impacting the viability of the organization, as well as harm to those the obligations are intended to protect. The organization should monitor its environments for new and revised obligations and utilize knowledgeable resources to become familiar with obligations and the requirements to meet them.

Examples

1.i. The organization ensures that the rights of the persons served are protected and advocates

for their rights. Personnel demonstrate knowledge of and compliance with all applicable laws. Policies regarding the human rights and dignity of the persons served have been written and communicated to personnel through the organization's code of ethics and to the persons served in a manner understandable to them. A good practice an organization may follow is to include this information in its employee handbook or present it through audiotapes, videotapes, pictures, and other media.

1.l. Local health and licensing agencies can provide guidance in this area.

1.E. 2. The organization implements written procedures to guide personnel in responding to:
  a. Subpoenas.
  b. Search warrants.
  c. Investigations.
  d. Other legal action.

Examples

With these responsibilities, the organization is committed to protecting its personnel when actions of the organization are being put under scrutiny. Personnel will be given assistance during any investigative process.

1.E. 3. Policies and written procedures address:
  a. Confidential administrative records.
  b. The records of the persons served.
  c. Security of all records.
  d. Confidentiality of records.
  e. Compliance with applicable laws concerning records.
  f. Time frames for documentation in the records of the persons served.

Intent Statements

In order to protect the privacy of all stakeholders and any confidential information that its records may contain, an organization ensures that it addresses the applicable legal and regulatory requirements concerning privacy of health information and confidential records. Security includes such things as storage, protection, retention, and destruction of records. Safeguards

such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

This standard applies to current and historical records and to hard copy records as well as electronic records.

Organizations are encouraged to review current provisions of legislation on freedom of information and protection of privacy (such as HIPAA in the USA and PIPEDA in Canada) for potential impact on the maintenance and transmission of protected health information. Of particular note are provisions related to information security, privacy, and electronic data interchange.

Examples

Security and confidentiality can be addressed through such mechanisms as having designated personnel who are responsible for records maintenance and control; limiting access to confidential records to authorized personnel only; protecting records from permanent loss or damage; ensuring that electronic records have regular backup; and clearly defining and implementing time frames and procedures for retention and destruction of records.

3.f. An organization would establish its own time frames for entries into records which could include time frames for entering critical incidents or interactions into the records of the persons served and time frames for entering confidential data into administrative records. It would also be the responsibility of an organization to determine what the content of its records will include or exclude.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Reports from regulatory agencies
- Reports associated with legal actions
- Reports associated with contractual relationships
- Policies and written procedures that address confidential administrative records and the records of the persons served
- Personnel policies manual

F. Financial Planning and Management

Description

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and annual performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

1.F. **1. The organization's financial planning and management activities are designed to meet:**
   a. Established outcomes for the persons served.
   b. Organizational performance objectives.

Examples

1.a. This may tie to Section 1.M. Performance Measurement and Management. See Standard 1.M.6. related to service performance indicators such as efficiency, effectiveness, access, and satisfaction.

1.b. The organization's performance objectives may include, but are not limited to areas of potential financial risk such as reductions in state or provincial funding or new regulations that might impact details of service or increasing the population served. This may tie to Standard 1.M.3. related to setting and measuring performance indicators for business function improvement.

1.F. **2. Budgets are prepared:**
   a. Prior to the start of the fiscal year.
   b. That:
      (1) Include:
         (a) Reasonable projections of:
            (i) Revenues.
            (ii) Expenditures.

(b) Input from various stake-holders, as required.

(c) Comparison to historical performance.

(d) Consideration of necessary cash flow.

(2) Are disseminated, as appropriate, to:

(a) Personnel.

(b) Other stakeholders.

(3) Are:

(a) Written.

(b) Approved by the identified authority.

Examples

The annual budget reflects projected income and expenses, and the organization regularly monitors its performance against the budget. Leadership reviews the budget at least annually. The time frame for approval of the budget may be dictated by funders' and organizational requirements and contracting processes. Input from professional and administrative personnel in budget development demonstrates the organization's intent to anticipate its fiscal needs.

Input from persons served can be gathered by a variety of means. For example:

- Formal meetings to discuss the budget.
- Informally, via ongoing conversations with staff.
- Through participation on the board or advisory groups.

2.b.(3)(b) Approval of the budget could be conducted by an owner, executive leadership, governing board, or other authority. If an organization is dependent on a state budget, which has not been finalized prior to the beginning of the fiscal year, an organization may adopt a provisional budget until the final state budget is approved for the year.

1.F. **3.** Actual financial results are:

a. Compared to budget.

b. Reported, as appropriate, to:

(1) Personnel.

(2) Persons served.

(3) Other stakeholders.

c. Reviewed at least monthly.

Examples

3.c. The monthly review of actual financial results may be conducted by program management, finance staff, or the governing board.

1.F. **4.** The organization identifies and reviews, at a minimum:

a. Revenues.

b. Expenses.

c. Internal:

(1) Financial trends.

(2) Financial challenges.

(3) Financial opportunities.

(4) Management information.

d. External:

(1) Financial trends.

(2) Financial challenges.

(3) Financial opportunities.

(4) Industry trends.

e. Financial solvency, with the development of remediation plans if appropriate.

Examples

4.c.–d. An organization could demonstrate that consideration of these items occurred through meeting minutes or during interviews with a surveyor in which the process of how these were considered is described.

4.c.(4) Management information may include items such as:

- Time spent on billable versus non-billable activities.
- Occupancy rate of residential beds.
- Number of available foster homes.

■ Caseload size.

■ Percentage of private pay versus Medicare/
Medicaid or pay from the provincial/
territorial public purse.

4.d. External events that have a financial impact
on the organization include items such as:

■ Changes in reimbursement rates.

■ Competition in the marketplace.

■ Changes in consumer preferences.

■ Interest rates and the availability of financing.

■ Regulatory and legislative changes.

4.d.(4) Industry trends may include items such
as:

■ Information that may be at a national, state or
provincial, regional or local level. This could
be a comparison to providers of similar ser-
vices throughout the region at the time or it
could also mean comparison to similar busi-
ness activities that are operated.

■ Practices in service delivery or business man-
agement that are becoming more widespread
and could impact the program.

An organization can demonstrate that consider-
ation of these items occurs through meeting
minutes or during interviews with a surveyor in
which the process of how these were considered
are described.

4.e. Financial solvency could be described as the
ability of an organization to meet its financial
obligations, long-term expenses, and to accom-
plish long-term expansion and growth.

1.F.   **5.** **If the organization has related entities,
it identifies:**

   a. **The types of relationships.**

   b. **Financial reliance on related entities.**

   c. **Responsibilities between related enti-
ties and the organization, including:**

      (1) **Legal.**

      (2) **Contractual.**

      (3) **Other.**

   d. **Any material transactions.**

Intent Statements

Full disclosure of relationships demonstrates
an organization's commitment to excellence
and transparency. The organization discloses
information to persons served and other stake-
holders that explains its assets and liabilities,
reflects the position and responsibilities of any
parent or sponsoring organizations, and discloses
any material and legal relationships with other
entities.

Examples

Organizations often form strategic relationships
with other entities to share financial and non-
financial resources or to guarantee debt. At times,
organizations benefit from a third party revenue
source. The relationship of this revenue source
and the risks or value of this relationship should
be disclosed.

Examples of relationships include:

■ Parent-subsidiary structures.

■ Affiliations.

■ Alliances.

■ Guarantees.

■ Limited partnerships.

■ Other third-party operating support.

■ Material contracts such as food services,
pharmacy, and therapy.

Disclosure of these relationships can be
accomplished through:

■ Audited financial statements.

■ Annual reports distributed to residents
and persons served.

■ Marketing materials.

■ Tax report filings.

5.d. Material, when used in accounting, is
defined as the magnitude of an omission or
misstatement of accounting information that
makes it probable that the judgment of a reason-
able person relying on that information would
have been changed or influenced by the omission
or misstatement. When used in finance, it refers
to the magnitude of the financial impact on
an organization. If the magnitude of the items
relative to the whole organization is significant,
then it is material. For example, a company
with $2,000 of total assets has $1,000 worth

of investments, the investment is material. A $1,000 impact on a $500 million total asset corporation is immaterial.

1.F. **6.** **The organization:**

   a. Implements fiscal policies and procedures, including internal control practices.

   b. Provides training related to fiscal policies and procedures to appropriate personnel including:

   (1) Initial training.

   (2) Ongoing training.

Intent Statements

To reduce risk, it is important that the organization, regardless of size, establish who has responsibility and authority in all financial activities, such as in purchasing materials and capital equipment, writing checks, making investments, and billing.

1.F. **7.** **If the organization bills for services provided, a review of a representative sampling of records of the persons served is conducted:**

   a. At least quarterly.

   b. To:

   (1) Document that dates of services provided coincide with billed episodes of care.

   (2) Determine that the bills accurately reflect the services that were provided.

   (3) Identify necessary corrective action.

Intent Statements

Determining that billing statements match service information in the records of the persons served is a proactive method for an organization to help reduce or eliminate costly audit exceptions. This review and corresponding corrective action will assist in that process.

Examples

This review focuses specifically on the appropriateness of billing and coding practices and can be conducted as part of the quarterly "quality review" that is required for behavioral health programs or as a separate process. In a program where individual records of the persons served are not maintained, this standard is not applicable.

The review is conducted by persons trained to compare the dates and service codes on the organization's billing system to the dates, units, and types of services provided to the persons served. This type of review is often conducted by trained support staff.

This type of review may be required by some funding or regulatory sources, but it is also a good practice to incorporate into a fiscal management program to ensure that services are being billed appropriately.

Although only a quarterly review is required, as part of risk management an organization may choose to conduct this review more frequently, such as when billing or coding procedures are revised, new personnel are hired, or new information systems are implemented or to determine accuracy of billing following corrective training.

1.F. **8.** **The organization, if responsible for fee structures:**

   a. Identifies the basis of the fee structures.

   b. Demonstrates:

   (1) Review of fee schedules.

   (2) Comparison of fee schedules.

   (3) Modifications when necessary.

   c. Discloses to the persons served all fees for which they will be responsible.

Intent Statements

An accountable organization assists the persons served in understanding the fee structure and whether there might be any additional charges to the individual.

Examples

On a regular basis, the organization can evaluate its current fee structure to ensure that the fees are adjusted as necessary to reflect changes in services, the cost of delivering service, and the local market.

8.b. The organization may demonstrate this in different ways. It might include dates on documents, mention this activity in meeting minutes, various staff could discuss how this process occurred, etc.

8.b.(2) Comparison of fee schedules could be with what it has charged before and what new analysis might show is needed; it could be comparing to fee schedules from the funding source. It does not require that it be external to the organization.

1.F. **9.** **If the organization takes responsibility for the funds of persons served, it implements written procedures that define:**
   a. **How the persons served will give informed consent for the expenditure of funds.**
   b. **How the persons served will access the records of their funds.**
   c. **How funds will be segregated for accounting purposes.**
   d. **Safeguards in place to ensure that funds are used for the designated and appropriate purposes.**
   e. **How interest will be credited to the accounts of the persons served, unless the organization is subject to guidelines that prohibit interest-bearing accounts.**
   f. **How monthly account reconciliation is provided to the persons served.**

Examples

This standard applies if the organization serves as a representative payee for the persons served, is involved in managing the funds of the persons served, receives benefits on behalf of the persons served, or temporarily safeguards funds or personal property for the persons served.

1.F. **10.** **There is evidence of an annual review or audit of the financial statements of the organization conducted by an independent accountant authorized by the appropriate authority.**

Intent Statements

An *accountant authorized by the appropriate authority* means a CPA in the United States; in Canada, he or she is a chartered accountant; in countries outside the United States and Canada, the terminology for a similar accountant qualified to conduct a review or audit would be used.

It is important for the CARF-accredited organization to determine that its financial position is accurately represented in its financial statements. Accountants may typically undertake three types of engagements: audit, review, and compilation. Each is described in more detail below, but in summary, the audit is the most extensive effort and accordingly the highest cost to the organization.

An audit requires an examination of the financial statements in accordance with generally accepted auditing standards, including tests of the accounting records and other auditing procedures as necessary. An audit will result in a report expressing an opinion as to conformance of the financial statements to generally accepted accounting principles.

A review consists principally of inquiries of company personnel and analytical procedures applied to financial data. It is substantially less in scope than an examination using generally accepted auditing standards. Typically, a review will result in a report expressing limited assurance that there are not material modifications that should be made to the statements.

As part of a compilation engagement, an accountant will compile the financial statements based on management representations without expressing any assurance on the statements. A compilation will not meet this standard.

Examples

The scope of this independent examination will vary based on the accounting requirements to which the organization is subject. It may be a full audit or a review. The CPA or chartered accountant retained must be independent of the organization and may not represent the organization's funding sources or be a member of the governance authority.

For a governmental entity, this standard may be met by review within its own system of oversight.

1.F. 11. If the review or audit generates a management letter, the organization:

   a. Provides the letter during the survey for review.

   b. Provides management's response, including corrective actions taken or reasons why corrective actions will not be taken.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Annual approved budgets
- Reviews of financial plans
- Financial audits or reviews
- Written procedures for handling the funds of the persons served
- Documented reviews of records of persons served
- Fiscal policies
- Financial remediation plans, if appropriate
- Fee schedules, if applicable
- A management letter, if applicable
- Cost analysis of services provided

G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to its people, property, income, goodwill, and ability to accomplish goals.

1.G. 1. The organization implements a risk management plan that:

   a. Includes:

      (1) Identification of loss exposures.

      (2) Analysis of loss exposures.

      (3) Identification of how to rectify identified exposures.

      (4) Implementation of actions to reduce risk.

      (5) Monitoring of actions to reduce risk.

      (6) Reporting results of actions taken to reduce risks.

      (7) Inclusion of risk reduction in performance improvement activities.

   b. Is:

      (1) Reviewed at least annually for relevance.

      (2) Updated as needed.

Intent Statements

The risk management plan is designed to manage risk and reduce the severity of a loss if one were to occur.

Examples

There will be a range of risks in all organizations, regardless of whether they are a for-profit or a nonprofit organization. Risk management focuses on an in-depth assessment of these risks and what must or can be done as preventive measures, coping measures should the risk occur, measures to protect the organization and prevent loss, and corrective measures to prevent the risk of further occurrence.

1.a.(1) Identifying exposure highlights those risks that may cause a loss and those resources of value that may be affected. Potential risks

may include changes in funding, new or growing populations, problems with the organization's facilities or grounds, newly identified security issues, or internal procedures.

1.a.(2) Analyzing exposure (risk analysis) determines the potential frequency and severity of any identified risk, as well as the overall financial burden of aggregate losses.

1.a.(3) Once an exposure is analyzed, there are several methods available to deal with the potential loss:

■ Risk control through avoiding the exposure altogether (if possible), reducing the probability of loss, reducing the severity of the consequences if a loss were to occur, and/or transferring the loss to another organization through a contractual transfer.

■ Risk financing is done by either assuming the financial responsibility for the loss (through self-insurance) or by transferring it to an outside organization (through insurance).

1.a.(5) Monitoring measures and comparing actual versus planned performance of the selected techniques enables the organization to evaluate the plan and determine whether different options may be necessary.

1.G. **2.** **As part of risk management, the insurance package of the organization:**
  a. **Is reviewed:**
    (1) **For adequacy.**
    (2) **On an annual basis.**
  b. **Protects assets.**
  c. **Includes:**
    (1) **Property coverage.**
    (2) **Liability coverage.**
    (3) **Other coverage, as appropriate.**

Intent Statements

When effectively managed, insurance, whether third-party or self-insurance, can cover many tangible risks an organization faces.

Examples

Insurance is an important component of an organization's risk management strategy. Insurance policies provide adequate amounts and types of coverage for all aspects of the

organization's operations and protect and defend persons, such as personnel and board members, volunteers, and persons served, against reasonable claims due to adverse events for which the organization is liable. Types of coverage typically include vehicles, workers' compensation, directors' and officers' liability, errors and omissions, property, and casualty.

The organization conducts a regular review of its insurance coverage with the assistance of someone who is knowledgeable about insurance needs and types of coverage. This person may be an experienced insurance broker who is aware of the needs, risks, and assets of the organization.

1.G. **3.** **The program implements written procedures regarding communications that address:**
  a. **Media relations.**
  b. **Social media.**

Examples

Media relations procedures might include who may or may not talk to the media, whom to notify of requests for interviews, whom to contact after hours, use of press releases, or media relations philosophy.

Social media procedures might address the program's definition of social media, e.g., Facebook, Twitter, blogs, message boards; acceptable uses of social media; who has access and authority to post or modify information; privacy settings; parameters for communicating with persons served and prospective persons served; protection of health information; and how violations of the procedures will be managed.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Risk management plan
- Financial reports
- Performance improvement plans
- Insurance policies and documents
- Written procedures regarding media relations and social media
- Reports from regulatory agencies

H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Applicable Standards

All standards in this subsection apply to all organizations unless otherwise indicated. When determining applicability, please refer to the Glossary for the definitions of *administration* and *employee-owner*.

- 1.H.11. applies only to programs that provide transportation services for the persons served.

- 1.H.6., 1.H.12., and 1.H.13. apply only to programs with facilities that meet one or more of the following:
  - Regularly utilized by the organization for service delivery, unless the facility is:
    - owned or operated by a person or entity other than the organization; **and**
    - used by the organization one hour or less in any week
  - Regularly used by the organization for administration, unless the facility is used:
    - only by employee-owners; or
    - by less than the equivalent of one full-time employee in any week

1.H.   **1. The organization maintains a healthy and safe environment.**

Examples

The physical environment of the organization shows evidence of ongoing attention to safe practices, reduction of health and safety risks, and an overall concern for the health and safety of the persons served and personnel. Health and safety requirements are sometimes determined by local or other governmental authorities. Documentation of daily maintenance tasks is not required.

1.H. **2. The organization has written procedures to promote the safety of:**
   a. **Persons served.**
   b. **Personnel.**

Intent Statements

Regardless of setting, the organization must demonstrate satisfactory efforts to provide services as safely as possible and promote a safe work environment.

Examples

Written procedures could include the identification of personnel responsible for implementation of health and safety procedures.

1.H. **3. Persons served receive education designed to reduce identified physical risks.**

Examples

When safety concerns are identified for persons served, information and training relative to that risk is offered as a means to reduce risk and promote safety.

1.H. **4. Personnel receive documented competency-based training:**
   a. **Both:**
      (1) **Upon hire.**
      (2) **Annually.**
   b. **In the following areas:**
      (1) **Health and safety practices.**
      (2) **Identification of unsafe environmental factors.**
      (3) **Emergency procedures.**
      (4) **Evacuation procedures, if appropriate.**
      (5) **Identification of critical incidents.**
      (6) **Reporting of critical incidents.**
      (7) **Medication management, if appropriate.**
      (8) **Reducing physical risks.**

Examples

4.b. In addition to training on health and safety in an office setting, training is provided on an ongoing basis regarding the potential risks involved in working in community settings or a person's home. Training includes, but is not limited to, identification of potential risks, ways to prevent risks, and emergency procedures.

The organization develops comprehensive procedures to ensure that personnel can demonstrate their competency in the health and safety arena. Consideration for planning and training activities are a primary objective.

Some organizations have found it helpful to begin by assigning responsibility for developing a training plan. The plan considers the training and information needs of personnel, contractors, visitors, managers, and those with an emergency response role identified in the plan. The plan identifies for a 12-month period:

- Who will be trained.
- Who will do the training.
- What training activities will be used.
- When and where each session will take place.
- What the objectives of each session will be.
- How the session will be evaluated and documented.

Reviews are conducted after each training activity. Training participants are involved in the evaluation process.

Some activities organizations may consider using are:

- Orientation and Education Sessions—These are regularly scheduled to allow discussion, provide information, answer questions, and identify needs and concerns.
- Tabletop Exercise—Members of the emergency management group meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios. This is a cost-effective and efficient way to identify areas of overlap and confusion before conducting more demanding training activities.
- Walk-Through Drill—The emergency management group and response teams actually perform their emergency response functions. This activity generally involves more people and is more thorough than a tabletop exercise.

■ Functional Drills—These drills test specific functions such as medical response, emergency notifications, and warning and communication procedures and equipment, though not necessarily at the same time. Personnel are asked to evaluate the systems and identify problem areas.

■ Evacuation Drills—Personnel walk the evacuation route to a designated area where the procedures for accounting for all personnel are tested. As they evacuate, participants are asked to make notes of things they notice that might become possible hazards during a real emergency evacuation (such as stairways cluttered with debris or smoke in the hallways).

■ Full-Scale Exercise—A real-life emergency situation is simulated as closely as possible. This exercise involves the organization's emergency response personnel, employees, the management, and community response organizations.

Employee Training—General training for all employees addresses:

■ Individual roles and responsibilities.

■ Information about threats, hazards, and protective actions.

■ Notification, warning, and communication procedures.

■ Means for locating family members in an emergency.

■ Emergency response procedures.

■ Evacuation, shelter, and accountability procedures.

■ Emergency shutdown procedures.

The scenarios developed during the vulnerability analysis can serve as the basis for training events.

1.H. **5. There are written emergency procedures:**
   a. For:
      (1) Fires.
      (2) Bomb threats.
      (3) Natural disasters.
      (4) Utility failures.
      (5) Medical emergencies.
      (6) Violent or other threatening situations.
   b. That satisfy:
      (1) The requirements of applicable authorities.
      (2) Practices appropriate for the locale.
   c. That address evacuation, as follows:
      (1) When evacuation is appropriate.
      (2) Complete evacuation from the physical facility.
      (3) The safety of evacuees.
      (4) Accounting for all persons involved.
      (5) Temporary shelter, when applicable.
      (6) Identification of essential services.
      (7) Continuation of essential services.
      (8) Emergency phone numbers.
      (9) Notification of the appropriate emergency authorities.
      (10) Evacuation routes that are:
         (a) Accessible.
         (b) Understandable to:
            (i) Persons served.
            (ii) Personnel.
            (iii) Other stakeholders, including visitors.

Intent Statements

Established emergency procedures that detail appropriate actions to be taken promote safety in all types of emergencies.

Being prepared and knowing what to do help the persons served and personnel to respond in all emergency situations, especially those requiring evacuation. The evacuation process guides the personnel to assess the situation, to take appropriate planned actions, and to lay the foundation for continuation of essential services.

Examples

The procedures should include actions to be taken by personnel in the event of an emergency,

consider any unique needs of the persons served, and be appropriate and specific to the service delivery site or location.

Dependant on the type of emergency, the procedure could include immediate response, evacuation, use of appropriate suppression techniques, notification of the proper authorities, sheltering in place, and reporting requirements.

In developing emergency procedures the organization identifies critical products, services, and operations that may be impacted in an emergency and backup systems, internal capabilities, and external resources that may be needed or accessed.

5.c. Evacuation may be addressed in a separate procedure or incorporated into relevant emergency procedures such as those for fire and bomb threats. The procedures address the entire spectrum of an evacuation, including an evacuation when evacuees cannot return to the facility. The procedures for evacuation identify the responsibilities of personnel who may assist in the process of evacuation.

Procedures include a predetermined site for the gathering of all individuals upon evacuation. The evacuation plan considers not only the possible physical barriers of the facility, but also the individualized needs of those to be evacuated, such as persons with mobility impairments who will need assistance, or persons with cognitive, hearing or visual impairments. The temporary shelter considers the unique health, safety, and accessibility needs of persons served, to the extent possible. Procedures identify protocol to follow in the event that an incident may require movement to a temporary shelter.

Procedures include the process for notifying personnel if individuals are not present. Procedures may include protocols that provide direction to personnel if services will be curtailed.

5.a.(1) Procedures for fire safety can include how staff will be trained on the use of fire suppression equipment, etc.

5.c.(5) Temporary shelter is typically needed if the organization provides a residential/housing, inpatient, day treatment, or crisis stabilization program in which the persons served remain at the site for extended hours; overnight; or for several days, weeks, or months.

5.c.(6)–(7) Essential services may include the provision of medications, residential or other housing support services, or assistance with daily living requirements.

5.c.(10) Accessible evacuation routes may be supported by signage such as diagrams, Braille representation or text showing corridors and line of travel to exit doors. Accessibility of signage considers location and height of signage and other needs relative to the persons served and other stakeholders. Additionally, the exit ways should be clear of obstructions such as equipment, furniture or locked doors. Evacuation routes should not result in individuals getting to an unsafe location such as ungraded land, a rooftop with no opportunity for egress, or where emergency personnel cannot reach the individuals.

5.a.(3) The organization evaluates safety concerns related to possible natural disasters and their potential effects on the organization's staff members, the persons served, and property and develops procedures detailing action to be taken in the event of occurrence of a natural disaster. Possible natural disasters are those typical of a particular geographic location. They may include tornadoes, severe rainstorms, hurricanes, floods, earthquakes, blizzards, ice storms, and snowstorms.

5.a.(4) Procedures for utility failures may include use of an emergency generator system; emergency lighting systems; battery-operated flashlights, lanterns, or lamps; cell phones; and a contract with a vendor to supply bottled water.

5.a.(6) Violent or other threatening situations may include explosions, gas leaks, biochemical threats, acts of terrorism, and use of weapons.

Resources

Local Red Cross associations, federal and state/provincial/territorial regulations, city/municipal and county disaster preparedness groups, and many websites offer current and useful information in the development of emergency plans.

The Federal Emergency Management Agency (FEMA) is a national resource for education,

training, and emergency information in the United States. FEMA has established an emergency planning guide for business and industry. The guide provides advice for creating and maintaining an overall emergency management plan specific to each organization's corporate culture. In addition, there are resources on the internet. Try websites such as **www.fema.gov/about/divisions/cpg.shtm** (Developing and Maintaining Emergency Operations Plans–Comprehensive Preparedness Guide), **www.disability.gov/emergency_preparedness**, and **www.ada.gov/emergencyprepguide.htm** where free copies of emergency procedures may be requested that could be incorporated into your plans.

Other websites that are resources in developing emergency procedures are:

- **www.dhs.gov/files/programs/citizens-preparedness.shtm**
- **inclusivepreparedness.org**
- Occupational Safety and Health Administration at the United States Department of Labor **www.osha.gov/SLTC/emergencypreparedness/index.html**
- Office of Disability Employment Policy at the United States Department of Labor **www.dol.gov/odep/programs/emergency.htm**
- U.S. Department of Transportation **www.dotcr.ost.dot.gov/asp/emergencyprep.asp**
- Emergency Evacuation Preparedness Guide **www.cdihp.org/products.html**
- Disaster Resources for People with Disabilities and Emergency Managers **www.jik.com/disaster.html**
- Disaster Preparedness for People with Disabilities **www.disability911.com**
- National Organization on Disability **nod.org/disability_resources/emergency_preparedness_for_persons_with_disabilities**

- Amputee Coalition of America resources for emergency preparedness **www.amputee-coalition.org/nllic_easyread.asp** and special supplement to ACA InMotion When Disaster Strikes—a Pocket Survival Guide **www.amputee-coalition.org/inmotion/jan_feb_08/pocket_survival_guide.html**
- ❦ ■ The Disaster Recovery Information Exchange (DRIE) has chapters throughout Canada **www.drie.org**
- ❦ ■ Public Safety Canada **www.publicsafety.gc.ca**. Provincial or territorial emergency measures organizations can also be used as resources.
- ❦ ■ The Canadian Centre for Emergency Preparedness **www.ccep.ca**
- ❦ ■ The Canadian Red Cross **www.redcross.ca**

1.H. **6. Unannounced tests of all emergency procedures:**
  a. **Are conducted at least annually:**
    (1) **On each shift.**
    (2) **At each location.**
  b. **Include complete actual or simulated physical evacuation drills.**
  c. **Are analyzed for performance that addresses:**
    (1) **Areas needing improvement.**
    (2) **Actions to be taken.**
    (3) **Results of performance improvement plans.**
    (4) **Necessary education and training of personnel.**
  d. **Are evidenced in writing.**

NOTE: *This standard does not apply to Community Housing or Supported Living (as listed in the standards manuals for Behavioral Health, Child and Youth Services, and Employment and Community Services) provided in individual apartments.*

Intent Statements

Practicing emergency procedures helps the persons served and personnel to better respond in actual emergency situations. Simulated evacuations should be limited to situations where actual evacuations are not possible. Emergency procedure testing is part of an organization's

performance improvement activities. Analysis of results of the tests may indicate ways to improve performance. Tests must be conducted at all facilities regularly utilized by the organization.

Examples

Each emergency procedure (e.g., the procedure for fires, bomb threats, natural disasters, utility failures, medical emergencies, and other threatening situations) is tested annually at all locations that pertain to the service seeking accreditation whether they are service sites or administration only. A test or drill does not necessarily require actual evacuation, although evacuation is preferred, when possible. The test or drill should be realistic and occur at random on different shifts, if applicable to the organization.

All persons served within the agency or organization require some form of training. Procedures for training include:

- Assessments that determine the individual needs in the event of an emergency situation of persons served.
- Needed training activities for persons served.
- Assistance from local resources emergency planning resources.
- Random and shift drills, as determined by the needs of persons served.
- Simulation of a full-scale emergency evacuation annually or as determined by the needs of persons served.
- Documentation and reporting regarding exercises and analysis of training drills for modification, if needed.

Emergency procedures include formal annual audits. Evaluation considerations include:

- Involving a health and safety committee or planning team to evaluate and update the organization's emergency management procedure.
- Identifying need areas and vulnerability and addressing these issues.
- Emergency procedure lessons learned from drills and actual events.
- Ensuring that responsibilities and roles are understood by all persons on the emergency management team.

- Emergency procedures reflecting physical plant or practice changes.
- Up-to-date records.
- Ensuring that outcomes of training objectives are met.
- Ensuring that community resources are consulted with annual updates.
- Updating letters of agreement annually.

Procedures are considered for evaluation and modification during the following times:

- Training.
- After training drills.
- As risks increase.
- After actual emergencies.
- When responsibility is reassigned.
- When changes are made to the physical plant.
- When changes occur in the physical plant proximity.
- When a policy or procedure is revised.
- When briefing personnel on emergency plan changes.

Persons served, as appropriate, are educated and trained about emergency and evacuation procedures.

1.H. **7. There is immediate access to:**
   a. **First aid expertise.**
   b. **First aid equipment and supplies.**
   c. **Relevant emergency information on the:**
      (1) **Persons served.**
      (2) **Personnel.**

Intent Statements

It is important to provide a safe setting for the persons served and personnel. The adequacy of first aid expertise reflects the needs of the population served as well as the service setting. Necessary emergency resources, including people trained to respond and the location of first aid equipment and supplies, are known and quickly available during program hours.

Examples

The organization defines how it will have immediate access to first aid. This may be

accomplished by training key personnel in first aid. If in a school or medical or correctional setting, personnel within the program/service site could be used.

7.c. This standard gives the organization flexibility in determining the most accessible location for emergency information. The location could depend on the size of the program or the organization, staffing patterns, and the type of program or setting. The organization may collect such information in the personnel or administrative files, records of persons served, a notebook, or a special file. In an inpatient or residential setting, it would be appropriate for the information to be in a format that could be removed from the site when an evacuation is necessary.

This is information that might be needed if personnel or a person served has an emergency and may include information on medical conditions, emergency contact persons, a primary care doctor, allergies, or the use of medications or assistive devices. If the persons served are transported for group activities or services, a summary of this information is available to the personnel overseeing the outing.

1.H. **8.** **The organization has written procedures regarding critical incidents that include:**
   a. **Prevention.**
   b. **Reporting.**
   c. **Documentation.**
   d. **Remedial action.**
   e. **Timely debriefings conducted following critical incidents.**
   f. **The following incidents, if appropriate:**
      (1) **Medication errors.**
      (2) **Use of seclusion.**
      (3) **Use of restraint.**
      (4) **Incidents involving injury.**
      (5) **Communicable disease.**
      (6) **Infection control.**
      (7) **Aggression or violence.**
      (8) **Use and unauthorized possession of weapons.**
      (9) **Wandering.**
      (10) **Elopement.**
      (11) **Vehicular accidents.**
      (12) **Biohazardous accidents.**
      (13) **Unauthorized use and possession of legal or illegal substances.**
      (14) **Abuse.**
      (15) **Neglect.**
      (16) **Suicide or attempted suicide.**
      (17) **Sexual assault.**
      (18) **Other sentinel events.**

Intent Statements

Although an organization is expected to have procedures that include all of the types of critical incidents listed in this standard, it would be possible for a procedure to adequately address more than one type of critical incident. An organization is not required to have a separate procedure for each type of incident as long as all critical incidents are appropriately considered.

Examples

The organization follows legal requirements regarding investigation and the reporting of incidents to the proper authorities. Reporting requirements can be obtained from licensing agencies, protection and advocacy services, and funding sources.

Policy is developed that includes the procedures in place for determining what constitutes a critical incident, how investigations are to be conducted, how documentation is to be completed, who is responsible for completing documentation, who is to be notified, and where written documentation of incidents is to be kept.

Regulations and/or policy may require documentation of what is considered a "near miss," in which serious consequences were avoided, but which would require review in order to promote a safer environment. This is a concept being effectively used by some organizations.

A training system is put in place to ensure that all personnel are trained in, and aware of, the reporting requirements. Due to the importance of this information, an organization may choose to make this training part of all employees' initial orientation and annual training. It may be helpful to document the completion of the training in an employee's personnel file and review the

information at the time of the employee's annual review.

The reporting of critical incidents is essential. Reporting ensures that information is communicated and that significant events that could jeopardize the health and safety of participants and personnel are documented.

A critical incident form can be developed so that all necessary information about the incident is included. Information to include on the incident form includes the date, time, and location of the incident; who was involved; what led to the incident; a description of what happened; the consequences of the incident; witnesses; who was notified; and follow-up recommendations. Personnel completing the form are to provide descriptive and factual information.

The organization determines and develops a policy determining what format and where the documentation of incidents is to be maintained. Licensing agencies view critical incident reports as confidential legal documents and require them to be stored in a secure area. Time lines regarding how long documentation of critical incidents must be kept are also typically set by licensing agencies.

An organization may be required to store incident reports in the records of the persons served, an incident file, etc. An incident log may also be kept to summarize causes and trends of incidents at a glance.

Software programs are being used by some organizations to ensure more consistency in documentation and to facilitate analysis.

As applicable, organizations should note requirements of:

■ Child abuse and neglect laws.

■ Vulnerable adult regulations.

■ In a correctional facility in the United States, the federal "Prison Rape Elimination Act of 2003."

8.f.(13) This includes use or possession of any licit substance that is in violation of the organization's policies and procedures.

1.H. **9.** **A written analysis of all critical incidents is provided to or conducted by the leadership:**
   a. **At least annually.**
   b. **That addresses:**
      (1) **Causes.**
      (2) **Trends.**
      (3) **Actions for improvement.**
      (4) **Results of performance improvement plans.**
      (5) **Necessary education and training of personnel.**
      (6) **Prevention of recurrence.**
      (7) **Internal reporting requirements.**
      (8) **External reporting requirements.**

Intent Statements

An integrated approach to the management of critical incidents is essential to effective risk management.

Examples

This report is a critical component to the concept of prevention in both risk management and performance improvement activities. In order to determine the causes and trends of critical incidents, an organization first develops a procedure that indicates how frequently reviews are to be conducted and the persons or positions responsible for the reviews.

Critical incidents may be reviewed by one or more committees to ensure that a thorough analysis is completed. An organization may develop a safety committee responsible for reviewing all incidents involving accidents, injuries, illnesses, and "near miss" events. A well-rounded committee would include members from the medical, administration, transportation, social services, human resources, and training and development departments.

An organization may also develop a human rights committee to review critical incidents. Members of this committee would benefit from a background in behavior analysis and client rights. This committee would review all critical incidents to determine antecedents, changes in client behavior, the influence of personnel interactions and interventions, the need for

environmental modifications, that client rights are upheld, and that individuals are treated with dignity and respect.

Regardless of who reviews critical incidents, a thorough analysis includes the following:

■ A determination of the cause of each incident. Did the incident occur as the result of an environmental flaw, a lack of personnel training factors, or a failure to follow the organization's policies and procedures?

■ Identification of trends in critical incidents. Are common themes emerging in the incident reports? An examination of trends evaluates the location of critical incidents, the time of incidents, the personnel involved in incidents, the involvement of persons served in incidents, the types of incidents, methods of intervention, etc.

■ The purpose of the above analysis is to enable the development of actions for improvement to prevent similar events from occurring in the future. Once an analysis of the incidents has been completed, the committee members are responsible for making recommendations and determining actions that the organization needs to take to improve the areas identified.

Recommendations may include environmental modifications, additional personnel training, changes in policies and procedures, and other actions. The designated committee revisits recommendations at its next meeting to evaluate the results of the actions taken for improvement, ensuring that the recommended changes that have been made were effective.

Meeting minutes are completed for each committee meeting. Minutes are shared with those in all areas affected by the committee's recommendations to ensure communication of need areas, as well as provide documentation of need.

9.b.(7)–(8) Regulations with regard to the reporting of an incident to the appropriate personnel may vary. Some incidents may involve issues that are internal to the operation of the organization and that are reported only to the appropriate supervisors. However, incidents of neglect, abuse, or death must be reported to the appropriate external authorities, as required by state, regional, or provincial/territorial law.

1.H. **10. The organization implements procedures:**
    a. **For:**
        (1) **Infection prevention.**
        (2) **Infection control.**
    b. **That include:**
        (1) **Training regarding:**
            (a) **Infections.**
            (b) **Communicable diseases.**
        (2) **Appropriate use of standard or universal precautions.**
        (3) **Guidelines for addressing these procedures with:**
            (a) **Persons served.**
            (b) **Personnel.**
            (c) **Other stakeholders.**

Intent Statements

The persons served, personnel, and other stakeholders should be provided with training based on individual needs. Each organization is encouraged to check legal and regulatory requirements regarding the use of standard or universal precautions in the programs provided and with the populations served.

Examples

The organization could provide staff education on universal precautions, hand washing technique, the use of alternative cleansing solutions, or the use of aseptic techniques. Posted signs, items in the newsletter, or other means could be used to educate family members, volunteers and other visitors about preventing the spread of infection. The organization could have surveillance activities for monitoring and trending acquired infections. A written infection control plan and other policies could be developed to include surveillance, isolation and precautions, health of persons served, employee health, education, antibiotic usage and resistance, and HIV-related issues.

10.b.(2) Each organization is encouraged to check legal and regulatory requirements regarding the use of standard or universal precautions in the programs provided and with the populations served. Laws and regulations vary by state and by program type.

10.b.(3)(a) The persons served will be provided with training based on individual needs such as risk-taking behavior, drug use, long-term involvement in services, or greater potential risk of exposure.

Education for the persons served regarding the prevention and control of infection or communicable diseases can occur during orientation, in individual and group sessions, and through provision of written materials.

Resources

Resources used in the development of infection control plans could include the Centers for Disease Control **www.cdc.gov**, the Association for Professionals in Infection Control and Epidemiology **www.apic.org**, the Public Health Agency of Canada **www.phac-aspc.gc.ca**, the Community and Hospital Infection Control Association of Canada (CHICA-Canada) **www.chica.org**, or state or provincial/territorial departments of health outbreak manuals.

1.H. 11. When transportation is provided for persons served there is evidence of:

   a. Appropriate licensing of all drivers.

   b. Regular review of driving records of all drivers.

   c. Insurance covering:

   (1) Vehicles.

   (2) Passengers.

   d. Safety features in vehicles.

   e. Safety equipment.

   f. Accessibility.

   g. Training of drivers regarding the organization's transportation procedures.

   h. Written emergency procedures available in the vehicle(s).

   i. Communication devices available in the vehicle(s).

   j. First aid supplies available in the vehicle(s).

   k. Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations.

   l. If services are contracted:

   (1) An annual review of the contract against elements a. through k. of this standard.

   (2) Knowledge by drivers of the unique needs of the persons served.

Intent Statements

Transportation for the persons served is provided in a safe manner consistent with the regulations of the local authorities. This standard will apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

Examples

11.a. Verification of driver's licenses occurs on all personnel, including volunteers, who provide transportation for persons served.

11.b. The review of driving records includes identified criminal record checks on persons providing transportation for children, adolescents, or vulnerable adults in addition to the review of driving records. The organization sets its own parameters regarding acceptability of driving records and determines the most opportune time to secure this information. It should, however, adhere to a time frame that ensures that a review is ongoing.

11.e. If an organization transports infants and children, the intent of this standard includes the use of age-appropriate restraining devices secured in the vehicles.

11.h. The written procedures for handling emergencies include roadside emergencies and individual emergencies that may occur during operation of the vehicle.

11.j. If personal vehicles are used to transport persons served, the organization might consider stocking a safety bag or kit with supplies that could be picked up whenever a personal vehicle is used.

1.H. **12.** **Comprehensive health and safety inspections:**
  a. **Are conducted:**
    (1) **At least annually.**
    (2) **By a qualified external authority.**
  b. **Result in a written report that identifies:**
    (1) **The areas inspected.**
    (2) **Recommendations for areas needing improvement.**
    (3) **Actions taken to respond to the recommendations.**

Intent Statements

Annual external inspections are completed to enhance and maintain the organization's health and safety practices. External inspections must include all facilities regularly utilized by the organization.

Examples

External inspection by a compliance/safety officer may include:

■ A representative of the fire department.

■ A representative of a local health department.

■ A licensed or registered safety engineer.

■ A representative of a state, provincial/territorial, or federal agency that provides OSHA, health, or physical plant inspections on a consultative or licensing basis. In Canada, this could include a representative from a provincial/territorial body designated under legislation related to workplace safety.

■ An engineer involved in industrial operations. This person is knowledgeable regarding the health and safety requirements applicable to the services provided.

■ A plant engineer or safety specialist.

■ A safety consultant who represents the organization's fire or workers' compensation carrier or who is in private practice.

■ An industrial health specialist.

■ A representative of the organization's insurance carrier or a private insurance carrier.

In those instances in which the program is provided by a unit of a larger entity, such as a hospital, the larger entity's safety engineers or other personnel are not considered external authorities. External means external to the entire system, not just to a unit of the organization. Exceptions include some settings such as Veterans Health Administration or Veterans Affairs Canada sites, other federal or tribal programs, and government-owned organizations where certain functions may be conducted by departments within the larger organization.

In these instances, the organization should contact the CARF office. Any external authority used by the organization (e.g., a representative of a licensure body) should be recognized and credentialed as such (e.g., a licensed or registered safety engineer or risk management authority).

The externally conducted inspections may include inspections of:

■ Emergency warning devices, means of egress, and emergency plans.

■ Operations involving hazardous materials and processes, including the safe and effective management of biohazardous materials.

■ Heating and cooling systems.

■ Walking and working surfaces.

■ Electrical systems.

■ Health and sanitation provisions with regard to food preparation, eating areas, and air contaminants.

■ The working environment, including ventilation, illumination, noise, and air contaminants.

■ Structural integrity of facility.

■ The provisions for fire protection to ensure that they are in accordance with applicable state, provincial/territorial, and local fire safety requirements.

■ Operation of machinery.

12.a.(1) One comprehensive external inspection is the minimum requirement of the standard. This inspection may be conducted in a single, uninterrupted process that moves methodically and comprehensively through an entire program area or physical location, or the organization may have several external inspections conducted that together constitute a comprehensive inspection

of all areas relevant to the operation of its programs or services.

1.H. **13.** **Comprehensive health and safety self-inspections:**

   a. **Are conducted at least semi-annually on each shift.**

   b. **Result in a written report that identifies:**

      (1) **The areas inspected.**

      (2) **Recommendations for areas needing improvement.**

      (3) **Actions taken to respond to the recommendations.**

Intent Statements

Regular self-inspections help personnel to internalize current health and safety requirements into everyday practices. Self-inspections must include all facilities regularly utilized by the organization.

Examples

A self-inspection is defined as one that is conducted by individuals or groups within the organizational structure. This includes professional personnel or internal groups who have received training in conducting inspections. Internal groups include safety committees, safety circles, or operation teams. Anyone within the organizational structure, such as managers, supervisors, direct service employees, and maintenance personnel, may participate in a self-inspection.

The purpose of self-inspections is to identify and correct existing workplace hazards and to determine whether regulatory standards are being met. A good practice for self-inspection is to use the same format and criteria as the external authority. A self-inspection can also be used to keep the organization ready for compliance inspections by external regulatory agencies. Ongoing evaluations are the key to continuous improvement. Because personnel are more readily available than outside parties to participate in ongoing evaluation, self-inspections figure prominently in the overall organizational health and safety audit plan and schedule.

The self-inspections should cover all applicable areas, including as appropriate:

- Heating and cooling systems.
- Electrical systems.
- Emergency warning devices.
- Walking and working surfaces.
- Ingress and egress.
- Health and sanitation related to:
  - Food preparation.
  - Eating areas.
  - Restrooms.
- Structural integrity of facility.
- Storage of hazardous materials.
- Fire protection systems and equipment.
- Air contaminants and ventilation.
- Recreation/visitation areas.
- Other areas appropriate to the services provided.

A small site may be fully evaluated in a single inspection, while inspection of a larger facility might need to be conducted in phases. Health and safety inspection plans are scheduled for the entire workplace twice a year.

Knowing when, where, and how specific safety policies and programs are succeeding or failing is crucial to continuous improvement. Thorough and objective evaluation of the overall health and safety program requires that an inspection be completed on each shift with a sample of staff members. Management needs to identify if employees and persons served are adhering to established health and safety policies and procedures. Regular inspections help determine if safety practices are being followed at each site and on each shift.

Any inspection process is incomplete until its findings have been reported to and acted on by management in a timely and meaningful manner. Management establishes standards for inspection reports and procedures for follow-up that facilitate improvement. Each inspection process concludes with a report that identifies areas covered in the inspection. Reported areas of noncompliance cite regulatory standards and describe the physical hazard, unsafe work

practice, or other area for improvement, in specific terms.

The report goes beyond the description of inspection details. The report includes the factors causing each deficiency, an evaluation of when and where similar hazards or deficiencies may exist, and guidelines for responding to them, which could include interim corrective measures.

Management or the designated personnel then develop an action plan for improvement. The action plan assigns a person or group as responsible and accountable for execution of the written plan of corrective action. The action plan identifies the specific hazards or deficiencies discovered in the inspection and conditions that could cause problems throughout the facility.

Management requires complete reports from the personnel accountable for follow-up to ensure that the action plan is being implemented. Evaluation and assessment of the outcomes of corrective actions are monitored so that the desired goals are being attained.

1.H. **14. If applicable, there are written procedures concerning hazardous materials that provide for safe:**
   a. Handling.
   b. Storage.
   c. Disposal.

Examples

Hazardous materials could include biohazardous substances, industrial strength cleaning supplies, oil-based paints, fluorescent light bulbs, copier toner, and computer monitors.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Safety policies and procedures
- Written emergency procedures
- External inspection reports
- Self-inspection reports, including response to recommendations
- Written emergency transportation procedures
- Copies of inspection reports conducted by competent external authorities
- Documentation of response to external inspection reports
- Written procedures regarding critical incidents
- Copies of incident reports, if applicable
- Written annual analysis of all critical incidents
- Procedures for the prevention and control of communicable diseases
- Procedures for the use of standard or universal precautions
- Documentation of provision of competency-based safety training for personnel
- Written procedures regarding the handling, storage, and disposal of biohazardous waste materials
- Evacuation route signage
- Written evidence of unannounced tests of all emergency procedures

I. Human Resources

Description

CARF-accredited organizations demonstrate that they value their human resources. It should be evident that personnel are involved and engaged in the success of the organization and the persons they serve.

1.I.   **1. There are an adequate number of personnel to:**

    a. Meet the established outcomes of the persons served.

    b. Ensure the safety of persons served.

    c. Deal with unplanned absences of personnel.

    d. Meet the performance expectations of the organization.

Intent Statements

Personnel may be employed full- or part-time, by contract, or other arrangement.

Examples

Required and needed staffing levels are maintained, and personnel turnover does not have a negative impact on the delivery of quality services and supports. No ratios are established by CARF for the number of persons served to the number of personnel. Sufficient backup is available in the event of personnel absences. The backup personnel plan is sufficient to allow minimal impact on the delivery of services and supports.

The organization's performance outcomes system can be used to measure the staffing pattern needs and configurations. See related standards in Sections 1.M. and 1.N. regarding the collection of effectiveness and efficiency data, the analysis of data for planning implications, and the use of information from performance reports to guide decision making related to resource allocation and personnel development.

1.I.   **2. The organization implements written procedures that address:**

    a. Verification of:

      (1) Backgrounds of personnel in the following areas, if required:

        (a) Criminal checks.

        (b) Immunizations.

        (c) Fingerprinting.

        (d) Drug testing.

      (2) The credentials of all applicable personnel (including licensure, certification, and registration) with primary sources.

    b. Time frames for verification of backgrounds and credentials, including:

      (1) Prior to the delivery of services to the persons served or to the organization.

      (2) Throughout employment.

    c. Actions to be taken in response to the information received concerning:

      (1) Background issues.

      (2) Credentials verification.

Intent Statements

Primary source verification can occur when credentials are initially earned, at the time of hire, or for existing personnel, prior to an accreditation survey. Copies of licenses/credentials provided directly by personnel do not meet the primary source verification requirement. When the licensing authority requires and verifies the education required for the license, evidence of licensing from the licensing authority as the primary source will also serve as evidence that the education has been verified.

2.b. Time frames are established by external authorities or in their absence by the organization.

Examples

Evidence of procedures for the verification of credentials may include documentation such as a standard form or checklist that is used by designated personnel who are responsible for obtaining verification of credentials or current licensure and other employee information.

2.a.(1)(a) CARF standards require criminal background checks for personnel providing direct services to children or adolescents.

2.a.(2) High school diplomas do not need primary source verification, but college degrees, when required for the position and not verified through a licensing authority would need to be verified with primary sources. Verbal, written, or electronic confirmation of credentials (including degrees) from state, provincial/territorial, or national boards; schools or institutions; and/or trade associations, or verification through a credential verification organization is required. Evidence of procedures for the verification of credentials may include documentation such as a standard form or checklist that is used by designated personnel who are responsible for obtaining verification of credentials or current licensure and other employee information. Designated personnel may obtain documentation through a variety of means, including the following:

■ An original letter or copy of a letter from the appropriate credentialing, licensing, or certification board.

■ A copy of a webpage listing (for those situations where verification is actually completed online or through the internet by checking a listing of licensed/certified personnel).

■ A copy of the license or certification provided by the credentialing organization.

■ A phone log or other notation made by an individual responsible for conducting primary source verification.

2.c. The organization has procedures in place in the event that credentials cannot be verified. Continued employment can be contingent upon positive verification for some positions; however, the organization makes the determination of when this should occur.

1.I. **3.** **The organization demonstrates:**
   a. **Recruitment efforts.**
   b. **Retention efforts.**
   c. **Identification of any trends in personnel turnover.**

Intent Statements

It is important to recruit and retain qualified personnel. Personnel turnover is problematic for the persons served and for the continued good business practices of the organization.

Examples

3.c. Turnover trends may be identified through exit interviews, climate surveys, salary surveys, or vacancy ratios.

1.I. **4.** **The organization:**
   a. **Identifies the competencies needed by personnel to:**
      (1) **Assist the persons served in the accomplishment of their established outcomes.**
      (2) **Support the organization in the accomplishment of its mission and goals.**
   b. **Assesses the current competencies of personnel at least annually.**
   c. **Provides resources to personnel for professional development.**

Examples

4.c. A variety of techniques may be used, such as holding staff meetings focused on theoretical concepts, presenting training films or guest speakers, or reviewing other reference materials, which could include books, articles, professional journals, magazines, newspapers, and internet access. The type of information will vary depending on the nature of the services provided.

1.I. **5.** **The organization provides documented personnel training:**
   a. **At:**
      (1) **Orientation.**
      (2) **Regular intervals.**
   b. **That addresses, at a minimum:**
      (1) **The identified competencies needed by personnel.**
      (2) **Confidentiality requirements.**
      (3) **Customer service.**
      (4) **Diversity.**
      (5) **Ethical codes of conduct.**

(6) Promoting wellness of the persons served.

(7) Person-centered practice.

(8) Personal privacy.

(9) Reporting of:

(a) Suspected abuse.

(b) Suspected neglect.

(10) Rights of the persons served.

(11) Rights of personnel.

(12) Unique needs of the persons served.

Intent Statements

In addition to training that occurs at or near the time of hire, training may occur following revisions to policies and procedures, during times of high turnover, and when new programs or services are added or new populations served.

5.b.(2) The confidentiality of the person served is protected by state, provincial/territorial, and federal laws. Personnel need training in these regulations so that they may demonstrate knowledge of and conformance to the laws related to confidentiality.

5.b.(4) Training related to diversity is directed toward promoting competency of personnel in working with culturally or otherwise diverse populations. An organization might integrate training on diversity as a component of all the training it conducts.

5.b.(5) Training on ethical codes of conduct can include professional and business ethics and/or specific ethical or conduct-related issues that the organization risks facing or has faced.

Examples

5.a.(1) The organization ensures that personnel who are new to a program are adequately trained prior to their providing direct services. A variety of techniques may be used, such as holding staff meetings focused on theoretical concepts, presenting training films or guest speakers, or reviewing other reference materials, which could include books, articles, professional journals, magazines, newspapers, and internet access.

5.b.(4) Training in cultural competency could be one of the ways to address diversity.

5.b.(6) Orientation and training for personnel on promoting wellness of the persons served might include topics such as special equipment, technology, and support services that would allow the persons served to remain active in their communities of choice; special health considerations and screenings that might be appropriate to the needs of persons served; how to assist persons served to gain increased knowledge and capability to manage their own health and advocate for their health needs; and information on advocacy groups and other resources they might access.

5.b.(7) Person-centered practice may also include family-centered services when applicable.

1.I. **6. Performance management includes:**

a. Job descriptions that are:

(1) Reviewed annually.

(2) Updated as needed.

b. Performance evaluations for all personnel directly employed by the organization that are:

(1) Based on:

(a) Job functions.

(b) Identified competencies.

(2) Evident in personnel files.

(3) Conducted:

(a) In collaboration with the direct supervisor.

(b) With evidence of input from the personnel being evaluated.

(4) Used to:

(a) Assess performance related to objectives established in the last evaluation period.

(b) Establish measurable performance objectives for the next year.

(5) Performed annually.

c. Reviews of all contract personnel utilized by the organization that:

(1) Assess performance of their contracts.

(2) Ensure that they follow all applicable policies and procedures of the organization.

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(3) Ensure that they conform to CARF standards applicable to the services they provide.

(4) Are performed annually.

Intent Statements

Evaluation of employees is an essential part of performance management. However, evaluation is not practical when there is no independent oversight authority. Accordingly, Standards 6.b.(1)–6.b.(5) do not apply to employees without individual or board supervision, or who are supervised by a board controlled by the employee or his or her family. For example, an unincorporated sole practitioner is exempt, as is a sole direct service professional who is the organization's only shareholder.

Examples

Job descriptions typically include job qualifications, the reporting supervisor, positions supervised, and position expectations. Job descriptions are kept current as positions change.

Performance evaluations are also a critical component of personnel success. It should be evident that personnel have been engaged actively in the evaluation process and have established performance goals for the next year.

6.c.(3) A good practice for a contract is to include the specific standards that the contracted professional or organization is to fulfill.

1.I. **7. If students or volunteers are used by the organization, there is a system of management that includes:**

 a. A signed agreement.

 b. Identification of:

  (1) Duties.

  (2) Scope of responsibility.

  (3) Supervision.

 c. Orientation.

 d. Training.

 e. Assessment of performance.

 f. Policies and written procedures for dismissal.

 g. Confidentiality policies.

 h. Background checks, when required.

Intent Statements

Students and volunteers play a role in many CARF-accredited organizations. The critical components identified in the standard assist the organization with decreasing its risk.

1.I. **8. The organization implements personnel policies that:**

 a. Are:

  (1) Accessible to applicable personnel.

  (2) Reviewed annually.

  (3) Updated as needed.

 b. Address, at a minimum:

  (1) Employee relations, including:

   (a) Grievance and appeal procedures for all personnel.

   (b) Disciplinary action.

   (c) Termination.

  (2) Employee selection, including:

   (a) Promotions.

   (b) Job postings.

  (3) Nondiscrimination in the areas of:

   (a) Employment.

   (b) Compensation.

   (c) Assignment of work.

   (d) Promotion.

Intent Statements

This standard does not require that each staff member be given a copy of the personnel policies, but it does require that each staff member has access to the personnel policies. Evidence that the personnel policies are provided or available to staff members does not have to be in writing.

8.b.(1)(a) The intent of this standard is that all personnel within an organization have access to an identified mechanism through which they may express concerns.

Examples

8.b.(1)(a) Procedures may vary for different types of personnel policies, union contracts, individual contract language, or governmental laws or regulations.

8.b.(2)(a)–(b) To retain personnel, it is important that there be good overall management of the employee evaluation and selection process, which includes the possibility of promotion or change in job functions. If a job is available, personnel know where it will be posted and are clear on whether there is a possibility of promotion from within the organization.

8.b.(3) Demonstration of nondiscrimination may include:

- An affirmative action or employment equity plan that demonstrates the organization's attempts to identify and solicit applications from members of equity target groups and protected classes.

- Published statements regarding equal employment opportunities and affirmative action.

- Evidence of contacts with public or private employment agencies soliciting qualified applicants who are members of equity target groups and protected classes.

- Other areas in which the organization demonstrates nondiscrimination, in addition to race, ethnicity, religion, disability, gender, sexual orientation, age, nation of origin, and other protected classes, including the persons served.

8.a.(2) In a publicly operated organization, the relationships between the individual staff members or elected representatives and the public agency as their employer may be governed by personnel policies, regulations, and procedures established either by the same public agency or by another public agency and not by the organization. Human resource policies may also include union contracts or may be identified in statute, administrative rule, or other governmental document. In either of these examples, the organization may have no ability to influence the content or the time lines of the review of the personnel policies and may be limited to only providing input.

1.I. **9. As applicable, the organization demonstrates a process that addresses the provision of services by personnel that are consistent with relevant:**
   a. **Legislation governing practices.**
   b. **Licensure requirements.**
   c. **Registration requirements.**
   d. **Certification requirements.**
   e. **Professional degrees.**
   f. **Professional training to maintain established competency levels.**
   g. **On-the-job training requirements.**
   h. **Professional standards of practice.**

Intent Statements

The organization verifies and ensures personnel provide services in accordance with relevant external or internal requirements and education.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written primary source verification
- Personnel policies
- Organizational chart
- Identification of personnel turnover rates
- Complete personnel records
- Record of initial and subsequent verification of credentials
- Signed agreements with and policies and written procedures for dismissal of volunteers, interns, etc.
- Record of the assessment of personnel training needs
- Record of initial and ongoing competency-based training
- Annual performance evaluations of all personnel directly employed by the organization
- Job descriptions
- Review of all contract personnel

J. Technology

Description

CARF-accredited organizations plan for the use of technology to support and advance effective and efficient service and business practices.

1. The organization implements a technology and system plan:
   a. **That includes:**
      (1) **Hardware.**
      (2) **Software.**
      (3) **Security.**
      (4) **Confidentiality.**
      (5) **Backup policies.**
      (6) **Assistive technology.**
      (7) **Disaster recovery preparedness.**
      (8) **Virus protection.**
   b. **To support:**
      (1) **Information management.**
      (2) **Performance improvement activities for:**
         (a) **Program/service delivery.**
         (b) **Business functions.**

Intent Statements

Information technology is an integral part of business strategies and practices. It is critical for organizations to proactively plan and take measures to avoid potential threats and ensure uninterrupted access to systems.

An organization should consider, as part of its technology and system planning, how it can use various types of technology to manage information and support its various improvement activities.

Examples

Most organizations have some form of information technology. If an organization did not have any technology, this written plan would address how the organization was strategically moving in that direction. A system could be a single desktop or a network of multiple computers. The organization's technology personnel, if applicable, should be involved in the development of the plan.

The organization assesses its use of technology to:

- Enhance individual services.
- Improve efficiency of personnel.
- Improve productivity of personnel.
- Communicate with stakeholders.
- Improve services to isolated populations, when applicable.

The organization may review its need to use or increase its use of the telephone, the internet, or telepsychiatry in order to better serve persons who are geographically or otherwise isolated.

1.a.(5) Backup of electronic records occurs regularly in relation to the organization's use of electronic systems, including security in case of a fire or other destruction.

Backup of electronic systems may occur to a server that is located in another building, to a network system, or to a portable disk or other format that is taken off site.

2. If the organization provides services via the internet, the organization provides for:
   a. **Security of personal information.**
   b. **Alternative access formats.**
   c. **Accessibility and accommodations.**
   d. **A user-friendly interface.**
   e. **Online information 24 hours a day, 7 days a week.**
   f. **Personnel to provide assistance with accessing services provided by the organization.**
   g. **Connections or links with local service providers or affiliates for personal contact and information.**

Intent Statements

This standard applies only if the program directly provides services through the internet. Using the internet for communication purposes only does not qualify as providing services via the internet.

Examples

It is important for organizations in the United States to pay particular attention to Health Insurance Portability and Accountability Act (HIPAA)

requirements as they relate to the transmission of protected health information (PHI) over the internet. Canadian organizations need to pay attention to the requirements of the Personal Information Protection and Electronic Documents Act (PIPEDA) and provincial/territorial freedom of information and protection of privacy legislation.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Technology and system plan
- Backup policies
- Performance improvement plans

K. Rights of Persons Served

Description

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

1.K. **1. The rights of the persons served are:**
   a. **Communicated to the persons served:**
      (1) **In a way that is understandable.**
      (2) **Prior to the beginning of service delivery or at initiation of service delivery.**
      (3) **Annually for persons served in a program longer than one year.**
   b. **Available at all times for:**
      (1) **Review.**
      (2) **Clarification.**

Intent Statements

To ensure that the persons served have a clear understanding of their rights, the organization communicates and shares these rights in a manner that is understandable to the persons served.

Examples

The amount of information provided may vary depending upon the type of service (i.e., crisis intervention or stabilization) or the condition of the person served (e.g., someone admitted for detoxification). The method used for communication should reflect the needs of the person served and may include verbal presentation, large print, translation into a different language, a consumer handbook, or use of a representative for the person served.

1.K. **2. The organization implements policies promoting the following rights of the persons served:**
   a. **Confidentiality of information.**
   b. **Privacy.**

c. Freedom from:

   (1) **Abuse.**

   (2) **Financial or other exploitation.**

   (3) **Retaliation.**

   (4) **Humiliation.**

   (5) **Neglect.**

d. **Access to:**

   (1) **Information pertinent to the person served in sufficient time to facilitate his or her decision making.**

   (2) **Their own records.**

e. **Informed consent or refusal or expression of choice regarding:**

   (1) **Service delivery.**

   (2) **Release of information.**

   (3) **Concurrent services.**

   (4) **Composition of the service delivery team.**

   (5) **Involvement in research projects, if applicable.**

f. **Access or referral to:**

   (1) **Legal entities for appropriate representation.**

   (2) **Self-help support services.**

   (3) **Advocacy support services.**

g. **Adherence to research guidelines and ethics when persons served are involved, if applicable.**

h. **Investigation and resolution of alleged infringement of rights.**

i. **Other legal rights.**

Intent Statements

To demonstrate relevant service delivery and appropriate ongoing communication with the persons served, the organization implements a system of rights that nurtures and protects the dignity and respect of the persons served. All information is transmitted in a manner that is clear and understandable.

Examples

2.a. In a behavioral health setting, the policies address the sharing of confidential billing, utilization, clinical, and other administrative and service-related information and the operation of any internet-based services that may exist. Information that is used for reporting or billing is shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the federal rules for addiction treatment programs (42 CFR) and HIPAA in the United States. Organizations need to pay particular attention to handling of PHI.

In Canada, the regulatory requirements may be found in:

- The federal Personal Information Protection and Electronic Documents Act (PIPEDA). In some provinces/territories, for example British Columbia, Alberta, and Quebec, the federal government has exempted organizations from PIPEDA because substantially equivalent provincial legislation is in place.

- Provincial legislation dealing with freedom of information and protection of personal information in the public sector.

- Legislation that deals specifically with health information in those provinces/territories that have such legislation.

The parameters of confidentiality may identify items that may or may not be disclosed without authorization for the release of information as well as those areas identified in mandatory disclosure laws and regulations. Confidentiality may be limited in such settings as criminal justice or when providing services to someone who demonstrates a risk to self or others.

When developing its confidentiality policy, the organization takes into consideration staff use of email, texting, blogging, and common forums such as Facebook and Twitter for work or work-related communication.

2.c. The organization ensures that the person served is protected from physical, sexual, psychological, and fiduciary abuse; harassment and physical punishment; and humiliating, threatening, or exploiting actions. Sexual abuse or harassment may include any gestures, verbal or physical, that reference sexual acts or sexuality or objectify the individual sexually. Fiduciary abuse refers to any exploitation of the persons served for financial gain. This abuse could include misuse of the funds of the persons served

or taking advantage of the provider relationship with the person served.

2.d. The persons served are provided with information pertaining to immediate, pending, and potential future treatment needs. Information is offered in a manner that is clear and understandable, with risks identified when applicable. In short-term care settings, the information may be provided verbally, with some written literature available. In longer-term programs, the information may be provided verbally, through educational or wellness workshops/sessions, through the distribution of literature, and through active participation in team meetings and treatment planning.

2.d.(2) The policy identifies how persons served can access their own record either visually or by obtaining a hard copy. It is expected that requests would be addressed in a timely manner. In lieu of laws or regulations that are more specific, a reasonable time frame would generally be 30 days.

2.e. Commitment to treatment or other legally imposed treatment or intervention may sometimes create situations where consent for treatment is not totally voluntary.

2.e.(2) In a behavioral health program, the policy regarding authorization for the release of information conforms to Standard 2.G.1. of this manual.

2.f. Information may be provided through service directories or a handbook for persons served as part of the orientation of the person served, on posted listings, or through direct interaction with program personnel.

1.K. **3.** **The program/service demonstrates:**

   a. **Knowledge of the legal decision-making authority of the persons served.**

   b. **When applicable, the provision of information to the persons served regarding resources related to legal decision-making authority.**

Intent Statements

The person served may not have the capacity or be of the age to make decisions in his or her own best interests. An individual may need to be assigned to make decisions regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from state to state or province to province; i.e., healthcare power of attorney, power of attorney, and guardianship. The program/service should be able to discuss how it addresses the issue of the legal decision-making authority of the persons served.

3.b. Any limitation on a person's legal decision-making authority should be continued only as long as is appropriate and necessary. The program/service assists the person served and his or her family members/support system to access resources, such as attorneys with expertise in this area, who can assist with facilitating changes, if appropriate, in legal autonomy status.

1.K. **4.** **The organization:**

   a. **Implements a policy and written procedure by which persons served may formally complain to the organization that specifies:**

      (1) **That the action will not result in retaliation or barriers to services.**

      (2) **How efforts will be made to resolve the complaint.**

      (3) **Levels of review, which include availability of external review.**

      (4) **Time frames that:**

         (a) **Are adequate for prompt consideration.**

         (b) **Result in timely decisions for the person served.**

      (5) **Procedures for written notification regarding the actions to be taken to address the complaint.**

      (6) **The rights of each party.**

      (7) **The responsibilities of each party.**

      (8) **The availability of advocates or other assistance.**

   b. **Makes complaint procedures and, if applicable, forms:**

      (1) **Readily available to the persons served.**

      (2) **Understandable to the persons served.**

c. **Documents formal complaints received.**

Intent Statements

The organization identifies clear protocols related to formal complaints, including grievances and appeals. An organization may have separate policies and procedures for grievances and appeals, or it may include these in a common policy and procedure covering complaints, grievances, and appeals.

1.K. 5. **A written analysis of all formal complaints:**

a. **Is conducted annually.**

b. **Determines:**

(1) **Trends.**

(2) **Areas needing performance improvement.**

(3) **Actions to be taken.**

Intent Statements

An analysis of formal complaints, grievances, and appeals can give the organization valuable information to facilitate change that results in better customer service and results for the persons served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies and written procedures for formal complaints
- Documentation of formal complaints received
- Consumer handbook, orientation materials, updated information regarding rights
- Policies addressing the rights of the persons served
- Records of filed complaints or appeals, if applicable
- Consumer handbook, orientation materials, updated information regarding rights

L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

1.L. 1. **The organization's leadership:**

a. **Assesses the accessibility needs of the:**

(1) **Persons served.**

(2) **Personnel.**

(3) **Other stakeholders.**

b. **Implements an ongoing process for identification of barriers in the following areas:**

(1) **Architecture.**

(2) **Environment.**

(3) **Attitudes.**

(4) **Finances.**

(5) **Employment.**

(6) **Communication.**

(7) **Transportation.**

(8) **Community integration, when appropriate.**

(9) **Any other barrier identified by the:**

(a) **Persons served.**

(b) **Personnel.**

(c) **Other stakeholders.**

Intent Statements

The leadership has a working knowledge of what should be done to promote accessibility and remove barriers. Organizations address accessibility issues in order to:

- Enhance the quality of life for those served in their programs and services.
- Implement nondiscriminatory employment practices.
- Meet legal and regulatory requirements.
- Meet the expectations of stakeholders in the area of accessibility.

The leadership should address how input was solicited from the persons served, personnel,

and other stakeholders to assist in the identification of barriers, and take into consideration any accessibility needs—physical, cognitive, sensory, emotional, or developmental—that may hinder full and effective participation on an equal basis with others.

Examples

Examples of accessibility planning may be found in minutes of meetings where analysis, action planning, and goals are established; in conversations with stakeholders; in focus groups and council meetings; in community events; in surveys, etc.

1.b.(1) Architectural or "physical" barriers are generally easy to identify and may include steps that prevent access to a building for an individual who uses a wheelchair, narrow doorways that need to be widened, bathrooms that need to be made accessible, the absence of light alarms for individuals who have a hearing impairment, and the absence of signs in Braille for individuals who have visual impairments.

1.b.(2) Environmental barriers can be interpreted as any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained. Some clinics may be located in areas where the persons served and/or personnel do not feel safe or feel that confidentiality may be risked.

In addition to such external environmental barriers, internal barriers may include noise level, lack of sound proof counseling rooms, highly trafficked areas used for service delivery, or type or lack of furnishing and décor that impact the comfort level of the persons served and personnel.

1.b.(3) Attitudinal barriers may include, but are not limited to:

- The terminology and language that the organization uses in its literature or when it communicates with persons with disabilities, other stakeholders, and the public (e.g., does the organization use "person first" language?).

- How persons with disabilities are viewed and treated by the organization, their families, and the community (e.g., dependent versus independent or interdependent and not valuable versus valuable.).

- Whether or not consumer input is solicited and used.

- Whether or not the eligibility criteria of the organization screen out individuals with specific types of disabilities.

1.b.(6) Communication barriers may include the absence of a telecommunication device for the deaf (TDD) and the absence of material in a language or format that is understood by the persons served.

1.b.(7) Transportation barriers may include persons being unable to reach service locations at all or to participate in the full range of services and other activities.

1.b.(8) Barriers to community integration include any barrier that would keep the persons served from returning to full participation in their community of choice. For example, participation in sports may be limited by the lack of a lift at the public swimming pool for access by persons served with limited mobility or the lack of scheduling availability of the local gym for an adaptive sports program; accommodations may be needed for the persons served to return to previous volunteer activities with the community food bank.

1.b.(9) Customer satisfaction surveys may help identify other barriers. Other barriers may include those raised by evolving technology, upkeep of previous repairs or changes, or issues more specific to the populations to whom the organization provides services.

Any other barriers to services that are identified should be addressed.

Resources

Information on the Accessibility for Ontarians with Disabilities Act, 2005 (AODA) is provided by the Ontario Ministry of Community and Social Services. The AODA website is located at **www.mcss.gov.on.ca/mcss/english/pillars/ accessibilityontario**. Information and resources for accessibility planning are available through this website.

Additional resources that may be helpful are available through the Canadian Standards Association, a not-for-profit membership-based association serving business, industry,

government and consumers in Canada and the global marketplace. The Canadian Standards Association website is located at **www.csa.ca**.

1.L. 2. The organization implements an accessibility plan that includes, for all identified barriers:
a. Actions to be taken.
b. Time lines.

Intent Statements

There may be barriers identified that the organization does not have the authority or resources to remove; effective accommodations may be the appropriate action to be taken in those circumstances.

Examples

Written documentation of potential barriers to services exists. When identifying potential barriers to services, the organization looks at barriers within the organization itself and in the community, including the attitudes that its staff members and other stakeholders have of persons with disabilities, which may greatly impact initial and ongoing access to services.

1.L. 3. An accessibility status report:
a. Is prepared annually.
b. Is in writing.
c. Includes:
(1) Progress made in the removal of identified barriers.
(2) Areas needing improvement.

Examples

The organization may choose to develop a schedule of time lines for removal of barriers or to implement improvements. The status report may include a method for the regular reporting of progress being made in the removal of barriers. Some organizations use simple checklists that are required monthly or quarterly that identify the date due, date completed, person responsible, and a place for comments when the goals are not met.

A status report may include:

- A description of the barriers.
- A description of the proposed solutions.

- A description of equivalent facilitation that is to be provided until actual barrier removal occurs.
- The person responsible.
- The date due.
- The actual completion date.
- Remarks.

1.L. 4. Requests for reasonable accommodations are:
a. Identified.
b. Reviewed.
c. Decided upon.
d. Documented.

Intent Statements

The organization evaluates and carefully considers the merits of all requests for accommodation to determine whether any remedial actions are appropriate.

Examples

Because a request is made for a reasonable accommodation does not automatically require that the organization meet the request. There should be a review of the request. How is the organization alerted to the need for the reasonable accommodation? What is the review process? Who is identified as responsible for approving or denying the accommodation request? What are the decision-making criteria?

When an accommodation cannot be made, the organization demonstrates a referral system that assists the persons served in the use of other resources that are accessible.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written accessibility plan
- Identification of accessibility barriers
- Annual accessibility status report by senior leadership
- Requests for reasonable accommodations
- Meeting minutes

Review Results

To stay on target at both strategic and tactical levels, the organization must constantly monitor and assess its performance against a series of performance indicators and targets. Only by setting specific, measurable goals and tracking performance can the organization determine the degree to which it is achieving the desired service and business outcomes. Appropriate organizational and stakeholder representatives must review and analyze results to determine areas for improvement. This review and analysis positions the organization to develop and initiate quality improvement changes.

M. Performance Measurement and Management

Description

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and analyzed, and information is used to manage and improve service delivery.

1.M. **1.** **The organization has a written description of its performance measurement and management system that includes, at a minimum:**

   a. **Mission.**

   b. **Programs/services seeking accreditation.**

   c. **Objectives of the programs/services seeking accreditation.**

   d. **Personnel responsibilities related to performance measurement and management.**

Intent Statements

A critical component of quality, the implementation of performance measurement and management systems for both business and service delivery allows an organization to look objectively at how well it is accomplishing its mission. There is a direct connection between a number of day-to-day processes addressed throughout the CARF standards, e.g., those related to financial management, complaint management, professional development for personnel, individualized service delivery, etc., and performance management in that those processes become sources of information used to analyze performance. This written description provides the context for the organization's efforts

and could be used to educate personnel and other relevant stakeholders about its approach to performance measurement and management, included in marketing or performance information that is shared with stakeholders, and/or incorporated into ongoing strategic planning activities.

Examples

1.c. The objectives of the programs/services offered include both business and service delivery objectives, e.g., the program will have less than a certain percentage of turnover in personnel who have been employed for more than a year, safety drills will be completed by a certain date, a certain percentage of persons served will return to work, or a certain percentage of persons served will return home without the need for assistance.

1.d. Personnel may have a variety of roles and responsibilities in implementing performance measurement and management systems, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.

1.M. **2. The organization demonstrates how its data collection system addresses the following:**
   a. Reliability.
   b. Validity.
   c. Completeness.
   d. Accuracy.

Intent Statements

Accurate and consistent data will be the deciding factor in the success of an organization moving to or maintaining a fact-based, decision-making model.

Examples

There are a variety of ways an organization can demonstrate that it addresses the integrity of the data it uses for outcomes assessment, performance improvement, and management decision making. These approaches can range from the simple to sophisticated. It is not required that the

organization subscribe to a proprietary data vendor in order to achieve data integrity.

2.a. Reliability. The organization takes steps to ensure that data are collected consistently in a way that could be reproduced at another time or by other data gatherers. For example:

- New and existing personnel are trained on recording each data element they are responsible for collecting; measures or codes are explained and periodically reviewed.

- Inter-rater reliability assessments can be conducted in which different staff members record measures for the same persons served, and data are compared statistically to assess whether different staff members arrive at the same ratings for a given individual.

- The organization wants to measure severity at intake to the program. It searches the literature and selects a measure that has been widely tested and demonstrated to be reliable with this population.

- The organization serves a large number of people each year. Rather than send satisfaction questionnaires to all of them, the organization selects a random sample of 50 percent from each of its program areas' clientele. Before the questionnaires are sent, the data manager reviews the characteristics of the sample to ensure that the sample is representative of the total group served in terms of diagnosis/reason for seeking services, age, gender, and ethnicity.

2.b. Validity. The organization chooses indicators, measures, and data elements that measure what it intends to measure. For example:

- Stakeholders express interest in return-to-work and in minimizing days lost due to incapacity for persons referred to the program. The organization chooses to collect employment status at follow-up and asks about the number of days of work lost due to activity limitations instead of just the diagnostic data it has always summarized.

- A program's stakeholders are interested in reducing the level of impairment in persons served. The program does a literature review and selects a standardized tool or measure known to be valid and reliable.

2.c. Completeness. The organization takes steps to ensure that the data used for decision making are as complete as possible, no accredited programs are omitted from the information and performance improvement effort, no groups of persons served are omitted from the data gathering or analysis, no data elements or indicators are systematically missing, and any database is checked for completeness of records before final analyses are run and decisions made. For example:

- The quality council and data manager collaborate on designing an information system regarding the persons served that includes necessary data elements for all programs of the organization. They decide to design an organizationwide system, but identify each record with the particular program in which the person participates so analysis can be done separately for all the programs to be surveyed.

- Staff training for the data-recording activities includes attention to the importance of recording each data field for every person served.

- The data manager routinely cross checks the number of client records in the database with the operations officer's report of the number of persons served during a reporting period to ensure that data are available on all persons served before analysis is conducted and reports are generated. Missing records are located and entered into the database before analysis is conducted.

2.d. Accuracy. The organization takes steps to ensure that data are recorded properly and that errors are caught and corrected. For example:

- Spot checks of the records of the persons served are made to ensure that data abstracted from the record are correctly placed into the database.

- The data manager routinely reviews the distribution of values in test data runs and asks the direct care staff members to double check the accuracy of cases that seem to be outside of expectations in terms of maximum or minimum values. (For example, did someone

really stay in the program 205 days or was it 20 days?)

1.M. **3.** The data collected by the organization:

   a. Include:
- (1) Financial information.
- (2) Accessibility status reports.
- (3) Resource allocation.
- (4) Surveys, if applicable.
- (5) Risk management.
- (6) Governance reports, if applicable.
- (7) Human resources activities.
- (8) Technology.
- (9) Health and safety reports.
- (10) Field trends, including research findings, if applicable.
- (11) Service delivery.

   b. Address:
- (1) The needs of persons served.
- (2) The needs of other stakeholders.
- (3) The business needs of the organization.

   c. Allow for comparative analysis.

   d. Are used to set:
- (1) Written business function:
  - (a) Objectives.
  - (b) Performance indicators.
  - (c) Performance targets.
- (2) Written service delivery:
  - (a) Objectives.
  - (b) Performance indicators.
  - (c) Performance targets.

Intent Statements

Organizations continually collect data from a variety of internal and external sources. These data are analyzed and the results are used to make informed decisions about the needs of the persons served and other stakeholders as well as the business needs of the organization.

Business function and service delivery objectives, performance indicators, and performance targets are set as appropriate to the specific needs of the organization. While there does not necessarily need to be a performance indicator and

target for each area of data collected, service delivery performance indicators at a minimum include indicators for effectiveness of services, efficiency of services, service access, and satisfaction with service delivery from a variety of perspectives including the persons who received the services and other stakeholders. See the Glossary for definitions of *performance indicator* and *performance target*.

Examples

The organization uses information and establishes performance indicators as appropriate to its specific needs. There does not necessarily need to be an indicator for each of these items.

3.a.(4) *Surveys* may refer to satisfaction questionnaires, state/provincial/territorial surveys, national surveys, CARF surveys, other accreditation surveys, needs assessments, etc.

The organization takes a proactive role by ensuring that specific activities, such as strategic planning and risk analysis, are conducted to protect the organization's assets, maintain its viability, and position itself as the quality expectations of stakeholders change.

In strategic planning, the organization may begin by doing an environmental scan and asking all of its stakeholders for input.

In its review of the implementation of the written accessibility plan, the organization ensures that the planned actions are actually taken to reduce barriers to services. This certainly has implications for budget planning.

Addressing business improvement strategies based on the information gathered can be done in a variety of ways:

- Periodically, a report could be completed that encompasses the critical issues surrounding business performance. With advance planning and a consistent outline to follow in order to comment on relevant data, the report could be pulled together at the end of the fiscal or calendar year, whichever time frame is more meaningful to the organization.

- In large organizations that have several administrative personnel, the report could be gathered by different personnel or board members and summarized by one individual. The board could address governance reports,

the lead financial person could summarize financial data, the safety lead could comment on relevant health/safety reports, and the technology lead personnel could summarize information that impacts technology needs.

- In smaller organizations that have few administrative personnel, one person might summarize the report. However, there should be less to comment on in each area, considering the different scopes of large and small organizations. As a result of the different complexities of varied organizations, the report should reflect the specific issues facing the organization.

- A large organization may produce a report that contains many pages, attachments, charts, and other relevant information. A small organization may produce a much shorter report, but it will still cover the topics relevant to its challenges.

1.M. **4. The organization collects data about the characteristics of the persons served.**

Examples

Smaller organizations may need to include all persons served in their performance improvement systems to ensure that the characteristics of persons served are included. However, when an organization serves a large number of individuals, the performance improvement system may include a representative sample of all individuals it served or intended to serve. A representative sample of the persons the program served, or intended to serve, could include categories of such characteristics as age, gender, ethnicity, linguistic needs, locations, and severity of disability/disorder. It is important to include the persons the organization served or intended to serve in order to ensure that those individuals who drop out prematurely or who do not return are included in the performance improvement system. Valuable information for program improvement can be gathered from persons who leave the program prior to successful completion. An organization that follows up only on successful discharges would not be in conformance to this standard.

1.M. 5. **The organization collects data about the persons served at:**

   a. **The beginning of services.**

   b. **Appropriate intervals during services.**

   c. **The end of services.**

   d. **Point(s) in time following services.**

1.M. 6. **The organization measures:**

   a. **Business function performance indicators.**

   b. **Service delivery performance indicators for each program/service seeking accreditation in each of the following areas:**

   (1) **The effectiveness of services.**

   (2) **The efficiency of services.**

   (3) **Service access.**

   (4) **Satisfaction and other feedback from:**

   (a) **The persons served.**

   (b) **Other stakeholders.**

Examples

6.b.(1) Effectiveness measures address the quality of care through measuring change over time. Specific effectiveness measures for behavioral health programs can include the following:

- Maintenance of abstinence.
- Community integration.
- Reduction or elimination of incidence of relapse.
- Reduction or elimination of negative involvement with the criminal justice system.
- Improvement of physical health.
- Improvement in school functioning.
- Reduction of hospitalization.
- Reduction of symptoms.
- Increase in the level of psychological functioning.
- Increase in self-esteem.
- Acceptance rate of participants into a program.

- Home visitation completion rates.
- Reduction of reported interventions by the program.
- Decreased episodes of anger.
- Reduction or elimination of the prevalence of a prevention target.
- Number, duration, and frequency of symptomatic and/or asymptomatic behaviors.
- Involvement in activities of daily living.
- Employment status.
- Community tenure.
- Housing situation.
- Receipt of entitlement benefits.
- Quality of relationships.
- Health status.
- Subjective psychological well-being.

6.b.(2) Efficiency measures are usually administratively oriented and may include, but are not limited to, the following:

- Service delivery cost per service unit.
- Occupancy rates.
- Retention rates.
- Direct service hours of clinical staff.
- Personnel turnover.
- Length of stay.
- Service utilization.

6.b.(3) Access to service can be measured by the following:

- Waiting time for routine or emergency care.
- Convenience of service hours and locations.
- Telephone response time or abandonment rates.
- Time taken to set a first or subsequent appointment.
- The success of formal referral mechanisms.
- Waiting list information on persons found ineligible for services.

6.b.(4) Satisfaction measures are usually oriented toward consumers, family members, personnel, the community, and funding sources and may include, but are not limited to, the following:

- Was the person served given hope?
- Was the person served treated with dignity and respect?
- Did the organization focus on the recovery for the person served?
- Were grievances or concerns addressed?
- Overall feelings of satisfaction.
- Use of informed choices about modes of treatment, medications, etc.
- Satisfaction with physical facilities, fees, access, service effectiveness, and service efficacy.

Data regarding the satisfaction of the persons served with services are collected from persons active in long-term services as well as from those who leave services in a relatively short time. Such data may be collected in a variety of ways, including interviews following discharge, telephone surveys, mail surveys, proxy measures used with persons unable to communicate directly, and formalized published satisfaction scales. The results of consumer satisfaction surveys can be collected either continuously throughout the year or at regularly scheduled points in time, such as quarterly.

1.M. **7. For each service delivery performance indicator, the organization determines:**
   a. **To whom the indicator will be applied.**
   b. **The person(s) responsible for collecting the data.**
   c. **The source from which data will be collected.**
   d. **A performance target based on an industry benchmark, the organization's performance history, or established by the organization or other stakeholder.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Management reports
- Strategic plans
- Budgets
- Accessibility plans
- Technology plans and analysis
- Risk analysis reports and information
- Environmental health and safety reports
- Financial reports
- Quality assurance reports
- Data collected
- Demographics information of persons served
- Satisfaction data of persons served

Effect Change

Following the review and analysis of results, the organization must carefully evaluate the information learned so that it may be translated into focused actions to improve performance against targets. The evaluation drives the organization to engage in a dynamic, proactive process to review, renew, or revise its strategy and tactics, while ensuring alignment of organizational purpose, service and business practices, and organizational resources. Achieving excellence requires a disciplined continuous improvement process.

N. Performance Improvement

Description

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

1.N.   **1. A written analysis is completed:**

    a. At least annually.

    b. That analyzes performance indicators in relation to performance targets, including:

      (1) Business functions.

      (2) Service delivery of each program seeking accreditation, including:

        (a) The effectiveness of services.

        (b) The efficiency of services.

        (c) Service access.

        (d) Satisfaction and other feedback from:

          (i) The persons served.

          (ii) Other stakeholders.

      (3) Extenuating or influencing factors.

    c. That:

      (1) Identifies areas needing performance improvement.

(2) Results in an action plan to address the improvements needed to reach established or revised performance targets.

(3) Outlines actions taken or changes made to improve performance.

Examples

The performance analysis reviews data aggregated at a program/service level for each program/service seeking accreditation in order that the action plan can target improvements at the individual program/service level.

1.a. An annual analysis of performance information provides information to aid in the strategic positioning of the organization.

An organization may choose to measure progress and conduct reviews more frequently because of the value the information provides in managing programs and services.

1.b. The performance analysis is designed to support the actions and activities for improving the business functions and service delivery of the organization through reviews by the governance authority, communicating information with stakeholders, and supporting the plans for improving individual service delivery. The summary analysis gives needed information for making decisions and improvements in services. Data and information in the report may be presented in written form, in charts, or in graphs.

1.c. Although CARF does not prescribe the style or structure of the action plan, best practices suggest plans contain at least the following:

- An update on action items from the previous report (i.e., what has been accomplished or has resulted from changes suggested by analysis of the previous year's outcomes)
- Demographic data
- Follow-up data collected from those who have exited services
- A report on the data collected (effectiveness, efficiency, service access and satisfaction measurements) for each program/service aggregated individually and discussion of analysis of the data

- A conclusion, including recommendations and a to-do list with action items

The intent is that the organization compare the results achieved for each of the targets to those identified for effectiveness, efficiency, service access, satisfaction of persons served, and satisfaction of other stakeholders.

An organization demonstrates commitment to the continuous improvement of organizational quality and service excellence. Information from the analysis is used for improving the delivery of and planning for services. Some examples of its use could include identifying efficient and effective methods of providing services/supports; recognizing personnel accomplishments; reassessing the mission; recruiting personnel based on outcome targets; and identifying issues, concerns, or trends that should be considered in changing services.

An annual action plan provides information to aid in the strategic positioning of the organization. The plan gives pertinent information for making decisions and improvements in services and actively supporting the actions and activities of organizational improvements through reviews by the governance authority, communication of information to stakeholders, and support of plans for improving individual service delivery.

1.N. **2. The analysis of performance indicators is used to:**

a. Review the implementation of:

(1) The mission of the organization.

(2) The core values of the organization.

b. Improve the quality of programs and services.

c. Facilitate organizational decision making.

d. Review or update the organization's strategic plan.

Examples

The organization demonstrates:

- Knowledge of the needs and goals of its customers (persons served and other stakeholders).

- Knowledge of the operational status of the organization, the business strategies it employs to be successful, and how performance improvement is utilized at all levels of the organization.
- How it measures the activities and goals of persons served.
- How it makes decisions to expand, open new sites, develop new services, modify a treatment approach, or change personnel patterns.
- Methods for reaching these decisions, which may include reviews of information, outcomes management reports, budgets, strategic plans, and satisfaction surveys. A CARF-accredited organization uses a fact-based decision-making process to identify and respond to organizational needs.

1.N. **3. The organization communicates performance information:**
   a. **To:**
      (1) **Persons served.**
      (2) **Personnel.**
      (3) **Other stakeholders.**
   b. **According to the needs of the specific group, including:**
      (1) **The format of the information communicated.**
      (2) **The content of the information communicated.**
      (3) **The timeliness of the information communicated.**
   c. **That is accurate.**

Intent Statements

In a consumer-driven market, CARF-accredited organizations realize the importance of sharing their performance information with the persons served and other stakeholders. The information is tailored to meet the needs of a variety of stakeholders both internal and external to the organization.

Examples

Sharing performance information with internal and external stakeholders is a vital aspect of continuously improving the services of the organization.

There are various ways to communicate outcomes information, including press releases, annual reports, posting summaries or graphics on the organization's website, and newsletters. The report is tailored to the audience in an understandable language or medium, including the use of charts, graphs, and audio- or videotapes. Typical practice in continuous quality improvement is to share the information with all stakeholders who have given input.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- An annual written analysis of performance
- Management reports
- Strategic plans
- Accessibility plans
- Technology plan
- Risk analysis reports
- Health and safety reports
- Financial reports
- Quality assurance reports
- Demographics information of persons served

SECTION 2

General Program Standards

Description

For an organization to achieve quality services, the persons served are active participants in the planning, prioritization, implementation, and ongoing evaluation of the services offered. A commitment to quality and the involvement of the persons served span the entire time that the persons served are involved with the organization. The service planning process is individualized, establishing goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served. The persons served have the opportunity to transition easily through a system of care.

Applicable Standards

The standards in Section 2 typically apply to all of the programs in Section 3; however, some exceptions apply. Please refer to the following table to determine the standards in Section 2 that are applicable to the programs in Section 3 for which your organization is seeking accreditation.

2.A. Program/ Service Structure	2.B. Screen-ing and Access	2.C. Person-Centered Plan	2.D. Transition/ Discharge	2.E. Medication Use	2.F. Nonviolent Practices	2.G. Records of the Persons Served	2.H. Quality Records Management
Assessment/Referral and Crisis and Information Call Centers							
apply 2.A.1.–8., 15., 17., 18., 21., and 22.	apply*	not applicable	not applicable	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others, as applicable.	apply*	apply*
Crisis Intervention, Crisis Stabilization, and Detoxification							
apply all	apply*	apply*	apply*	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others, as applicable	apply*	apply all
Diversion							
apply 2.A.1.–10., and 16.–18.	not applicable	not applicable	not applicable	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others as applicable	not applicable	not applicable
Employee Assistance							
apply all	apply*	apply*	apply*	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others, as applicable	apply*	apply all
Integrated Behavioral Health Primary Care							
apply all	apply all	apply all	not applicable	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others, as applicable	apply all	apply all
Prevention							
apply 2.A.1.–8. and 17.	not applicable	not applicable	not applicable	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others as applicable	not applicable	not applicable
Student Counseling							
apply all	apply 2.B.1.–9.d.(1)(e) 10., and 15.	not applicable	not applicable	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others as applicable	not applicable	apply all
All other Behavioral Health Core Programs							
apply all	apply all	apply all	apply all	apply 2.E.1.; all others, as applicable	apply 2.F.1.; all others, as applicable	apply all	apply all

* Note of exception:
In these clinically driven programs of brief duration, documentation may not be as extensive as in programs of longer duration.
Consumer-run programs may not necessarily reflect in-depth clinical documentation.

A. Program/Service Structure

Description

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

2.A. **1. Each program/service:**

   a. **Documents the following parameters regarding its scope of services:**

   (1) **Population(s) served.**
   (2) **Settings.**
   (3) **Hours of services.**
   (4) **Days of services.**
   (5) **Frequency of services.**
   (6) **Payer sources.**
   (7) **Fees.**
   (8) **Referral sources.**
   (9) **The specific services offered, including whether the services are provided directly or by referral.**

   b. **Shares information about the scope of services with:**

   (1) **The persons served.**
   (2) **Families/support systems, in accordance with the choices of the persons served.**
   (3) **Referral sources.**
   (4) **Payers and funding sources.**
   (5) **Other relevant stakeholders.**
   (6) **The general public.**

   c. **Reviews the scope of services at least annually and updates it as necessary.**

Intent Statements

The scope is defined at the level of the program/service and provides the persons served, families/support systems, referral sources, payers, and other relevant stakeholders with information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons

served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.

Examples

Many organizations may incorporate this information in the program description required in Standard 2.A.8.

Resources

1.b. Resources/links for creating printed materials in language that can be understood by persons served include:

- **www.ric.org/cror/healthliteracy.aspx**
- **www.ahrq.gov/populations/sahlsatool.htm**
- **www.cpha.ca/en/pls.aspx**
- **www.noslangues-ourlanguages.gc.ca/**
- **www.cpha.ca/uploads/portals/h-l/ directory_e.pdf**
- **www.literacybc.ca/Info/clear_language.pdf**
- **www.nald.ca/litweb/litweb.htm**
- **www.literacy.ca/?q=literacy/clearwriting**

2.A. **2. The organization provides the resources needed to support the overall scope of each program/service.**

Intent Statements

The ability to provide the program/services defined in the scope statement is evidenced by adequate materials, equipment, supplies, space, finances, training, and human resources.

Examples

The program has the facilities, space, materials, and staffing to provide the proper amount of care for the proper length of time based on the needs of the persons served.

Resources may include confidential interview rooms if face-to-face counseling is provided or large space if the program includes the use of group activities.

2.A. **3.** **Based on the scope of each program/ service provided, the organization documents its:**
   a. **Entry criteria.**
   b. **Transition criteria.**
   c. **Exit criteria.**

Intent Statements

The organization determines which persons it is qualified and able to serve and identifies conditions/time/events for transition and/or exit. This includes transitions to other levels of care/services as well as transitions within a program/service. Transition criteria may also address continuing stay criteria.

Examples

While a program/service may use terms that are different than those above, the concepts are the same.

3.a. Entry criteria may also be called admission criteria, enrollment criteria, or move-in criteria.

Entry criteria regarding admission and readmission should be clearly written, adhered to, and consist of how to prioritize admissions, decision making responsibilities, and what would cause a person seeking services to be excluded or found ineligible.

When this determination is formalized and in writing, it significantly minimizes subjectivity during the screening or admission process.

Clearly written and defined admission criteria reduce the need to exercise subjective judgment in making a decision regarding whether a particular program is applicable to a person's needs.

The criteria address both the initial admission of a person served and subsequent readmissions.

3.b.–c. Transition criteria may also be called referral, aftercare, or continuing care criteria or guidelines. Exit criteria may also be called agreement or contract termination criteria or discharge criteria.

Written transition and discharge criteria are established and are used in such documents as program descriptions, admission/readmission criteria, or other documents.

2.A. **4.** **When a person served is found ineligible for services:**
   a. **The person served is informed as to the reasons.**
   b. **In accordance with the choice of the person served:**
      (1) **The family/support system is informed as to the reasons.**
      (2) **The referral source is informed as to the reasons.**
   c. **Recommendations are made for alternative services.**

Examples

Persons who are found to be ineligible for services are given the reasons and directed to alternative or more appropriate services.

4.a. Informing the person as to why they are ineligible gives them the opportunity to more effectively target a service delivery system.

4.b. In some situations, the referral source is providing the information for the screening and will obviously be informed as to reasons for ineligibility without specific consent.

2.A. **5.** **Each program/service implements procedures that address unanticipated service modification, reduction, or exits/ transitions precipitated by funding or other resource issues.**

Intent Statements

The program/service demonstrates its knowledge of funding sources and their expectations and time frames for discontinuing or changing the program/service. While funding issues impact entry and exit decisions, the program/service consistently advocates for needs of the persons served.

2.A. **6.** **Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**

Intent Statements

The service delivery model and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes.

Examples

The organization uses field-recognized practices and, ideally, adopts evidence-based or research-supported practices where the evidence and research are sound.

Some interventions may be more commonly accepted by a particular culture or supported by evidence as more effective when used within specific populations or to treat certain disabilities or disorders.

Evidence of conformance to this standard may be demonstrated through minutes of meetings in which these topics were discussed, literature available to the personnel in a program library, development of treatment guidelines, etc. Resources used in this process might include journal subscriptions, on-line access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, in-service programs, journal clubs, collaborative resources, or education efforts with other area providers of services.

2.A. **7. To facilitate integrated service delivery, each program/service implements communication mechanisms regarding the person served that:**
   a. Address:
      (1) Emergent issues.
      (2) Ongoing issues.
      (3) Continuity of services, including:
         (a) Contingency planning.
         (b) Future planning.
      (4) Decisions concerning the person served.
   b. Ensure the exchange of information regarding the person-centered plan.

Intent Statements

This standard addresses the need for timely communication to ensure services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples

Communication mechanisms may include written communication; face-to-face meetings; inservices; or the use of lectures, video or audio tapes, one-on-one teaching, etc.

2.A. **8. Each core program for which the organization is seeking accreditation has a written program description that guides the delivery of services and includes:**
   a. A description of the program.
   b. The philosophy of the program.
   c. Program goals.
   d. Description of the service/treatment modalities to be provided to achieve the program objectives.
   e. Identification or a description of special populations and mechanisms to address their needs.

Intent Statements

The intent of this standard is to clearly define, in writing, how service delivery is accomplished. Description would include broad strategies to be used to achieve objectives and the rationale for the choice of service modality(ies). Many organizations may incorporate the information required in a program description to meet Standard 2.A.1.a.

Examples

The written program description can be described in policy and procedure manuals, the performance improvement plan, program handbooks, brochures, or other documentation. It may vary in length, depending on the size of the organization and the services that are provided.

8.a. The program description includes information such as the populations and age groups served, relevant characteristics of the populations, hours and days of operation, after-hours contact, and admission criteria.

8.b.–c. The philosophy and goals of a program may be the same as the philosophy and goals of the organization; however, they are restated in the program descriptions for clarity.

8.e. Special populations may include children and adolescents, aging and older adults, pregnant women, persons with intellectual or other developmental disabilities, persons with HIV/AIDS, IV drug users, DUI offenders, sexual offenders, or substance abuse offenders.

2.A. **9.** **Services are designed and implemented to:**
  a. **Support the recovery, health, or well-being of the persons or families served.**
  b. **Enhance the quality of life of the persons served.**
  c. **Reduce symptoms or needs and build resilience.**
  d. **Restore and/or improve functioning.**
  e. **Support the integration of the persons served into the community.**

Intent Statements

Services provided by the organization are designed and implemented to increase independence and maximize integration into the community.

9.a. Recovery focuses on the development of new meaning and purpose as individuals or families grow beyond the problems associated with the concerns that led them to seek services, i.e. mental illness, addiction, or family violence.

2.A. **10.** **When the program is identified as a treatment program, it identifies:**
  a. **Treatment modalities used.**
  b. **The credentials of staff qualified to provide identified treatment modalities.**

2.A. **11.** **When applicable, there are policies and written procedures that address positive approaches to the program's use of behavioral interventions, including:**
  a. **An emphasis on building positive relationships with persons served.**
  b. **Evaluation of the environment.**
  c. **Appropriate interaction with staff to:**
    (1) **Promote de-escalation.**
    (2) **Manage behavior.**
  d. **Empowering persons served to manage their own behavior.**

Intent Statements

The intent of the standard is that organizations have policies and procedures that support the use of positive alternatives to behavioral interventions such as redirecting and de-escalation in its effort to avoid negative behaviors by the persons served. The policies and procedures should reflect the use of positive approaches prior to the implementation of behavioral interventions. The organization demonstrates commitment to a system that nurtures personal growth and dignity, and it supports the use of positive approaches and supports. This standard would apply to any program that deals with persons with a history of behavioral problems (e.g., anger, PTSD) or where the goal is to help the persons served change their behavior. Thus, you could see these policies and procedures in almost any behavioral health program except, perhaps prevention/diversion or call centers.

2.A. **12.** **When applicable, the program identifies:**
  a. **Written procedures governing the use of:**
    (1) **Special treatment interventions.**
    (2) **Restrictions of rights.**
  b. **Methods to ensure that intrusive procedures are administered in a safe manner, with consideration given to the:**
    (1) **Physical history of the persons served.**
    (2) **Developmental history of the persons served.**

(3) **Abuse history of the persons served.**

c. **A process of regularly evaluating:**

(1) **Any restrictions placed on the:**

(a) **Rights of the persons served.**

(b) **Privileges of the persons served.**

(2) **Methods to reinstate restricted or lost:**

(a) **Rights of the persons served.**

(b) **Privileges of the persons served.**

(3) **The purpose or benefit of any type of restriction on rights or privileges.**

Intent Statements

12.a.(1) When used, special treatment interventions are individually applied based on the specific needs of the persons served and as determined safe and effective.

12.c. Some organizations, aside from using seclusion/restraint, restrict privileges when a person enters treatment. As a general rule, the rights of persons served are described in writing in the organization's client rights statement or document and are "non-negotiable"; i.e., they cannot be lost by the person served or taken away by the organization. In contrast, privileges are often extended to persons served as a result of exceptional conformance to program rules or due to extraordinary progress. Privileges, unlike client rights, can be lost through violations of program rules or a failure to demonstrate progress in treatment.

Examples

12.a. Special treatment interventions may span the range from electroconvulsive therapy (ECT) to loss of phone and visitation privileges. This standard includes all interventions used, as appropriate to the person served, including involuntary emergency medication.

12.b. Examples of intrusive procedures may include strip searches or pat downs.

12.c. For example, an alcohol and drug residential treatment program may not allow visitors the first week a person is in treatment, or a weekend pass may be revoked if a person served has

violated the conditions of treatment for that particular organization.

2.A. **13. The program receives medical consultation regarding medically related policies or procedures, when appropriate.**

Intent Statements

Medical consultation is typically provided by a medical director who is a physician. However, there may be circumstances in which the consultation is provided by a licensed physician's assistant, a nurse practitioner, or a registered nurse. The person does not have to be a staff member but can be connected through a contract or a consulting or voluntary agreement.

Examples

Medical consultation may be indicated for policies and procedures involving medication use, seclusion or restraint, human resources, health and safety, admission eligibility, infection control, medical emergencies, or other medically related issues.

2.A. **14. In a medically supervised program, there is a medical director who is a physician.**

Intent Statements

To ensure that proper care is provided in a medically supervised program, there should be medical director who is a physician.

Examples

This includes medically supervised detoxification, inpatient treatment, partial hospitalization, or residential treatment programs serving persons with medical needs.

In an addiction treatment program, the program is encouraged to use a physician certified in addiction treatment by the American Society of Addiction Medicine (ASAM) or the American Board of Addiction Medicine (ABAM).

2.A. **15. The program offers one or more of the following:**

a. **Peer support.**

b. **Local advocacy groups.**

c. **Consumer/survivor/ex-patient groups.**

d. **Self-help groups.**

e. **Other avenues of support.**

Intent Statements

The program will provide, arrange, or refer when needed to applicable support services.

Examples

15.a. Peer support services may be provided by peer staff or through the use of on-site support groups. Peer support may be provided by individuals with direct consumer experience or family members of persons served.

15.b. Such local groups could include:

- Alcoholics Anonymous or other 12-step groups, such as Alanon/Alateen.
- The local chapter of the National Alliance for the Mentally Ill.
- The local chapter of the Association of Psychosocial Rehabilitation Services.
- Medical condition support groups.
- Parents Anonymous.
- Veterans service organizations.
- The local chapter of People First.
- The local area Center for Independent Living.

Efforts should also be made to recognize culturally specific support groups.

2.A. **16. The program ensures that information and education that is relevant to the needs of the persons served is provided.**

Examples

Information may be provided that focuses on medical, housing, mental health, alcohol, and other drug issues; relationships; life skills, etc. Education may be provided through:

- Individual and group sessions.
- Group education.
- Audio/video or written materials.
- The internet.
- Resource listings.

Education may also be provided through other resources, including community colleges and area special education providers, and community

providers and may include assisting the persons served to access information on their own.

2.A. **17. As appropriate, families are:**

a. **Encouraged to participate in educational programs offered by the organization.**

b. **Invited to participate in clinical programs or services with the persons served, with consent or legal right.**

Intent Statements

Families participate as appropriate through education and/or clinical programs.

2.A. **18. Written procedures specify that the program provides or arranges for crisis intervention services.**

Intent Statements

The organization must have procedures for crisis intervention.

Examples

The organization may have its own on-call or direct crisis response service or may contract or collaborate with area providers that offer crisis intervention services.

2.A. **19. For personnel providing direct services, the organization includes the following in its assessment of competency and competency-based training:**

a. **Areas that reflect the specific needs of the persons served.**

b. **Clinical skills that are appropriate to the position.**

c. **Person-centered plan development.**

d. **Interviewing skills.**

e. **Program-related research-based treatment approaches.**

Intent Statements

The Intent of this standard is to ensure the necessary competencies are established and demonstrated.

Examples

In most organizations, the evaluation of staff competencies begins with ensuring that all

clinical staff members are licensed/certified by a credentialing body that uses a competency-based process for issuing licenses and certification. Beyond that, evaluation of professional competencies is part of an ongoing process of supervision that provides direct and periodic observation and documentation of screenings, intakes, group and individual counseling/therapy sessions, and other events involving service delivery.

Competency-based training may include training that is provided or recognized by a professional association, part of a formal training curriculum, or approved for continuing education units (CEUs) by a credentialing or licensing body. Competency in the areas in which training has occurred can be assessed by observing work and documenting that the skills or knowledge presented are being used on the job, through supervision and clinical review when assessments can be made regarding the retention and use of the training information, or through post-tests that are administered.

When needed, competency-based training is provided through inservice or access to external resources.

2.A. **20. Team members, in response to the needs of the persons served:**

  a. **Help empower each person served to actively participate with the team to promote recovery, progress, or well-being.**

  b. **Provide services that are consistent with the needs of each person served through direct interaction with that person and/or with individuals identified by that person.**

  c. **Are culturally and linguistically competent.**

  d. **Meet as often as necessary to carry out decision-making responsibilities.**

  e. **Document:**
    (1) **The attendance of participants at team meetings.**
    (2) **The results of team meetings.**

Intent Statements

The size and composition of the team will vary according to the services provided to each person served. Certain programs, services, or needs of the persons served may require that the team include personnel from a variety of disciplines.

Examples

20.a. This may be demonstrated through the active involvement of the person served in the development of the person-centered plan, participation in team meetings, or periodic review of identified goals.

2.A. **21. A designated individual(s) assists in coordinating services for each person served by:**

  a. **Assuming responsibility for ensuring the implementation of the person-centered plan.**

  b. **Ensuring that the person served is oriented to his or her services.**

  c. **Promoting the participation of the person served on an ongoing basis in discussions of his or her plans, goals, and status.**

  d. **Identifying and addressing gaps in service provision.**

  e. **Sharing information on how to access community resources relevant to his or her needs.**

  f. **Advocating for the person served, when applicable.**

  g. **Communicating information regarding progress of the person served to the appropriate persons.**

  h. **Facilitating the transition process, including arrangements for follow-up services.**

  i. **Involving the family or legal guardian, when applicable or permitted.**

  j. **Coordinating services provided outside of the organization.**

Intent Statements

Having a person designated to coordinate services ensure a more seamless process, thereby increasing the likelihood that all pertinent areas are effectively addressed.

Examples

The individual(s) who coordinates services may be an employee of the organization, a peer advocate, on the organization's payroll, under a contractual arrangement, on an internship, or a volunteer placement. Various designations may be used, such as peer advocate, case manager, case coordinator, program coordinator, primary clinician/contact, or team leader.

21.e.–f. For persons with intellectual or other developmental disabilities who are in long-term residential services, this means offering community-based options such as independent living programs.

21.h. Includes the transition of the person served from one program to another within the same organization.

2.A. **22. The organization has a plan and written procedures for the supervision of all individuals providing direct services.**

Intent Statements

The intent of this standard is to ensure that all individuals providing direct services (including staff members, volunteers, trainees, interns, and contractees) are provided with appropriate supervision or direction. Because of labor relations concerns, procedures may differ when the organization uses contractees.

Examples

Supervision may occur through the supervisor's participation in treatment/service planning meetings, organizational staff meetings, side-by-side sessions with the person served, or one-to-one meetings between the supervisor and personnel.

2.A. **23. Documented ongoing supervision of clinical or direct service personnel addresses, when applicable:**

a. **Accuracy of assessment and referral skills.**

b. **The appropriateness of the treatment or service intervention selected relative to the specific needs of each person served.**

c. **Treatment/service effectiveness as reflected by the person served meeting his or her individual goals.**

d. **The provision of feedback that enhances the skills of direct service personnel.**

e. **Issues of ethics, legal aspects of clinical practice, and professional standards, including boundaries.**

f. **Clinical documentation issues identified through ongoing compliance review.**

g. **Cultural competency issues.**

Intent Statements

This standard addresses clinical supervision and the provision of clinical consultation as opposed to what may be considered daily supervision. Clinical supervision is provided by persons qualified to provide this service as determined by state/provincial licensure or certification, the experience level of the supervisor, or the organization's rules governing the qualifications of clinical supervisors. Clinical oversight may vary when supervising licensed practitioners.

Examples

Supervision may occur through the supervisor's participation in treatment/service planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and personnel.

Clinical supervision documentation specifically includes assessment of professional competencies and clinical skills and recommendations for improvement, as opposed to daily supervision.

When direct service staff are consultants or independent contractors, expectations regarding 23.a.–g. may be identified in written agreement.

23.d. May include information on best practices or identify areas for needed professional growth.

2.A. **24. The organization implements policies and procedures:**

   a. **For:**

   (1) **Persons served.**

   (2) **Personnel.**

   b. **That address the handling of items brought into the program, including:**

   (1) **Illegal drugs.**

   (2) **Legal drugs.**

   (3) **Prescription medication.**

   (4) **Weapons.**

   (5) **Tobacco products.**

Intent Statements

Policies and procedures for the handling of items brought into the program would include all physical locations and vehicles owned or operated by the organization.

Examples

24.b.(1) Illegal drugs include street drugs and alcohol (if under the legal drinking age).

24.b.(2) Legal drugs may include over-the-counter drugs, vitamins, herbs, and alcohol.

24.b.(5) Tobacco products can include chewing tobacco, green cigarettes, etc.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ A written plan for each core program surveyed

■ Documentation of the attendance of participants at team meetings

■ Written procedures for crisis intervention services

■ Documentation of team meetings

■ Record of competency-based training

B. Screening and Access to Services

Description

The process of screening and assessment is designed to determine a person's eligibility for services and the organization's ability to provide those services. A person-centered assessment process helps to maximize opportunities for the persons served to gain access to the organization's programs and services. Each person served is actively involved in, and has a significant role in, the assessment process. Assessments are conducted in a manner that identifies the historical and current information of the person served as well as his or her strengths, needs, abilities, and preferences. Assessment data may be gathered through various means including face-to-face contact, telehealth, or written material; and from various sources including the person served, his or her family or significant others, or from external resources.

NOTE: *Please refer to the grid of Applicable Standards on page 96 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.*

2.B. **1. Person-centered care is demonstrated throughout the screening and/or assessment process.**

2.B. **2. The program demonstrates efforts to minimize the times between first contact, screening, and admission or referral.**

Screening/Eligibility

2.B. **3. The organization implements policies and written procedures that define:**
   a. **If/how screening is conducted.**
   b. **Eligibility for services.**

   c. **How admissions are:**
      (1) **Conducted.**
      (2) **Prioritized, if necessary.**
   d. **Who is responsible for making admission decisions.**
   e. **Exclusionary or ineligibility criteria.**

2.B. **4. When screening is conducted by the organization, it:**
   a. **Is documented.**
   b. **Includes a review of each person's eligibility for admission based on:**
      (1) **Presenting problem(s).**
      (2) **Identification and documentation of any urgent or critical needs of the person to be served.**
      (3) **Legal eligibility criteria, when applicable.**
      (4) **Availability of funding sources.**
   c. **Identifies:**
      (1) **Whether the organization can provide the appropriate services needed.**
      (2) **Alternate resources when services cannot be provided.**
   d. **Includes:**
      (1) **An interview with the person to be served or referral source.**
      (2) **When appropriate, a pre-admission on-site visit to the organization and its programs by the person to be served/legal guardian.**
   e. **Ensures that:**
      (1) **Screening tools used are uniformly administered.**
      (2) **Personnel are trained on use of tools prior to administration.**

Intent Statements

The admission process includes the screening of potential persons to be served.

Examples

Screening may include a review of all information available, discussions with referral

sources, and, if necessary, face-to-face contacts. Information may be found in admission reports or screening logs.

4.b.(3) May include residency, geographic area, status of person served, or other criteria.

4.b.(4) May include public sources, grant eligibility, private pay resources, or third-party funding.

4.d.(1) An interview can be done face-to-face, via telephone interview, or by other technological means; and may include parents, guardians, or others.

4.d.(2) May be more applicable prior to admission to a residential program.

4.e. This standard is applicable only when screening tools are used.

2.B. **5.** **If the screening identifies an urgent and critical need, appropriate action is taken immediately.**

Intent Statements

The organization safely responds to the person's needs whether directly or through referral.

2.B. **6.** **If a crisis assessment is conducted:**
  a. **It is documented.**
  b. **The following are addressed:**
     (1) **Suicide risk.**
     (2) **Danger to self or others.**
     (3) **Urgent or critical medical condition(s).**
     (4) **Immediate threat(s).**

2.B. **7.** **If the screening identifies unsafe substance use:**
  a. **A brief intervention is conducted either directly, through referral, or as part of the treatment program.**
  b. **The individual is referred for a full assessment, if needed.**

2.B. **8.** **If a waiting list is maintained, the organization:**
  a. **Documents the person's:**
     (1) **Date of placement on the list.**
     (2) **Identified needs.**
  b. **Maintains current waiting list information through:**
     (1) **Ongoing review and updating of the list.**
     (2) **Identified procedures for referral of persons in crisis to necessary care.**
  c. **Documents all contacts with the persons on the waiting list.**
  d. **Responds to long-term waiting lists through:**
     (1) **Strategic or community-based planning.**
     (2) **Involvement of support services.**
     (3) **Referral to available services/ community supports.**

Intent Statements

The use of a waiting list involves an active review process that leads to a determination of eligibility based on the organization's entrance/admission criteria. It also helps to ensure needed services are being provided in a timely manner.

Examples

Referral lists are not the same as waiting lists. They are different in that referral lists include all persons referred for services. Such lists are not necessarily used to determine the sequence of admission.

In certain situations, such as under Centers for Medicare and Medicaid Services (CMS) waivers, there may be requirements that there be no waiting list.

8.b.(1) Review of a waiting list may be documented in meeting minutes or by signing and dating the list itself to indicate review.

Monitoring a waiting list could include tracking the length of time on the waiting list before admission and the percentage of persons admitted. This information may assist in an organization's planning process.

8.d.(3) Evidence of referrals or other actions taken may be included on the waiting list itself or documented in a referral log.

Orientation

2.B. **9.** Each person served receives an orientation that:
  a. Is provided in a timely manner based on:
    (1) The person's presenting condition.
    (2) The type of services provided.
  b. Is understandable to the person served.
  c. Is documented.
  d. Includes, as applicable:
    (1) An explanation of:
      (a) The rights and responsibilities of the persons served.
      (b) Complaint and appeal procedures.
      (c) Ways in which input can be given.
      (d) The organization's:
         (i) Confidentiality policies.
        (ii) Intent/consent to treat.
       (iii) Behavioral expectations of the person served.
        (iv) Transition criteria and procedures.
         (v) Discharge criteria.
        (vi) Response to identification of potential risk to the person served.
       (vii) Access to after-hour services.
      (viii) Standards of professional conduct related to services.
        (ix) Requirements for reporting and/or follow-up for the mandated person served, regardless of his or her discharge outcome.
      (e) Any and all financial obligations, fees, and financial arrangements for services provided by the organization.
      (f) The program's health and safety policies regarding:
         (i) The use of seclusion or restraint.
        (ii) Use of tobacco products.
       (iii) Illegal or legal substances brought into the program.
        (iv) Prescription medication brought into the program.
         (v) Weapons brought into the program.
      (g) The program rules and expectations of the person served, which identifies the following:
         (i) Any restrictions the program may place on the person served.
        (ii) Events, behaviors, or attitudes and their likely consequences.
       (iii) Means by which the person served may regain rights or privileges that have been restricted.
    (2) Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits.
    (3) Education regarding advance directives, when indicated.
    (4) Identification of the purpose and process of the assessment.
    (5) A description of:
      (a) How the person-centered plan will be developed.
      (b) The person's participation in goal development and achievement.

(c) **The potential course of treatment/services.**

(d) **How motivational incentives may be used.**

(e) **Expectations for legally required appointments, sanctions, or court notifications.**

(6) **Identification of the person(s) responsible for service coordination.**

Intent Statements

This standard relates to the involvement of the persons served and their understanding of exactly what will happen as services are delivered. While the orientation can be provided in a written or verbal manner, documentation supports that it has been conducted. Orientation can be provided by more than one person and over time. The extensiveness of the orientation may be impacted by the type of service provided or the condition of the person served at the time of admission.

Examples

9.b. When written material is given to the persons served regarding their rights, orientation, and other topics, it should be provided at a comprehensive reading level.

9.d.(1)(c) This would include an explanation of the organization's practices for obtaining input from the persons served as well as opportunities offered through the organization's outcomes management process, specifically regarding assessment of service and satisfaction by the person served. Input may be given through groups or individual sessions, suggestion boxes; surveys, grievance forms, etc.

9.d.(1)(e) Information includes length of time benefits will be paid by payer source if this information is available at time of orientation and how updates of benefits will be provided.

9.d.(1)(f)(iii) Includes alcohol and over-the-counter medications.

9.d.(3) Includes psychiatric advance directives, when legally available. The following factors will impact the applicability of this standard: state

laws or regulations, the type of service provided, or the specific population served.

See the Glossary for the definition of *advance directives*.

Assessment

2.B. 10. **Assessments are conducted by qualified personnel:**
  a. **Knowledgeable to assess the specific needs of the persons served.**
  b. **Trained in the use of applicable tools, tests, or instruments prior to administration.**
  c. **Able to communicate with the persons served.**

Examples

Qualified personnel are determined by the organization's leadership. The organization may base its determination on the skills, experience, and/or education of personnel and by state, federal, provincial, or other regulating guidelines.

2.B. 11. **When assessment results in diagnosis(es), the diagnosis is determined by a practitioner legally qualified to do so in accordance with all applicable laws and regulations.**

2.B. 12. **The assessment process includes information obtained from:**
  a. **The person served.**
  b. **Family members/legal guardian, when applicable and permitted.**
  c. **Other collateral sources, when applicable and permitted.**
  d. **External sources, when the need for specified assessments not able to be provided by the organization is identified.**

Intent Statements

12.c. This information is obtained with the permission of the person served unless a legal relationship indicates contact without permission.

Examples

12.c. Collateral sources may include:

- Parents/guardians.
- Teachers.
- Social workers.
- Probation officers.
- Physicians.
- Friends.
- Peers.

2.B. **13.** **The assessment process:**

    a. **Focuses on the person's specific needs.**

    b. **Identifies the goals and expectations of the person served.**

    c. **Is responsive to the changing needs of the person served.**

    d. **Includes provisions for communicating the results of the assessments to:**

      (1) **The person served/legal guardian.**

      (2) **Applicable personnel.**

      (3) **Others as appropriate.**

    e. **Provides the basis for legally required notification when applicable.**

    f. **Occurs within time frames established by the organization or external regulatory requirements.**

    g. **Reflects significant life or status changes of the person served.**

Intent Statements

Assessment information may be ongoing and collected over time or by various programs within an organization. The expectation is that the program has collected information adequate to result in individualized and goal-oriented, person-centered planning.

13.b. This part of the assessment identifies what the person wants or why the person is coming for services.

Examples

13.a. Specific needs may be related to:

- Age or developmental level.
- Gender.

- Sexual orientation.
- Social preferences.
- Cultural background.
- Psychological characteristics.
- Physical condition.
- Spiritual beliefs.

13.e. Notification may include child protective services, committing or referring courts, a local provider identified under the Indian Child Welfare Act, or probation or parole officers.

2.B. **14.** **The assessment process gathers and records sufficient information to develop a comprehensive person-centered plan for each person served, including information about the person's:**

    a. **Presenting issues from the perspective of the person served.**

    b. **Urgent needs, including:**

      (1) **Suicide risk.**

      (2) **Personal safety.**

      (3) **Risk to others.**

    c. **Personal strengths.**

    d. **Individual needs.**

    e. **Abilities and/or interests.**

    f. **Preferences.**

    g. **Previous behavioral health services, including:**

      (1) **Diagnostic history.**

      (2) **Treatment history.**

    h. **Mental status.**

    i. **Medication, including:**

      (1) **Medication history and current use profile.**

      (2) **Efficacy of current or previously used medication.**

      (3) **Medication allergies or adverse reactions to medications.**

    j. **Physical health information, including:**

      (1) **Health history.**

      (2) **Current health needs.**

    k. **Co-occurring disabilities, disorders, and medical conditions.**

l. **Current level of functioning.**
m. **Pertinent current and historical life information, including his or her:**
    (1) **Age.**
    (2) **Gender, sexual orientation, and gender expression.**
    (3) **Culture.**
    (4) **Spiritual beliefs.**
    (5) **Education history.**
    (6) **Employment history.**
    (7) **Living situation.**
    (8) **Legal involvement.**
    (9) **Family history.**
    (10) **Relationships, including families, friends, community members, and other interested parties.**
n. **History of trauma:**
    (1) **That is:**
        (a) **Experienced.**
        (b) **Witnessed.**
    (2) **Including:**
        (a) **Abuse.**
        (b) **Neglect.**
        (c) **Violence.**
        (d) **Sexual assault.**
o. **Use of alcohol, tobacco, and/or other drugs.**
p. **Risk-taking behaviors.**
q. **Literacy level.**
r. **Need for assistive technology in the provision of services.**
s. **Need for, and availability of, social supports.**
t. **Advance directives, when applicable.**
u. **Psychological and social adjustment to disabilities and/or disorders.**
v. **Resultant diagnosis(es), if identified.**

Intent Statements

The intent of the standard is to collect an adequate amount of information to develop an appropriate plan of care and to subsequently provide appropriate and safe services. The information may be obtained from external sources.

🍁 **Note:** *In Canadian programs (such as Outpatient Treatment) where laws or regulations prohibit the*

collection of specifically identified information, an abbreviated assessment is allowed.

Examples

In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, Detoxification, or Employee Assistance Programs), peer-run/driven programs (such as Community Integration), or targeted case management such as Healthy Families America (HFA), the amount of information collected may be limited by time or the condition of the person served or the nature of service being provided.

14.b. When past suicide attempts have been identified or a suicide risk is determined, assessment of the severity of the suicide intent is documented and suicide precautions initiated.

Other precautions may include a safe, secure, and observable space; ongoing observation; and removal of items that could potentially be used to cause harm.

14.c. Personal strengths may include assets, resources, and natural positives.

14.d. Individual needs may include liabilities, weaknesses, and what the person needs to recover.

14.e. Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

14.f. Preferences are those things the person served feel will enhance his or her treatment experience.

14.g. Previous behavioral health data may include:

- Psychiatric assessments.
- Psychological assessments.
- Medication use.
- Hospitalizations.
- Alcohol and other drug services.
- Pertinent medical care.
- Community programs.

14.j.(2) Includes dental health, as well as visual or hearing concerns, when they appear to be a contributing factor to the presenting condition of the person served.

14.k. It is particularly important to identify any co-occurring disabilities and/or disorders, including primary care issues that may impact the therapeutic relationship with the person served.

14.l. Current levels of functioning may include cognitive, emotional, and behavioral functioning.

14.m.(2)–(4) Gender, sexual orientation, gender expression, cultural background, and spiritual beliefs may be essential components to recovery or treatment and therefore are not excluded as a factor when gathering information.

14.n.(2)(a) Abuse may include previous trauma survivor concerns; spousal/partner abuse; abuse suffered as a child; physical, sexual, emotional, or psychological abuse; PTSD; and information, when applicable, as to whether the person served was a victim, perpetrator, or witness.

14.t. The intent of the standard is to provide the person served with the specific opportunity to communicate whether or not he or she has an advance directive that may impact the course of the particular services provided. See the Glossary for the definition of *advance directives*. Applicability will generally occur in those states that allow psychiatric advance directives.

2.B. **15. The assessment process includes the preparation of a written interpretive summary that:**
   a. **Is based on the assessment data.**
   b. **Identifies any co-occurring disabilities, co-morbidities, and/or disorders.**
   c. **Is used in the development of the person-centered plan.**

Intent Statements

The interpretive summary is a paragraph or paragraphs written to integrate and interpret from a broader perspective all history and assessment information collected. It should identify co-occurring disabilities and address how they are considered when developing the person-centered plan.

Examples

The interpretive summary could address:

- The central theme(s) apparent in the presentation of the person served.

- Histories and assessments (medical, psychosocial, spiritual, or vocational), with special emphasis on potential interrelationships between sets of findings.

- The perception of the person served of his or her needs, strengths, limitations, and problems.

- Clinical judgments regarding both positive and negative factors likely to affect the person's course of treatment and clinical outcomes after discharge (i.e., recovery).

- Recommended treatments, including any special assessments or tests, as well as routine procedures (e.g., laboratory tests).

- A general discussion of the anticipated level of care, length, and intensity of treatment and expected focus (goals) with recommendations.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies and procedures defining access to services
- Policies and procedures for the screening process
- Documentation of initial screening
- Criteria for admission to and exclusion from services
- Waiting lists and relevant written procedures, if applicable
- Documentation of contact made with persons on the waiting list
- Documentation of ineligibility and recommendations for alternative services
- Documentation of orientation
- A copy of the rules of the program
- Individual records
- Initial and ongoing assessments
- An interpretive summary

C. Person-Centered Plan

Description

Each person served is actively involved in and has a significant role in the person-centered planning process and determining the direction of his or her plan. The person-centered plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the person served, as well as identified challenges and potential solutions. The planning process is person-directed and person-centered. The person-centered plan may also be referred to as an individual service plan, treatment plan, or plan of care. In a family-centered program, the plan may be for the family and identified as a family-centered plan.

NOTE: *Please refer to the grid of Applicable Standards on page 96 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.*

2.C. **1.** A written person-centered plan is:

    a. **Developed with:**

        (1) **The active participation of the person served.**

        (2) **The involvement of family/legal guardian of the person served, when applicable and permitted.**

    b. **Prepared using the information from the assessment process.**

    c. **Based upon the person's:**

        (1) **Strengths.**

        (2) **Needs.**

        (3) **Abilities.**

        (4) **Preferences.**

    d. **Focused on the integration and inclusion of the person served into:**

        (1) **His or her community.**

        (2) **The family, when appropriate.**

        (3) **Natural support systems.**

        (4) **Other needed services.**

    e. **Communicated to the person served in a manner that is understandable.**

    f. **Provided to the person served, when applicable.**

Intent Statements

Although CARF does not prescribe any particular form or format to be used for the person-centered plan, this standard has specific requirements with regard to the components of the plan and how to develop and review it.

1.d. This standard requires both integration and inclusion, which is interpreted to mean that the person is present at and participates in integrated settings and situations.

Examples

1.c.(1) Personal strengths may include assets, resources, and natural positives.

1.c.(2) Individualized needs may include liabilities, weaknesses, and what the person needs to recover.

1.c.(3) Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

1.c.(4) Preferences are those things the person served feel will enhance his or her treatment experience.

1.d.(3) Natural supports may include extended family, friends, volunteer organizations, self-help or support groups, churches or other religious/ spiritual supports.

2.C. **2.** The person-centered plan includes the following components:

    a. **The identification of the needs/ desires of the person served through:**

        (1) **Goals that are expressed in the words of the person served.**

        (2) **When necessary, clinical goals that are understandable to the person served.**

        (3) **Goals that are reflective of the informed choice of the person served or parent/guardian.**

    b. **Specific service or treatment objectives that are:**

        (1) **Reflective of the expectations of:**

            (a) **The person served.**

            (b) **The service/treatment team.**

(2) **Reflective of the person's:**
    (a) **Age.**
    (b) **Development.**
    (c) **Culture and ethnicity.**

(3) **Responsive to the person's disabilities/disorders or concerns.**

(4) **Understandable to the person served.**

(5) **Measurable.**

(6) **Achievable.**

(7) **Time specific.**

(8) **Appropriate to the service/ treatment setting.**

c. **Identification of specific interventions, modalities, and/or services to be used.**

d. **Frequency of specific interventions, modalities, or services.**

e. **When applicable, information on, or conditions for:**

(1) **Any needs beyond the scope of the program.**

(2) **Referrals for additional services.**

(3) **Transition to other community services.**

(4) **Community-based service options available to persons in long-term residential support programs.**

(5) **Available aftercare options, when needed.**

f. **When applicable, identification of:**

(1) **Legal requirements.**

(2) **Legally imposed fees.**

Intent Statements

The person-centered plan includes two main components, the first of which addresses the global needs of the person served. The organization demonstrates, through the identification of goals, its knowledge and awareness of the critical global needs of the person served. This component includes goals expressed in the words of the person served and is based on his or her needs and preferences. While goals written in clinical terms may also be required, it is expected that these goals will be understandable to the person served.

The second component of the plan provides the blueprint for individual service development and is consistent with the outcomes expected by the person served and the organization. This includes the development of clinical service or treatment objectives that are measurable and time specific.

2.f.(2) This standard refers to any court-ordered restitution or fines.

Examples

The person-centered plan may vary in size and complexity based on the type of service provided. In a short-term crisis program, such as crisis intervention, crisis stabilization, or detoxification, the plan may address only the immediate stabilization of the person served and the transition to other services.

2.a.(1) The words of the person served may be quoted, paraphrased, written by him or her, or described. Direct quotes are not required.

2.C. **3. Person-centered plans are reviewed periodically with the person served to:**

a. **Reflect current issues.**

b. **Maintain relevance.**

c. **Modify goals, objectives, and interventions, when necessary.**

d. **Maintain visitation plans and/or court orders, when applicable.**

Intent Statements

Regular review and modification to meet the needs of the person served are key components of this standard. The organization determines its time frames for regular review to ensure that the person-centered plan remains current at all times.

2.C. **4. Progress toward achievement of service or treatment objectives for the person served is:**

a. **Documented.**

b. **Utilized for service or treatment improvement.**

c. **Communicated to the person served.**

2.C. **5. When assessment identifies a potential risk for dangerous behaviors, a personal safety plan:**

    a. Is completed:

        (1) With the person served.

        (2) As soon as possible after admission.

    b. Includes:

        (1) Triggers.

        (2) Current coping skills.

        (3) Warning signs.

        (4) Preferred interventions necessary for:

            (a) Personal safety.

            (b) Public safety.

        (5) Advance directives, when available.

Intent Statements

The intent of this standard is that as much information is collected as necessary to identify methods for safety responding to dangerous behaviors exhibited by the person served. The plan identifies how to recognize and respond to a person with escalating behavior in a manner that is safe, effective, and clinically responsible.

Examples

A personal safety plan may be referred to as a crisis intervention or behavioral management treatment plan, a crisis plan, or may be referred to in a psychiatric advance directive.

2.C. **6. When the person served has concurrent disorders or disabilities and/or co-morbidities:**

    a. The person-centered plan specifically addresses these conditions in an integrated manner.

    b. Services are provided by personnel, either within the organization or by referral, who are qualified to provide services for persons with concurrent disabilities and/or disorders.

Intent Statements

Given the incidence of concurrent disabilities and/or disorders, effectively addressing these is critical to successful recovery. The intent of this standard is that when the assessment identifies concurrent needs, they are addressed either through provision of service by the organization or referral to other providers.

Examples

6.a. In addition to behavioral health issues, such as addictions or mental illness, and intellectual or other developmental disabilities, concurrent disabilities and disorders include all chronic medical conditions for which the organization will provide or ensure monitoring/treatment.

2.C. **7. If services are provided to persons who have intensive medical needs:**

    a. The person-centered plan specifically addresses how services will be provided in a manner that ensures the safety of the person served.

    b. Services are provided in accordance with all regulatory requirements.

Intent Statements

7.a. Services to individuals with intensive medical needs should include specific measures to prevent injury, abuse, and neglect.

7.b. Regulatory requirements to which the program might be under could include Medicaid rules.

Examples

Intensive medical needs could include short-term serious injuries, the risk of experiencing symptoms in response to substance withdrawal, or long-term medical conditions requiring staff support or attention.

2.C. **8. Progress notes:**

    a. Document:

        (1) Progress toward achievement of identified:

            (a) Objectives.

            (b) Goals.

        (2) Significant events or changes in the life of the person served.

(3) The delivery and outcome of specific interventions, modalities, and/or services that support the person-centered plan.

(4) Changes in:

(a) Frequency of services.

(b) Levels of care.

b. Are:

(1) Signed.

(2) Dated.

Intent Statements

The progress notes are signed and dated by each individual making an entry into the record. A reviewer of the progress notes is able to readily identify the goals and objectives that were achieved or revised during the reporting period, occurrences in the life of the person served that may impact the course of treatment or service, and the specific services and interventions that the organization has provided.

Examples

8.a.(1) May include SOAP (subjective, objective, assessment, and plan) notes.

8.b. The use of initials would not meet the intent of the standard unless a signature sheet is used to verify the person signing. Electronic systems that restrict or automatically identify the person entering the data and the date the information is entered will conform to the intent of this standard.

8.b.(2) *Dated* refers to the month, day, and year, but does not require the specific time of day.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Person-centered plans
- Primary assessment and interpretive summary
- Progress notes

D. Transition/Discharge

Description

Transition, continuing care, or discharge planning assists the persons served to move from one level of care to another within the organization or to obtain services that are needed but are not available within the organization. The transition process is planned with the active participation of each person served. Transition may include planned discharge, placement on inactive status, movement to a different level of service or intensity of contact, or a re-entry program in a criminal justice system.

The transition plan is a document developed with and for the person served and other interested participants to guide the person served in activities following transition/discharge to support the gains made during program participation. It is prepared with the active participation of person served when he or she moves to another level of care, after-care program, or community-based services. The transition plan is meant to be a plan that the person served uses to identify the support that is needed to prevent a recurrence of symptoms or reduction in functioning. It is expected that the person served receives a copy of the transition plan.

A discharge summary is a clinical document written by the program personnel who are involved in the services provided to the person served and is completed when the person leaves the program (planned or unplanned). It is a document that is intended for the record of the person served and released, with appropriate authorization, to describe the course of services that the program provided and the response by the person served.

Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual's ongoing recovery or well-being. The organization proactively attempts to connect the persons served with the receiving service provider and contact the persons served after formal transition or discharge to gather needed information related to their post-discharge status. Discharge information is reviewed to determine the effectiveness of its

services and whether additional services were needed.

Transition planning may be included as part of the person-centered plan. The transition plan and/or discharge summary may be a combined document as long as it is clear whether the information relates to transition or pre-discharge planning or identifies the person's discharge or departure from the program.

Note: *Please refer to the grid of Applicable Standards on page 96 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.*

2.D. **1. The program implements written procedures for:**
   a. **Referrals.**
   b. **Transfer to another level of care, when applicable.**
   c. **Transfer to other services.**
   d. **Inactive status, if appropriate.**
   e. **Discharge.**
   f. **Follow-up.**

Examples

Identified needs may be specific to the individual's age, gender, disability/disorder, or other special circumstances.

Referrals may be made for:

- Alcohol and other drug services.
- Case management.
- Community housing programs.
- Supported living programs.
- Day habilitation programs.
- Community employment services.
- Domestic violence services.
- Crisis intervention services.
- Electronic or virtual services.
- Inpatient services.
- Medical services.
- Medication management.
- Meeting legal requirements of the person served.
- Outpatient therapy services.
- Partial hospitalization.

- Psychological services.
- Psychiatric services.
- Recreation/community living services.
- Relapse prevention groups.
- Residential treatment.
- Self-help groups.
- Social/protective services.
- Therapeutic foster care.
- Vocational rehabilitation.
- Employment services.
- Psychosocial rehabilitation.
- Psychosocial education, including training in money management and personal living skills.
- Income maintenance.
- Dietary services.
- Physical/occupational therapy.
- Speech-language pathology.
- Developmental training.
- Educational services.
- Person-centered plan coordination.
- Continuing care.

Transition

2.D. **2. When clinically indicated, transition planning is initiated with the person served as early as possible in the person-centered planning and service delivery process.**

Intent Statements

Ideally, transition planning is done prior to or at the onset of treatment. The transition period is particularly critical in that it tends to place many pressures on the person served, the organization, and the community. Therefore, adequate preparation for transition requires giving more than routine notice to the person served that he or she is nearing completion of the program. It is necessary that there be early and active involvement by the person served, the family, referral sources, and other community agencies that will be serving the person. Transition services are particularly critical when adolescents are reaching the age of

majority and will require ongoing services in adulthood.

Examples

Transition planning for persons with intellectual disabilities should be a part of planning from the beginning. Persons are given supports to explore other options that are available and connected with resources for growth, such as self-advocacy groups.

Clinical indication recognizes that in certain programs, transition planning may be delayed.

In longer-term programs, such as assertive community treatment, initial planning may focus on engagement as opposed to transition. In a membership-based program, transitioning may be a choice of the person served. In an opioid treatment program, the preferred goal may be continued engagement as opposed to transition.

2.D. **3. The written transition plan:**

    a. **Is prepared or updated to ensure a seamless transition when a person served:**

       (1) **Is transferred to another level of care or an aftercare program.**

       (2) **Prepares for a planned discharge.**

    b. **Identifies the person's current:**

       (1) **Progress in his or her own recovery or move toward well-being.**

       (2) **Gains achieved during program participation.**

    c. **Identifies the person's need for support systems or other types of services that will assist in continuing his or her recovery, well-being, or community integration.**

    d. **Includes information on the continuity of the person's medication(s), when applicable.**

    e. **Includes referral information, such as contact name, telephone number, locations, hours, and days of services, when applicable.**

    f. **Includes communication of information on options and resources available if symptoms recur or additional services are needed, when applicable.**

Intent Statements

An essential concept of this standard is to ensure a smooth or seamless transition when a person served is transferred to another level of care, another component of care, or an aftercare program, or is discharged from the program.

Examples

A transition plan may be identified as another title such as continuing care plan, referral plan, discharge plan, or aftercare plan (see the Glossary for definition).

In some programs, a similar plan may be prepared when the person served is placed on inactive status. There may be times when the transition plan is incorporated into the person-centered service/treatment plan of the person served.

It is recognized that there may be times when the person served chooses to abruptly leave a program and transition planning is not possible. In those cases, documentation would include a discharge summary.

2.D. **4. The written transition plan is:**

    a. **Developed with the input and participation of:**

       (1) **The person served.**

       (2) **The family/legal guardian, when applicable and permitted.**

       (3) **A legally authorized representative, when appropriate.**

       (4) **Team members.**

       (5) **The referral source, when appropriate and permitted.**

       (6) **Other community services, when appropriate and permitted.**

    b. **Given to individuals who participate in the development of the transition plan, when permitted.**

Intent Statements

4.b. A copy of the plan is provided to transition planning participants when beneficial to the person served, as an assist to the referral source or the receiving program(s).

Discharge

2.D. 5. For all persons leaving services, a written discharge summary is prepared to ensure that the person served has documented treatment episodes and results of treatment. The discharge summary:

  a. Includes the date of admission.

  b. Describes the services provided.

  c. Identifies the presenting condition.

  d. Describes the extent to which established goals and objectives were achieved.

  e. Describes the reasons for discharge.

  f. Identifies the status of the person served at last contact.

  g. Lists recommendations for services or supports.

  h. Includes the date of discharge from the program.

Intent Statements

A discharge summary is a tool that facilitates continuity of care and serves to document a baseline which may be helpful for future service provision.

Examples

5.d. This could include gains achieved by the persons served during program participation, strides made by the person served in the recovery process, or any positive move toward well-being.

5.g. This should include referral resource information, contact name, telephone number, and hours and days of operation.

2.D. 6. When an unplanned discharge occurs, follow-up is conducted as soon as possible to:

  a. Provide necessary notifications.

  b. Clarify the reasons for the unplanned discharge.

  c. Determine with the person served whether further services are needed.

  d. Offer or refer to needed services.

Examples

6.a. Notifications may be required when the person served is referred under legal process such as a commitment or court-ordered services; when the person served is under legal custody or guardianship; or under certain contracts for services.

2.D. 7. When a transition plan or discharge summary is provided to external programs/services to support a person's transition or discharge, it includes the person's identified:

  a. Strengths.

  b. Needs.

  c. Abilities.

  d. Preferences.

Intent Statements

It is important to identify and pass on information about a person's strengths, needs, abilities, and preferences to other treatment providers to ensure continuity of care. This may be done by sharing the transition plan, the discharge summary, or other comparable documents.

Examples

7.a. Personal strengths may include assets, resources, and natural positives.

7.b. Individualized needs may include liabilities, weaknesses, and what the person needs to recover.

7.c. Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

7.d. Preferences are those things the person served feel will enhance his or her treatment experience.

2.D. 8. When a person is transferred or discharged, the program identifies:

  a. A process to ensure coordination.

  b. The person responsible for coordinating the transfer or discharge.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written procedures for referrals, transfers, discharges, and follow-up
- Written transition plans
- Written discharge summaries

E. Medication Use

Description

Medication use is the practice of handling, prescribing, dispensing, and/or administering medications to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious. Medication use may include self administration, or be provided by personnel of the organization or under contract with a licensed individual. Medication use is directed toward maximizing the functioning of the persons served while reducing their specific symptoms and minimizing the impact of side effects.

Medication use includes prescribed or sample medications, and may, when required as part of the treatment regimen, include over-the-counter or alternative medications provided to the person served. Alternative medications can include herbal or mineral supplements, vitamins, homeopathic remedies, hormone therapy, or culturally specific treatments.

Medication control is identified as the process of physically controlling, transporting, storing, and disposing of medications, including those self administered by the person served.

Self administration for adults is the application of a medication (whether by injection, inhalation, oral ingestion, or any other means) by the person served, to his/her body; and may include the organization storing the medication for the person served, or may include staff handing the bottle or blister-pak to the person served, instructing or verbally prompting the person served to take the medication, coaching the person served through the steps to ensure proper adherence, and closely observing the person served self-administering the medication.

Self administration by children or adolescents in a residential setting must be directly supervised by personnel, and standards related to medication use applied.

Dispensing is considered the practice of pharmacy; the process of preparing and delivering a prescribed medication (including samples) that has been packaged or re-packaged and labeled

by a physician or pharmacist or other qualified professional licensed to dispense (for later oral ingestion, injection, inhalation, or other means of administration).

Prescribing is evaluating, determining what agent is to be used by and giving direction to a person served (or family/legal guardian), in the preparation and administration of a remedy to be used in the treatment of disease. It includes a verbal or written order, by a qualified professional licensed to prescribe, that details what medication should be given to whom, in what formulation and dose, by what route, when, how frequently, and for what length of time.

Applicable Standards

- All organizations must apply Standard 2.E.1. A policy for Standard 2.E.1. is developed by the organization or each program regardless of its involvement in medication use, that details the position of the organization on these procedures.

- All organizations must consider standard 2.E.2. and apply it based on the population served and the programs or services provided.

- If an organization controls medications, Standard 2.E.2., when applicable, and 2.E.3., will also apply.

- If an organization provides any additional aspects of medication use, all standards in this subsection are applicable to the degree that they define the organization's practice.

All policies and procedures related to medication use and medication monitoring are implemented consistent with federal, state, or provincial laws and licensure requirements.

To clarify whether your programs provide any level of medication use, as defined by CARF, contact the CARF office.

2.E. **1. The organization has a policy that identifies:**

  a. **Whether or not medications are used in its programs.**

  b. **The process for persons served to obtain medications needed to promote recovery and/or desired treatment/service outcomes, including whether or not it directly provides:**
     (1) **Medication control.**
     (2) **Prescribing.**
     (3) **Dispensing.**
     (4) **Administering.**

Training and Education

2.E. **2. In response to the needs of the persons served and the type of service provided, documented ongoing training and education regarding medications:**

  a. **Is received by:**
     (1) **The persons served.**
     (2) **When applicable, individuals and family members with legal right or identified by the persons served.**
     (3) **Personnel providing direct service to the person served.**

  b. **Includes:**
     (1) **How the medication works.**
     (2) **The risks associated with each medicine.**
     (3) **The intended benefits, as related to the behavior or symptom targeted by this medication.**
     (4) **Side effects.**
     (5) **Contraindications.**
     (6) **Potential implications between medications and diet/exercise.**
     (7) **Risks associated with pregnancy.**

(8) **The importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence.**

(9) **The need for laboratory monitoring.**

(10) **The rationale for each medication.**

(11) **Early signs of relapse related to medication efficacy.**

(12) **Signs of nonadherence to medication prescriptions.**

(13) **Potential drug reactions when combining prescription and nonprescription medications, including alcohol, tobacco, caffeine, illegal drugs, and alternative medications.**

(14) **Instructions on self-administration, when applicable.**

(15) **Wellness management and recovery planning.**

(16) **The availability of financial supports and resources to assist the persons served with handling the costs associated with medications.**

Intent Statements

The intent of this standard is to ensure that appropriate education and ongoing training is provided to the persons served, family members, individuals identified by the persons served, the team, and service providers.

The intent of this standard is to ensure that training is provided that covers all of the pertinent areas of medication management.

Examples

2.a.(2) Based on the age or competency of the person served, training and education may need to be provided to others involved in the administration or monitoring of medications.

2.b.(13) Alternative medications can include:

- Experimental medications not readily available by prescription.
- Herbal supplements, homeopathic remedies, vitamins and mineral supplements, and hormone therapy.
- Culturally specific treatments prescribed by traditional healers (e.g., Native American medicine men or women, curanderas, and shamans).

Medication Control

2.E. **3.** **When the organization physically controls medications (including medications self-administered by the person served or the use of samples), written procedures are implemented and include:**

a. **Compliance with all applicable local, state or provincial, and federal laws and regulations pertaining to medications and controlled substances, including on-site pharmacy services and dispensing.**

b. **Purchase, when applicable.**

c. **Transportation and delivery, when applicable.**

d. **Safe storage.**

e. **Safe handling.**

f. **Packaging and labeling, when applicable.**

g. **Management of biohazards associated with the use of medications.**

h. **Safe disposal.**

i. **Inventory.**

j. **Self-administration.**

k. **Off-site use.**

Examples

3.k. Including home visits, when applicable.

2.E. 4. When medications are prescribed for or provided to a person served, or when a person (including those self-administering medications) is served in a residential program:

  a. An up-to-date individual record of all medications, including nonprescription and nonpsychoactive medications, includes:

    (1) The name of the medication.

    (2) The dosage.

    (3) The frequency.

    (4) Instructions for use, including the method/route of administration.

    (5) The prescribing professional.

  b. The program provides ready access to the telephone number of a poison control center to:

    (1) The program personnel.

    (2) The persons served.

  c. Written procedures address:

    (1) How medications will be integrated into the overall plan of the person served.

    (2) The process for identifying, responding to, documenting, and reporting medication reactions.

    (3) Actions to be followed in case of emergencies related to the use of medications.

Examples

4.a. May be in separate medical record, as long as it is accessible.

Medication Prescribing, Dispensing, and Administering

2.E. 5. An organization that provides prescribing, dispensing, or administering of medications implements written procedures that include:

  a. Compliance with all applicable local, state or provincial, and federal laws and regulations pertaining to medications and controlled substances, including on-site pharmacy services and dispensing.

  b. Active involvement of the persons served, when able, or their parents or guardians, when appropriate, in making decisions related to the use of medications.

  c. Availability of a physician, pharmacist, or qualified professional licensed to prescribe for consultation 24 hours a day, 7 days a week.

  d. Documentation and reporting of:

    (1) Observed and/or reported medication reactions.

    (2) Medication errors.

  e. Review of past medication use, including:

    (1) Effectiveness.

    (2) Side effects.

    (3) Allergies or adverse reactions.

  f. Identification of alcohol, tobacco, and other drug use.

  g. Use of over-the-counter medications.

  h. Use of medications by women of child bearing age.

  i. Use of medications during pregnancy.

  j. Special dietary needs and restrictions associated with medication use.

  k. Necessary laboratory studies, tests, or other procedures.

l. When applicable, documented assessment of abnormal involuntary movements at the initiation of treatment and every six months thereafter for persons served receiving typical antipsychotic medications.

m. When possible, coordination with the physician(s) providing primary care needs.

n. Review of medication use activities, including medication errors and drug reactions, as part of the quality monitoring and improvement system.

Intent Statements

This standard does not apply in programs when medication use is limited to self administration.

Examples

5.c. Consistent with state and provincial licensure, physician assistants, nurse practitioners, prescribing professionals, or qualified professionals licensed to prescribe may substitute for physician availability. Consultation can be obtained through direct employment, contract or consultant agreement, or medical facility agreements. Organizations may use telepsychiatry or telemedicine as a method of obtaining consultation.

5.d. May be reported by the person served or in response to staff observation.

5.l. Documentation occurs when medications, which may result in the identified side effects, are prescribed. Documentation may include formal assessment or the result of observation by appropriate medical personnel.

2.E. **6.** An organization that provides prescribing of medications has written procedures that include:

a. Screening for common medical co-morbidities using evidence- or consensus-based protocols.

b. Evaluation of co-existing medical conditions for potential medication impact.

c. Identifying potential drug interactions, including the use of over-the-counter or homeopathic supplements.

d. Documentation or confirmation of informed consent for each medication prescribed, when possible.

e. Continuing a prescribed medication if a generic medication is not available.

f. Continuity of medication use when identified as a need in a transition plan for a person served.

Examples

6.a. The ADA/APA have published consensus guidelines for identification and management of diabetes in patients prescribed psychotropic medications.

6.d. May include info on alternative meds or alternatives to the use of meds, as well as intended benefits, possible side effects or contra-indications. Evidence of consent for prescribing of medications may include formal signed consent forms; a notation by the prescribing individual in the record of the person served that the medication has been discussed and agreed upon; or medication to be prescribed listed on a person-centered plan actively developed with the person served.

2.E. **7.** An organization that provides prescribing of medications demonstrates:

a. To the extent possible, the use of treatment guidelines and protocols to:

(1) Promote state-of-the-art prescribing.

(2) Ensure safety of the person served.

b. A program of medication utilization evaluation, which includes measures of:

(1) Effectiveness.

(2) Satisfaction of person served.

Intent Statements

There is emerging consensus in psychiatry and other medical disciplines on best practices in

medication prescribing, including the use of guidelines, algorithms, and protocols as well as the evaluation of the efficacy and safety of new medications. Each organization regularly monitors and evaluates these practice trends in the field and considers the use of formularies to measure cost effectiveness to the person served. Reasons for not adopting such practices should be explained.

7.b. The medication utilization evaluation is conducted by a qualified physician, pharmacist, or other professional with legal prescribing authority who is not immediately responsible for the prescribing process but able to provide feedback to the prescribing practitioner. When available, a system of internal peer review may be used.

Examples

7.b. The mechanism for periodic review of actual prescribing practices may include the following:

■ Adherence to guidelines and algorithms.

■ Documentation of appropriate clinical exceptions.

■ Off-formulary prescribing.

■ Polypharmacy and inappropriate or excessive prescribing.

■ Monitoring for side effects.

■ Therapeutic benefit.

■ Practitioner trends.

2.E. **8.** **In an organization that provides prescribing of medications, a documented peer review is conducted:**

   a. **At least annually.**

   b. **On a representative sample of records of persons for whom prescriptions were provided.**

   c. **To assess the appropriateness of each medication, as determined by:**

     (1) **The needs and preferences of each person served.**

     (2) **The efficacy of the medication.**

   d. **To determine if:**

     (1) **The presence of side effects, unusual effects, and contraindications were identified and addressed.**

     (2) **Necessary tests were conducted.**

   e. **To identify:**

     (1) **The use of multiple simultaneous medications.**

     (2) **Medication interactions.**

Intent Statements

The peer review is conducted by a qualified physician, pharmacist, or other professional with legal prescribing authority who is not immediately responsible for the prescribing process but able to provide feedback to the prescribing practitioner. When available, a system of internal peer review may be used. The peer review can be conducted by mid-level practitioners; however, only within the scope of their prescribing privileges.

Examples

The frequency of the reviews depends on:

■ The degree of severity of the person's disability/disorder.

■ Whether multiple medications are provided and other contraindications exist.

■ The intensity of the program.

■ The average length of stay.

8.c.(2) See the Glossary for the definition of *efficacy*.

2.E. **9.** **In an organization that provides prescribing of medications, information collected from the peer review process is:**

   a. **Reported to applicable staff.**

   b. **Used to improve the quality of services provided.**

   c. **Incorporated into the organization's performance improvement system.**

10. An organization that provides dispensing or administering of medications implements written procedures that address:

    a. **Staff credentials and competencies.**

    b. **Documentation of medication administration, errors, and reactions.**

    c. **Documentation of the use and benefits of as-needed (prn) doses.**

    d. **Coordination when a medication is prescribed by a source other than the organization.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies related to medication use
- Written procedures regarding medication use
- Documentation of ongoing training and education regarding medications for the persons served, individuals, and family members, when applicable, and personnel providing direct services
- Policies and written procedures regarding the practices of prescribing, dispensing, or administering medications, when applicable
- Up-to-date individual records of all medications
- Documentation of the administration of medications and related safety practices
- Documentation of all prescribed medications
- Documentation of a peer review of the prescribing of medications
- Individual records, medication logs, and physician notes

F. Nonviolent Practices

Description

Programs strive to be learning environments and to support persons served in the development of recovery, resiliency, and wellness. Relationships are central to supporting individuals in recovery and wellness. Programs are challenged to establish quality relationships as a foundation to supporting recovery and wellness. Providers need to be mindful of developing cultures that create healing, healthy and safe environments, and include the following:

- Engagement
- Partnership—power with, not over
- Holistic approaches
- Respect
- Hope
- Self direction

Programs need to recognize that individuals may require supports to fully benefit from their services. Staff are expected to access or provide those supports wanted and needed by the individual. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement.

Even with supports, there are times when individuals may show signs of fear, anger, or pain, which may lead to aggression or agitation. Staff members are trained to recognize and respond to these signs through de-escalation, changes to the physical environmental, implementation of meaningful and engaging activities, redirection, active listening, etc. On the rare occasions when these interventions are not successful and there is imminent danger of serious harm, seclusion or restraint may be used to ensure safety. Seclusion and restraint are never considered treatment interventions; they are always considered actions of last resort. The use of seclusion and restraint must always be followed by a full review, as part of the process to eliminate the use of these in the future.

The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use

of seclusion or restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice. Each organization still utilizing seclusion or restraint should have the elimination thereof as an eventual goal.

Restraint is the use of physical force or mechanical means to temporarily limit a person's freedom of movement; chemical restraint is the involuntary emergency administration of medication, in immediate response to a dangerous behavior. Restraints used as an assistive device for persons with physical or medical needs are not considered restraints for purposes of this section. Briefly holding a person served, without undue force, for the purpose of comforting him or her or to prevent self-injurious behavior or injury to self, or holding a person's hand or arm to safely guide him or her from one area to another, is not a restraint. Separating individuals threatening to harm one another, without implementing restraints, is not considered restraint.

Seclusion refers to restriction of the person served to a segregated room with the person's freedom to leave physically restricted. Voluntary time out is not considered seclusion, even though the voluntary time out may occur in response to verbal direction; the person served is considered in seclusion if freedom to leave the segregated room is denied.

Seclusion or restraint by trained and competent personnel is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm. Peer restraint is not considered an acceptable alternative to restraint by personnel. Seclusion or restraint is not used as a means of coercion, discipline, convenience, or retaliation.

In a correctional setting, the use of seclusion or restraint for purposes of security is not considered seclusion or restraint under these standards. Security doors designed to prevent elopement or wandering are not considered seclusion or restraint. Security measures for forensic purposes, such as the use of handcuffs instituted by law enforcement personnel, are not subject to these standards. When permissible,

consideration is made to removal of physical restraints while the person is receiving services in the behavioral health care setting.

Applicable Standards

All organizations must apply Standard 2.F.1. Statements and procedures clearly outline the expectations regarding response by personnel to emergencies involving assault or aggression. All policies and procedures related to seclusion and restraint are implemented consistent with federal, state, or provincial laws and licensure requirements.

All organizations must consider Standard 2.F.2. and apply it based on the population served and the programs or services provided.

If an organization uses seclusion or restraint, all standards in Section 2.F. apply.

To determine if an organization's intervention methods are defined by CARF as seclusion or restraint, contact the CARF office.

2.F. **1. The organization has a policy that identifies:**
   a. **How all personnel employed by the organization will be trained on the prevention of workplace violence.**
   b. **How it will respond to aggressive or assaultive behaviors.**
   c. **Whether, and under what circumstances:**
      (1) **Seclusion is used within the programs it provides.**
      (2) **Restraints are used within the programs it provides.**

Intent Statements

Personnel understand the organization's expectations for responding to threatening or violent behavior. A policy is required that details whether or not the organization uses seclusion or restraint. Therefore, every organization seeking accreditation must have a policy statement that outlines its position on the use of seclusion or restraint. Personnel and the persons served understand the organization's policy and position on the use of seclusion and restraint, and it is clearly

understood under what circumstances, if any, seclusion or restraint would be used.

2.F. **2.** **As applicable to the population served, all direct service or front-line personnel employed by the organization receive documented initial and ongoing competency-based training in:**

　　a. **The contributing factors or causes of threatening behavior, including training on recovery and trauma-informed services and the use of personal safety plans.**

　　b. **The ability to recognize precursors that may lead to aggressive behavior.**

　　c. **How interpersonal interactions, including how personnel interact with each other and with the persons served, may impact the behaviors of the persons served.**

　　d. **Medical conditions that may contribute to aggressive behavior.**

　　e. **The use of a continuum of alternative interventions.**

　　f. **The prevention of threatening behaviors.**

　　g. **Recovery/wellness oriented relationships and practices.**

　　h. **How to handle a crisis without restraints, in a supportive and respectful manner.**

Examples

2.e. Examples may include engagement, one-to-one attention, meditation, mediation, de-escalation, self-protection, time out, re-direction, sensory or comfort rooms, prompting, or active listening.

Organizations may consider training in eCPR, a holistic empowering approach to assisting persons served to cope with emotional crisis. Information on this approach can be found at **www.emotional-cpr.org**.

2.g. In a program serving persons with mental illness, recovery is well defined at **www.samhsa.gov** and identifies ten fundamental components of recovery.

2.F. **3.** **All personnel involved in the direct administration of seclusion or restraint receive documented initial and ongoing competency-based training, provided by persons or entities qualified to conduct such training, on:**

　　a. **When and how to restrain or seclude while minimizing risk.**

　　b. **Recognizing signs of physical distress in the person who is being restrained or secluded.**

　　c. **The risks of seclusion or restraint to the persons served or personnel, including:**

　　　　(1) **Medical risks.**

　　　　(2) **Psychological risks.**

　　d. **First aid and CPR.**

　　e. **How to monitor and continually assess for the earliest release.**

　　f. **The practice of intervention done by an individual.**

　　g. **The practice of intervention done by a team.**

2.F. **4.** **If the organization uses seclusion and/or restraint, a plan is implemented to minimize or eliminate the use of restraints and/or seclusion that includes:**

　　a. **Identification of the role of leadership.**

　　b. **Use of data to inform practice.**

　　c. **Development of workforce attitudes, skills, and practices that support recovery.**

　　d. **Identification of:**

　　　　(1) **Specific strategies to prevent crisis.**

　　　　(2) **Timelines to reduce the use of seclusion and restraint.**

　　e. **Identification of roles for persons served and advocates in determining if crisis procedures and practices are implemented in a positive and proactive fashion.**

f. A review of the role of the debriefing process in supporting the reduction of the use of seclusion or restraint.

Examples

4.b. Examples may include data from organization debriefings, best practices from literature, and assessing biomechanical safety of techniques used.

4.d. Examples may include: full assessment of persons served that identify assessment for risk of violence, medical risk factors, trauma history, positive behavior support, trauma informed services (educates staff about how trauma affects persons' behaviors), building healthy relationships with boundaries, safety plans including advance directives, or assessing physical and environmental factors.

2.F. 5. A written status report on the plan for minimization or elimination of the use of seclusion and/or restraint:
  a. Is prepared annually.
  b. Includes:
     (1) Goals and timelines.
     (2) Progress made.
     (3) Areas still needing improvement.
     (4) Factors impeding elimination of the use of seclusion and restraint.

2.F. 6. If the organization uses seclusion or restraint, written procedures for the use of specific interventions include protocols for:
  a. Adults.
  b. Children and adolescents.
  c. Persons with special needs.
  d. Team interventions, including:
     (1) Defining team leadership.
     (2) Assigning team duties.

2.F. 7. If a personal safety plan exists for the person served, it is readily available for immediate reference.

2.F. 8. An organization that uses seclusion or restraint has policies that specify that:
  a. All attempts will be made to de-escalate crises and use seclusion or restraint only as a safety intervention of last resort.
  b. Seclusion or restraint (whether physical, mechanical, or chemical) is administered by behavioral health personnel who are trained and competent in the proper techniques of administering or applying and monitoring the form of seclusion or restraint ordered.
  c. Seclusion or restraint is used only for intervention in an individual's emergency situation and to prevent harm to him/herself or others.
  d. Seclusion or restraint is not used as coercion, discipline, convenience, or retaliation by personnel in lieu of adequate programming or staffing.

Intent Statements

Each program strives for a restraint-free environment and uses techniques, such as mediation and conflict resolution, as preventive measures.

Examples

8.b. Personnel administering seclusion or restraint receive annual training and demonstrate competencies on the particular intervention ordered and used. Seclusion or restraint is used only by personnel of the organization.

8.d. Seclusion or restraint is not considered an appropriate substitution for inadequate staffing. Inadequate staffing is defined as either maintaining a staffing pattern that is too low for the numbers of persons served and/or maintaining staff members who do not have the training, education, and experience to intervene safely without using seclusion or restraint.

2.F. **9.** **An organization that uses seclusion or restraint implements written procedures that specify that:**

a. **The intake evaluation of the person served:**
   (1) **Includes:**
      (a) **A review of the medical history to determine whether seclusion or restraint can be administered without risk to health and safety.**
      (b) **An assessment of physical, sexual, and emotional abuse, neglect, trauma, and exposure to violence.**
   (2) **Identifies contraindications to be considered prior to the use of seclusion or restraint.**

b. **Appropriate interaction with staff occurs as an effort to de-escalate threatening situations.**

c. **Standing orders are not issued to authorize the use of seclusion or restraint.**

d. **Immediate assessment of contributing environmental factors that may promote maladaptive behaviors are identified and actions taken to minimize those factors.**

e. **The simultaneous use of seclusion and restraint is prohibited unless a staff member has been assigned for continual face-to-face monitoring.**

f. **The physical plant can safely and humanely accommodate the practice of seclusion or restraint.**

g. **When seclusion or restraint is used:**
   (1) **Documentation confirms that identified contraindications were taken into consideration prior to the use of seclusion or restraint.**
   (2) **It is ordered by a physician or designated qualified behavioral health practitioner who has training and competence in the prevention and management of behaviors that are a danger to self or others.**
   (3) **It is administered in a safe manner, with consideration given to the physical, developmental, and abuse/neglect history of the person served.**
   (4) **Personnel are trained to monitor for the unique needs of a person in seclusion or restraint.**
   (5) **As soon as the threat of harm is no longer imminent, the person is removed from seclusion or restraint.**
   (6) **Staff communicate to the person being secluded or restrained their intention to keep them and others safe, and how the specific procedure being used will keep them and others safe.**
   (7) **When seclusion or restraint is used, a trained staff member must be assigned for continual monitoring.**
   (8) **Immediate medical attention is made available for any injury resulting from seclusion or restraint.**

Intent Statements

The intent of these standards is not to condone or promote the use of seclusion or restraint. The purpose is to set guidelines for the handling of emergency or highly disruptive situations requiring this level of intervention.

Examples

9.b. Appropriate interaction may be continuous in some cases or may be significantly less intrusive when the interaction appears to be exacerbating the potentially harmful behavior.

9.c. This standard refers to orders for an individual person served.

9.d. Attention is given to the internal environment of the treatment setting and how it impacts the behavior, interactions, and communication between personnel and the persons served.

9.g.(2) See the Glossary for the definition of *qualified behavioral health practitioner*.

9.g.(4) Consideration is given to the unique needs of children, older adults, persons with HIV, and to persons with varying developmental functioning levels as well as to a person's history of sexual or physical abuse or neglect.

2.F. **10.** **Organizations using seclusion or restraint implement written procedures to require that:**

a. **Documentation demonstrates that less restrictive intervention techniques were used prior to the use of seclusion or restraint.**

b. **A designated, qualified, and competent physician or qualified behavioral health practitioner provides face-to-face evaluation of the person served within one hour of the order for seclusion or restraint being given.**

c. **An order for seclusion or restraint is time limited and does not exceed four hours for an adult. For a child or adolescent, the order does not exceed one hour.**

d. **Orders for seclusion or restraint may be renewed for a total of up to 24 hours. Orders for renewal may only occur following a face-to-face assessment by a designated, trained, and competent qualified behavioral health practitioner.**

e. **After 24 hours, a new order is required following a face-to-face evaluation by a designated, qualified, and competent physician or qualified behavioral health practitioner.**

f. **Appropriately trained personnel continually assess, monitor, and re-evaluate the person served to determine whether seclusion or restraint is still needed.**

g. **All orders are entered into the record of the person served as soon as possible but not more than two hours after implementation.**

h. **The designated and qualified personnel sign the order within the time period mandated by law.**

i. **Face-to-face attention, including attention to vital signs and the need for meals, liquids, bathing, and use of the restroom, is given to a person in seclusion or restraint at least every 15 minutes by authorized personnel.**

j. **Documentation of re-evaluations and face-to-face attention is entered into the record.**

k. **As applicable and permitted, there is documentation that the family or significant other(s), legal guardian, advocate, and/or treating practitioner of the person served is notified as soon as possible but at least within ten hours of the initial use of seclusion or restraint.**

Intent Statements

The intent of this standard is to minimize the potential negative impact from the use of seclusion or restraint.

10.a. When an organization uses seclusion or restraint, the documentation related to the reasons for its use discusses how less-restrictive methods were tried and failed or the reasons less-restrictive methods were considered inappropriate and, therefore, were not used.

10.b. The face-to-face evaluation needs to assess the physical, emotional, and psychological well-being of the person served.

10.f. Every effort should be made to discontinue the use of seclusion or restraint in as short a time as is safely possible.

10.i. Attention is given every 15 minutes for the duration of the use of seclusion or restraint and involves direct observation. Documentation of this observation is a critical component of this standard. The observation includes a review of the criteria for release of the order.

Examples

10.b. See the Glossary for the definition of *qualified behavioral health practitioner*.

10.c. The order may be written or verbal, depending on the applicable federal, state, or

provincial laws. Once the order is obtained, both the order and the actual intervention will not exceed the time limits of four or one hour(s).

10.i. This can be conducted by a qualified behavioral health practitioner or other designated personnel appropriately trained to check vital signs and monitor needs of the person served.

2.F. **11.** **A room designated for the use of seclusion or restraint has:**
  a. **A focus on the comfort of the person served, including:**
     (1) **Adequate air flow.**
     (2) **Comfortable temperature.**
     (3) **A safe, comfortable seating and/or lying arrangement.**
  b. **An identified plan for emergency exit.**
  c. **Access to bathroom facilities, directly or through escort.**
  d. **Sufficient lighting.**
  e. **Observation availability.**
  f. **Call capability when ongoing direct observation is not utilized.**
  g. **A location that promotes the privacy and dignity of the person served.**

2.F. **12.** **Following the use of seclusion or restraint, a debriefing is conducted as soon as possible (preferably within 24 hours) after the incident. The debriefing includes:**
  a. **The person served, for the purpose of:**
     (1) **Hearing from the person served what he/she experienced and/or his/her perspective.**
     (2) **Informing the person as to why the restraint/seclusion was used.**
     (3) **Returning control to the person served.**
  b. **Involved staff members.**
  c. **Others observing the incident, when permitted.**

  d. **Others (family/guardian/significant others) requested by the person served, unless clinically contraindicated.**
  e. **A documented discussion that addresses:**
     (1) **The incident.**
     (2) **Its antecedents.**
     (3) **An assessment of contributing factors on an individual, programmatic, and organizational basis.**
     (4) **The reasons for the use of seclusion or restraint.**
     (5) **The specific intervention used.**
     (6) **The person's reaction to the intervention.**
     (7) **Actions that could make future use of seclusion or restraint unnecessary.**
     (8) **When applicable, modifications made to the treatment plan to address issues or behaviors that impact the need to use seclusion or restraint.**

2.F. **13.** **The use of seclusion or restraint always is documented as a critical incident.**

2.F. **14.** **The chief executive or designated management or supervisory staff member reviews and signs off on all uses of seclusion or restraint:**
  a. **After every occurrence.**
  b. **Within a designated time frame.**
  c. **To determine conformance with applicable policies/procedures.**

2.F. **15.** **The use of seclusion or restraint is:**

   a. **Recorded in the information system.**

   b. **Reviewed for:**

      (1) **Analysis of patterns of use.**

      (2) **History of use by personnel.**

      (3) **Environmental contributing factors.**

      (4) **Assessment of program design contributing factors.**

   c. **Used for performance improvement.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies and written procedures that govern the use of seclusion or restraint

- A policy regarding the organization's response to aggressive or assaultive behaviors, training on the prevention of workplace violence, and its position on the use of seclusion or restraint

- Documentation of initial and ongoing competency-based training on seclusion and/or restraint

- A plan to minimize or eliminate the use of restraints and/or seclusion

- An annual written status report on the plan to minimize or eliminate the use of restraints and/or seclusion

- Written procedures for team interventions

- Documented evidence that all other intervention techniques were used first

- Individual records with complete documentation of orders, face-to-face evaluations and assessments, and ongoing monitoring checks

- Documentation of debriefings and discussions held following the use of seclusion or restraint

- Documentation of the notification of the family or significant other(s) of the use of seclusion or restraint

- Documentation of any use of seclusion or restraint as a critical incident

- Recording of the use of seclusion or restraint in the organization's information system

- Documentation of personal safety plans, as applicable

G. Records of the Persons Served

Description

A complete and accurate record is developed to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served.

NOTE: *Please refer to the grid of Applicable Standards on page 96 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.*

2.G. **1.** The organization implements policies and procedures regarding information to be transmitted to other individuals or agencies that include:

   a. The identification of information that can legally be shared without an authorization for release of information.

   b. Forms to authorize release of information that:

   (1) Comply with applicable laws.

   (2) Identify, at a minimum:

   (a) The name of the person about whom information is to be released.

   (b) The content to be released.

   (c) To whom the information is to be released.

   (d) The purpose for which the information is to be released.

   (e) The date on which the release is signed.

   (f) The date, event, or condition upon which the authorization expires.

   (g) Information as to how and when the authorization can be revoked.

   (h) The signature of the person who is legally authorized to sign the release.

Intent Statements

Organizations in the United States submitting or maintaining information in electronic formats regarding the persons served need to pay particular attention to requirements of the HIPAA (PIPEDA/FOIPA in Canada). Authorization to share information is documented and specifically refers to the information being transmitted. Signed authorization forms that are not specific or that are "boilerplates" will not meet this standard.

The standards do not address the specific instances in which it is necessary to have a signed release-of-information form. The intent of this standard is that, if the organization is providing any information that identifies a person served, it has an authorized release-of-information form completed, unless exempted by law. However, this does not mean that there should be a separate release form for every instance (every phone call or conversation with the same agency) in which information is released; one release per agency or person, with a time limitation, is sufficient. There are occasions when signed release-of-information forms are required by law.

Examples

1.b.(2)(f) Release forms stipulate the expiration date by either providing an actual date or by indicating that the release is valid for only a specific amount of time from the date it was signed.

Typically, the authorization will not exceed one year. However, some laws may require that the authorization for release of information be for the tenure of a specific relationship; i.e., during the length of a person's time on probation or parole.

2.G. **2.** The individual record communicates information in a manner that is:

   a. Organized.

   b. Clear.

   c. Complete.

   d. Current.

   e. Legible.

Intent Statements

The intent of this standard is that the records be organized in a systematic way to ensure that information is readily accessible. CARF does not

prescribe any particular type of organizing or filing system.

Examples

2.c. Complete refers to a central record containing information regarding all the services the person receives. This is considered the main record.

2.G. **3. All documents generated by the organization that require signatures include original or electronic signatures.**

Intent Statements

Written signatures are defined as full signatures, not initials. Electronic systems that restrict or automatically identify the person entering the data and the date the information is entered will conform to the intent of this standard.

Examples

Electronic signatures may include Authenticode™, VeriSign®, or equivalent signatures.

2.G. **4. The individual record includes:**
   a. **The date of admission.**
   b. **Information about the individual's personal representative, conservator, guardian, or representative payee, if any of these have been appointed, including the name, address, and telephone number.**
   c. **Information about the person to contact in the event of an emergency, including the name, address, and telephone number.**
   d. **The name of the person currently coordinating the services of the person served.**
   e. **The location of any other records.**
   f. **Information about the individual's primary care physician, including the name, address, and telephone number, when available.**
   g. **Healthcare reimbursement information, if applicable.**

   h. **The person's:**
      (1) **Health history.**
      (2) **Current medications.**
      (3) **Preadmission screening, when conducted.**
      (4) **Documentation of orientation.**
      (5) **Assessments.**
      (6) **Person-centered plan, including reviews.**
      (7) **Transition plan, when applicable.**
   i. **A discharge summary.**
   j. **Correspondence pertinent to the person served.**
   k. **Authorization for release of information.**
   l. **Documentation of internal or external referrals.**

Intent Statements

In order to be comprehensive, the records of the persons served should contain the information above.

Examples

4.h. A transition plan would not be relevant if the person served left services without notice.

4.i. There should be a discharge summary for all persons who have left an organization's services.

2.G. **5. Entries to the records of the persons served follow the organization's policy that specifies time frames for entries.**

Intent Statements

Clearly defined time lines for admission notes, assessments, treatment plans, and progress notes are important for comprehensive and efficient service provision.

Examples

Time frames are needed for treatment planning and can be based on federal, state, provincial, or funding source requirements.

2.G. **6. If duplicate information or reports from the main record of a person served exist, or if working files are maintained, such materials:**

    a. **Are not substituted for the main record.**

    b. **Are considered secondary documents, with the main record of the person served receiving first priority.**

Intent Statements

Although duplicate records may be maintained at multiple sites, a central record is kept current and complete.

Examples

In some settings, separate treatment and medical records are required to be maintained. Together, these constitute a single, main record.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Individual records
- A policy for making entries to records
- Release forms
- Duplicate reports or files

H. Quality Records Management

Description

The organization has systems and procedures that provide for the ongoing monitoring of the quality, appropriateness, and utilization of the services provided. This is largely accomplished through a systematic review of the records of the persons served. The review assists the organization in improving the quality of services provided to each person served.

NOTE: *Please refer to the grid of Applicable Standards on page 96 to determine how these standards will be applied to the core program or service areas for which you are seeking accreditation.*

2.H. **1. The organization, using the records of the person served, conducts or participates in a review of the services provided:**

    a. **At least quarterly.**

    b. **That addresses:**

        (1) **The quality of service delivery.**

        (2) **Appropriateness of services.**

        (3) **Patterns of service utilization.**

    c. **That is documented.**

2.H. **2. The quarterly review is performed:**

    a. **By personnel who are trained and qualified.**

    b. **On a representative sample of:**

        (1) **Current records.**

        (2) **Closed records.**

    c. **In accordance with an established review process.**

Intent Statements

Records should be reviewed by personnel who are trained to perform the reviews.

Examples

The procedures for review of services may include:

- Oversight of the review process by the management of the organization.

- Use of individual reviewers who carry out professional functions and who may be either internal or external to the organization. A committee is not required to carry out the professional reviews.

- In small organizations and small remote sites, the accomplishment of reviews through ongoing supervision and case review, a system of quarterly peer review, or the use of an outside reviewer on a quarterly basis.

In a program with short lengths of stay, or in situations where the records will not be available following discharge, a review of the records of the persons served may include a review of the records of those persons discharged during the current quarter as well as persons currently being served.

In programs serving few people or having long terms of treatment, it may only be possible to review closed records annually.

2.b. See the Glossary for the definition of *representative sample*.

2.H. 3. **When records are selected for review, the person responsible for providing the service/treatment is not:**

  a. **Solely responsible for the selection of his/her records to be reviewed.**

  b. **A reviewer of his/her records.**

Examples

Creative means may be used if there is a limited number of qualified personnel available to perform a review. For example, if there is only one therapist on staff, an organization may invite another similarly qualified individual who works in the geographic area to review the quality of the person-centered plans. The organization should consult state/provincial/territorial/tribal and federal confidentiality regulations with regard to who can assist in the review of services and the confidentiality assurances necessary for the review to be completed.

2.H. 4. **The records review addresses whether:**

  a. **The persons served were:**

    (1) **Provided with an appropriate orientation.**

    (2) **Actively involved in making informed choices regarding the services they received.**

  b. **Confidential information was released according to applicable laws/regulations.**

  c. **The assessments of the persons served were thorough, complete, and timely.**

  d. **The goals and service/treatment objectives of the persons served were:**

    (1) **Based on:**

      (a) **The results of the assessments.**

      (b) **The input of the person served.**

    (2) **Revised when indicated.**

  e. **The actual services were related to the goals and objectives in the person's plan.**

  f. **The actual services reflect:**

    (1) **Appropriate level of care.**

    (2) **Reasonable duration.**

  g. **The person-centered plan was reviewed and updated in accordance with the organization's policy.**

  h. **When applicable, the following have been completed:**

    (1) **Transition plan.**

    (2) **Discharge summary.**

  i. **Services were documented in accordance with the organization's policy.**

  j. **When billing for services occurs, the clinical documentation is consistent with billing records.**

Intent Statements

This type of review is often referred to as a quality assurance or peer review, and it focuses on the care of the persons served on a case-by-case basis.

It provides an opportunity for professional staff members (and qualified others) to objectively review and suggest alternative program or service strategies to the team responsible for establishing and carrying out the person's individual program.

Examples

For short-term services: When assessment and referral or brief services, such as crisis intervention, detoxification, or employee assistance, are provided, the review will address only those portions of this standard that are applicable.

4.j. Documentation and billing review conducted as part of the quality review may be performed by administrative support personnel.

2.H. **5.** **The organization demonstrates that the information collected from its established review process is:**

    a. **Used to improve the quality of its services through performance improvement activities.**

    b. **Used to identify personnel training needs.**

    c. **Reported to applicable personnel.**

Intent Statements

The quality record review should be used to identify training needs and to improve the quality of services.

Examples

Evidence of quality improvement could be demonstrated through the provision of training to personnel, revision of policies, development of new processes or protocols, or other organizational change.

5.a. Quality improvement may be demonstrated through:

- Revisions to overall programmatic design, curriculum, equipment, environment, or delivery methods.

- Personnel competencies, staffing ratios, or consultation/affiliation resources available or needed by the program(s).

- Financial resource planning or allocation to program(s).

- Correlation between the summarized results of these reviews and results obtained from the organization's performance improvement system. This may also include modifying a performance improvement system to more accurately track the outcomes, progress, or effectiveness of a program on those served.

5.b. Information gathered should be assessed for potential training needs.

5.c. Information gathered should be shared with applicable personnel.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Documentation of a quarterly professional review of current and closed records

- Evidence that the review addresses the areas listed can be demonstrated on a checklist, table, or other type of form that summarizes the review

- Evidence that the review is done by trained and qualified personnel; a policy can state who the organization determines to be qualified and trained, and signed reviews can support that the policy is being met

SECTION 3

Behavioral Health Core Program Standards

Description

The standards in this section address the unique characteristics of each type of core program area. Behavioral health programs are organized and designed to provide services for persons who have or who are at risk of having psychiatric disorders, harmful involvement with alcohol or other drugs, or other addictions or who have other behavioral health needs. Through a team approach, and with the active and ongoing participation of the persons served, the overall goal of each program is to improve the quality of life and the functional abilities of the persons served. Each program selected for accreditation demonstrates cultural competency and relevance. Family members and significant others are involved in the programs of the persons served as appropriate and to the extent possible.

Applicable Standards

All organizations applying for accreditation for a behavioral health core program are responsible for applying the standards in Sections 1–2, unless otherwise indicated under the applicable standards section and in the table in Section 2. General Program Standards.

Note the requirements for programs serving children and adolescents under the Guidelines for Organizations Seeking a Specific Population Designation on the following page.

Behavioral Health Field Categories

For each behavioral health core program selected for accreditation, an organization must identify under which behavioral health field category the core program operates. Field categories are used to characterize the purpose, intent, and overall focus of a core program and to distinguish the specific fields in behavioral health that the core program reflects and serves.

The behavioral health field categories are Alcohol and Other Drugs/Addictions, Mental Health, Psychosocial Rehabilitation, Family Services, Integrated AOD/Mental Health, and Integrated DD/Mental Health. The following are descriptions of each field category:

- **Alcohol and Other Drugs/Addictions:** Core programs in this field category are designed to provide services for persons who have or are at risk of having harmful involvement with alcohol or other drugs/addictions. These programs use a team approach to minimize the effects and risks associated with alcohol, other drugs, or other addictions.

- **Mental Health:** Core programs in this field category are designed to provide services for people with or who are at risk for psychiatric disabilities/disorders or have other mental health needs. These programs encompass a wide variety of therapeutic settings and intervention modalities and may provide services to those with behavioral health disabilities or co-occurring disabilities; intellectual or developmental disabilities; victims or perpetrators of domestic violence or abuse; persons needing treatment because of eating or sexual disorders; and/or drug, gambling, or internet addictions.

- **Psychosocial Rehabilitation:** Core programs in this field category demonstrate a strong collaborative partnership with the persons served, the development of opportunities for personal growth, a commitment to community integration, goal-oriented and individualized supports, and the promotion of satisfaction and success in community living. Programs in this category may serve persons with a variety of concerns, including persons with developmental or physical disabilities.

- **Family Services:** Core programs in this field category are designed to maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals. Core programs in this field category are directed at the reduction of symptoms and/or the improvement of functioning for the person served or family unit.

- **Integrated AOD/Mental Health:** Core programs in this field category are designed to provide a combination of alcohol and other drugs/addictions and mental health services. This may include services provided in a psychosocial format. Services may be provided through a seamless system of care for individuals with needs in one or both areas or for persons with identified co-occurring disorders, including any of the concerns listed under the Mental Health field category.

- **Integrated DD/Mental Health:** Core programs in this field category are designed to provide services to persons whose primary diagnoses are intellectual or other developmental disabilities and who are at risk for or exhibiting behavioral disorders or have identified mental health needs. These programs encompass many therapeutic settings and intervention modalities and a commitment to community integration.

- **Comprehensive Care:** Core programs in this field category are designed to provide any combination of behavioral health services related to mental illness, addictions or intellectual/developmental disabilities, and management of or coordination with the healthcare needs of the person served. This field category applies only to Health Home or Integrated Behavioral Health/ Primary Care programs.

Guidelines for Organizations Seeking a Specific Population Designation

If an organization is required or chooses to add one of the following Specific Population Designations to a core program(s) being surveyed, the standards for these designations will be applied at the time of the survey in addition to the core program standards. See Sections 4.B.–F. for applicable standards.

The Specific Population Designations available are:

- 4.B. Children and Adolescents (CA) (May be required—see following note.)
- 4.C. Consumer-Run (CR)
- 4.D. Criminal Justice (CJ) (May be required—see following note.)
- 4.E. Juvenile Justice (JJ) (May be required—see following note.)
- 4.F. Medically Complex (MC) (May be required; includes Medically Complex for Children/Adolescents (MCCA)—see following note.)
- 4.G. Eating Disorders (ED) (includes Eating Disorders for Children/Adolescents (EDCA—see following note.)

NOTE: *If children or adolescents (up to age 18) are served in any behavioral health core program (except Prevention or Diversion) for which the organization is seeking accreditation, the standards in Section 4.B. Children and Adolescents (CA) <u>or</u> 4.E. Juvenile Justice (JJ) must be applied.*

An organization seeking accreditation for an Eating Disorders program for Children/Adolescents (EDCA) must apply the standards in Sections 4.B. and 4.G.

If an organization is seeking accreditation for a Diversion or Prevention program that serves youths under 18 years of age, it is not necessary to apply the standards in Section 4.B. or 4.E., as they are intended for treatment-oriented programs that admit or enroll the persons served.

If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the standards in Section 4.D. Criminal Justice (CJ) [or 4.E. Juvenile Justice (JJ), for populations under 18 not tried as adults] must be applied.

If a core program for which the organization is seeking accreditation is designed primarily to serve persons who meet the definition of medically complex, or the program serves only this target population, the medically complex standards must be applied.

Organizations seeking accreditation for a core program for children/adolescents who meet the definition of medically complex (MCCA) must apply the standards in Sections 4.B. and 4.F.

For Opioid Treatment Programs Outside of the United States

- 4.A. Addictions Pharmacotherapy (AP) can be applied as a specific population designation for opioid treatment programs located outside of the United States.
- An Addictions Pharmacotherapy program that serves children/adolescents (APCA) must apply the standards in Sections 4.A. and 4.B.
- Opioid Treatment Programs within the United States must use the *Opioid Treatment Program Standards Manual.* Contact CARF for further assistance if necessary.

A. Assertive Community Treatment (ACT)

Description

Assertive Community Treatment (ACT) is a multidisciplinary team approach that assumes responsibility for directly providing acute, active, and ongoing community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The program team provides assistance to individuals to maximize their recovery, ensure consumer-directed goal setting, assist the persons served to gain hope and a sense of empowerment, and provide assistance in helping the persons served become respected and valued members of their community. The program provides psychosocial services directed primarily to adults with severe and persistent mental illness who often have co-occurring problems, such as substance abuse, or are homeless or involved with the judicial system.

The team is the single point of clinical responsibility and is accountable for assisting the person served to meet his or her needs and to achieve his or her goals for recovery. Multiple members of the team are familiar with each person served to ensure the timely and continuous provision of services. Services are provided on a long-term care basis with continuity of caregivers over time. The majority of services are provided directly by ACT team members, with minimal referral to outside providers, in the natural environment of the person served and are available 24 hours a day, 7 days per week. Services are comprehensive and highly individualized and are modified as needed through an ongoing assessment and treatment planning process. Services vary in intensity based on the needs of the persons served.

Assertive Community Treatment has been identified as an effective model for providing community-based services for persons whose needs and goals have not been met through traditional office-based treatment and rehabilitation services. Desired outcomes specific to ACT services may include positive change in the following areas: community tenure, independent living, quality of life, consumer satisfaction of the person served, functioning in work and social domains, community integration, psychological condition, subjective well-being, and the ability to manage his or her own health care.

In certain geographic areas, Assertive Community Treatment programs may be called Community Support programs, Intensive Community Treatment programs, Mobile Community Treatment Teams, or Assertive Outreach Teams.

Applicable Standards

An organization seeking accreditation for an assertive community treatment program must apply the standards in Sections 1 and 2, in addition to the standards in this subsection.

3.A. **1. Assertive community treatment (ACT) services are provided by one or more multidisciplinary treatment teams.**

3.A. **2. The ACT team:**
   a. **Has sufficient staff to provide identified hours of coverage.**
   b. **Includes the variety of disciplines necessary to meet the needs of the persons served.**
   c. **Annually reviews its capacity to provide comprehensive integrated treatment services.**
   d. **Makes recommendations to the organization's administration to ensure the team's ability to meet the needs of the persons it serves.**

Intent Statements

2.a. Staff sufficiency includes plans for backup in case of emergency and planned absences.

3.A. **3. Based on the needs of the persons served, the composition of the ACT team provides for a staff-to-client ratio of at least one full-time equivalent direct care staff member for each eight to fifteen persons served.**

Intent Statements

Caseloads would be expected to be lower (one to eight or ten) in a program that serves a greater percentage of persons with acute needs, experiences a high turnover of persons served, or is provided in a more rural area that requires a greater amount of travel time. If the ACT team serves a broader population or continues to provide supports to persons served who are functioning at a higher, more stable level, the caseloads may move toward the higher end of the range (one to twelve or fifteen). Caseload size is indexed to the severity of need and functioning level of the persons served.

3.A. **4. The ACT team is coordinated by a team leader who:**
   a. **Is a qualified behavioral health practitioner.**
   b. **Has specialized knowledge and competencies that meet the needs of the persons served.**
   c. **Provides clinical supervision to ACT team staff.**
   d. **Provides direct services to persons served by the ACT team.**

Intent Statements

4.a. See the Glossary for the definition of a *qualified behavioral health practitioner*.

3.A. **5. The majority of the ACT team members are qualified behavioral health practitioners.**

Intent Statements

The program can demonstrate that on a consistent basis the ACT team is composed primarily of qualified behavioral health practitioners.

3.A. **6. Each ACT team has one or more nursing staff members who:**
   a. **Participate(s) in treatment planning meetings based on the needs of the persons served.**
   b. **Provides sufficient nursing coverage to meet the needs of the persons served.**
   c. **Directly provide(s) services.**

Intent Statements

The number of nursing staff members may vary depending on the responsibilities of the nursing staff and the needs of the persons served. Nurses provide nursing consultation to the team. It is expected that registered nursing coverage would relate to the amount of medical or medication use responsibilities required. Systems should be in place to provide for backup in case of emergency or planned absences.

3.A. **7. Each ACT team has a psychiatrist or a physician specialist in addiction medicine who:**
   a. **Is a member of the team.**
   b. **Directly provides services.**
   c. **Is available to participate in treatment planning meetings based on the needs of the persons served.**
   d. **Provides clinical consultation and supervision to the team.**

Intent Statements

On a team providing services to persons with psychiatric needs, a psychiatrist is a member. A team primarily serving persons with addictions may have a physician specialist.

3.A. **8. The organization demonstrates its efforts to recruit staff or volunteers, who are peers, to become team members and to provide peer support or consultation to persons served by the ACT team.**

Intent Statements

Peer support staff members or volunteers can provide a unique perspective to the rest of the team and work to foster positive, effective relationships with the persons served. This position may be shared between two or more individuals.

3.A. **9. The treatment plan is reviewed at least quarterly and modified as necessary based on the needs of the person served.**

Intent Statements

State, federal, or provincial regulations may require the program to review treatment plans on a more frequent basis.

3.A. 10. The ACT team:

a. Is the central point for delivering services, as based on the needs of the persons served.

b. Is available to the persons served.

c. Directly conducts initial and ongoing assessments of the person served.

d. Directly provides treatment planning.

e. Delivers the majority of the treatment, rehabilitation, and recovery support services needed by the persons served, including:

   (1) Symptom assessment and management.

   (2) Individual supportive therapy.

3.A. 11. The ACT team directly provides the following crisis intervention services:

a. Developing an initial crisis intervention plan upon contact for each person served.

b. Providing telephone intervention services.

c. Providing face-to-face assessment services.

d. Providing mobile services.

e. Having written emergency procedures that address:

   (1) Screening for medical or emergency psychiatric services when indicated.

   (2) Making referrals to emergency medical or psychiatric services when indicated.

   (3) Identifying personnel trained in emergency procedures.

   (4) Handling standing orders, when appropriate.

f. Identifying procedures for:

   (1) Involving significant others with the consent of the persons served.

   (2) Obtaining information on advance directives of the persons served, when available.

g. On-call availability 24 hours a day, 7 days a week.

h. Collaboration with other community organizations that provide emergency services to ensure continuity of care of the persons served.

Intent Statements

In a rural setting, the ACT team provides or assists in the delivery of the crisis intervention services. During normal hours of operation the rural ACT team provides crisis intervention services directly. During other hours, it may arrange coverage through a reliable and trained crisis intervention service.

11.g. May be provided by telephone coverage.

3.A. 12. The ACT team directly provides the following case management services:

a. Assisting the persons served to:

   (1) Achieve their objectives.

   (2) Optimize their independence.

   (3) Optimize their productivity through community supports or linkages.

   (4) Develop additional competencies needed in order to increase social support networks.

b. Assisting the persons served to access transportation when needed.

c. Assisting the persons served to understand the impact of employment on accessing and securing future benefits.

3.A. 13. The ACT team directly provides the following community integration services:

 a. Enhancing the understanding of the persons served regarding their psychiatric disorders or behavioral health needs.

 b. Improving the ability of the persons served to cope with their current conditions.

 c. Assisting the persons served to achieve their goals of choice in the following areas:

 (1) Community living.

 (2) Vocational/educational development.

 (3) Use of leisure-time opportunities.

Examples

A variety of means, including teaching, planning of social and leisure-time activities, side-by-side support and coaching, and organizing individual and group social and recreational activities can be used to assist the persons served in community integration. These supports are directed toward assisting the persons served in improving communication skills; developing assertiveness and increased self-esteem; developing social skills and meaningful personal relationships; effectively relating to landlords, neighbors, and others; and familiarizing themselves with and increasing their use of available social and recreational opportunities.

13.c.(2) May include volunteer activities.

3.A. 14. The ACT team assists the persons served in securing arrangements to meet their basic needs, including:

 a. Financial benefits.

 b. Food, clothing, and household goods.

 c. Short-term shelter.

 d. Long-term housing.

 e. Housing subsidies.

 f. Medical benefits/care.

 g. Dental benefits/care.

 h. Vision benefits/care.

Examples

14.a. Financial benefits can include social security income, social security disability income, food stamps, and other financial resources available to the persons served.

3.A. 15. The ACT team assists the persons served in securing and maintaining housing that is:

 a. Safe.

 b. Affordable.

 c. Accessible.

 d. Consistent with the goals and choices of the person served.

3.A. 16. The ACT team directly provides services to support activities of daily living in community-based settings through:

 a. Individualized assessment.

 b. Problem solving.

 c. Side-by-side assistance and support.

 d. Skill training.

 e. Ongoing supervision.

 f. Securing of environmental adaptations, if needed.

3.A. 17. Daily living support activities include assisting the persons served to gain or use the skills required to:

 a. Maintain personal hygiene and grooming.

 b. Perform household activities.

 c. Develop or improve money-management skills.

 d. Access means of transportation.

 e. Maintain good physical health and nutrition.

3.A. 18. The ACT team is directly responsible for providing medication management in accordance with the standards in Section 2.E. Medication Use.

3.A. **19.** **The ACT team psychiatrist routinely, with the consent of the persons served, and as appropriate:**

  a. **Assesses the symptoms and behaviors of the persons served and prescribes appropriate medication.**

  b. **Regularly reviews and documents the symptoms as well as the response of the persons served to the prescribed medication treatment.**

  c. **Educates the persons served, and their family and significant others when appropriate, regarding their disabilities and abilities.**

Intent Statements

  19.a. Although the ACT team psychiatrist is usually the psychiatrist responsible for prescribing medications to persons served by the team, in unique situations, a person served may continue to receive services from a psychiatrist with whom a therapeutic relationship has been previously established.

3.A. **20.** **The ACT team directly provides substance abuse services that include interventions that assist persons served to:**

  a. **Identify substance use and its effects.**

  b. **Recognize the relationships between substance use, mental illness, and psychotropic medications.**

  c. **Develop motivation for decreasing substance use.**

  d. **Develop coping skills and alternatives to substance use.**

  e. **Achieve periods of abstinence and stability.**

  f. **Access/utilize self-help or support groups.**

3.A. **21.** **The ACT team directly provides vocational services by actively assisting the person served to find, obtain, and maintain employment or volunteer opportunities in community-based sites that are consistent with their goals and choices.**

Intent Statements

  If the ACT team collaborates with other providers of vocational services, the expectation is that they are actively involved in ensuring that the services are provided and available to the persons served. Simply having the services available or referring the persons served to other providers would not meet the intent of this standard.

3.A. **22.** **With consent of the persons served, the ACT team provides services to the families and other major supports of the persons served, including:**

  a. **Education about the illness/disorder of the persons served.**

  b. **Education about the strengths and abilities of the persons served.**

  c. **When applicable, education about the role of the family in the therapeutic process.**

  d. **Intervention to prevent or resolve conflict.**

  e. **Ongoing communication and collaboration between the team and the family.**

3.A. **23.** **The ACT team provides:**

  a. **Assertive outreach and engagement to assist the persons served in their own environment.**

  b. **At least 75 percent of its service contacts in the community, outside of the clinical office setting.**

Intent Statements

  An essential principle of ACT programs is that the team members provide support and services to the persons served in the community and their natural environment.

3.A. 24. **The ACT team:**

 a. **Provides multiple contacts per week based on the clinical needs of the persons served.**

 b. **Increases service intensity to the persons served when their needs require additional contacts.**

3.A. 25. **The ACT team provides ongoing support and liaison services for persons who are hospitalized or in criminal justice or other restrictive settings.**

Intent Statements

The length of time during which these supportive services occur may be limited by state or other regulations.

3.A. 26. **The ACT team provides outreach and follow-up to persons who have been admitted to its program, are in active status, and:**

 a. **Become isolated in the community.**

 b. **Are admitted to more intensive levels of treatment but are likely to return to the program.**

3.A. 27. **ACT programs operate in response to the needs of the persons served, with flexible hours of operation that include evenings, weekends, nights, and holidays.**

3.A. 28. **Team members on duty have daily staff meetings to:**

 a. **Review the clinical status of the persons served.**

 b. **Review the current needs of the persons served.**

 c. **Update staff members on treatment contacts that occurred during the previous day(s).**

 d. **Identify contacts with the persons served that need to occur.**

 e. **Develop the daily work schedule for the team.**

 f. **Review treatment plans, when appropriate.**

 g. **Adjust service intensity for persons served as needed.**

 h. **Plan for potential emergency and crisis situations.**

Intent Statements

Team members in a rural area may periodically use telephonic, electronic, or other means to conduct staff meetings.

3.A. 29. **Information shared at organizational staff meetings is documented.**

Examples

Documentation may occur in a daily log, weekly contact schedule for each person served, progress note in the record of the person served, or daily staff assignment sheet.

3.A. 30. **Designated space is available for team meetings.**

3.A. 31. **Clinical supervision of all team members is ongoing and sufficient to ensure quality services.**

Examples

Clinical supervision may occur through the supervisor's participation in treatment planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and staff members.

3.A. 32. **Clinical supervision is provided by the team leader, psychiatrist, or other designated and qualified person on the team.**

3.A. **33.** The team has access to the records of the persons served at all times.

3.A. **34.** The team interacts with community organizations, agencies, and groups to facilitate community adjustment and access to resources for the persons served.

3.A. **35.** Discharge from the program occurs:
   a. When the persons served and program staff members mutually agree to the termination of services.
   b. When the person served moves outside the geographic area of the team's responsibility. In such cases, the ACT team:
      (1) Arranges for transfer of mental health service responsibility to a provider in the location to which the person served is moving.
      (2) When feasible, maintains contact with the person served until service transfer is arranged.
   c. When the person served demonstrates an ability to function in all major role areas (i.e., work, social, self-care), with only minimal assistance from the program for a period of one year or more as agreed to by the person served and his or her ACT team.
   d. When the person served is not court ordered and requests termination of services.
   e. When the team, despite repeated efforts, cannot locate the person served.

3.A. **36.** Documentation of discharge is completed by identified member(s) of the treatment team.

Intent Statements

Documentation of discharge is done in accordance with Section 2.D. Transition/Discharge and Standard 4.i. in Section 2.G. Records of the Persons Served.

3.A. **37.** Discharge documentation includes the signature of:
   a. The primary case manager for the person served.
   b. The team leader.
   c. The psychiatrist, when possible.
   d. The person served, when possible.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Initial and ongoing assessments
- Treatment plan
- Crisis intervention plan developed per intervention
- Written emergency procedures
- Individualized assessment of activities of daily living skills
- Documentation of medication treatment and symptomatology and side effects
- Review of clinical records, daily work schedule, treatment plans, and progress notes
- Discharge plan

B. Assessment and Referral (AR)

Description

Assessment and referral programs provide a variety of activities, including prescreening, screening, psychosocial assessment, determination of need, and referral to appropriate level of care. The provision of information on available resources is not considered a full assessment and referral program. An adequate assessment must be conducted to provide more informed referrals.

Such programs may be separate, freestanding programs, an independent program within a larger organization, or a specifically identified activity within a system of care. Organizations performing assessment and referral as a routine function of entrance into other core programs, such as their outpatient treatment, case management, or residential programs, are not required to apply these standards unless they are specifically seeking accreditation for assessment and referral.

Applicable Standards

An organization seeking accreditation for an assessment and referral program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

3.B.   **1. The program implements policies and procedures for assessment and referral that include:**

  a. **Identification of the use of valid, reliable, or standardized assessment tools, tests, or instruments.**

  b. **A demonstrated method of identifying appropriate levels of care for the person served.**

  c. **Linkage to:**

  (1) **Emergency services.**

  (2) **Crisis intervention services, as needed.**

Intent Statements

1.a. Valid and reliable assessment tools consist of public- or private-domain tests and instruments that have been validated for use as methods of screening and assessing the severity of symptoms and level of functioning.

1.b. The organization should use valid assessment tools that determine the level of care or have criteria in place for level-of-care placement.

3.B.   **2. The program provides the following services in collaboration with the person served:**

  a. **Assessment of the needs of the person served.**

  b. **Identification of the choices available for community resources.**

  c. **Provision of informational materials pertaining to community resources, when possible.**

  d. **Identification of services that are:**

  (1) **Culturally appropriate.**

  (2) **Age appropriate.**

  e. **Implementation of methods to:**

  (1) **Determine if services were accessed by the persons served.**

  (2) **Provide follow-up, when indicated.**

Examples

2.b. The program may provide information through the use of a community resource site, brochures, or service listing(s).

3.B.   **3. When requested, the program provides a written summary of the assessment and referral(s) to the person served or his or her legal representative.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies for assessment and referral
- Assessment tools
- A community resources file

C. Case Management/ Services Coordination (CM)

Description

Case management/services coordination programs provide goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Successful service coordination results in community opportunities and increased independence for the persons served. Programs may provide occasional supportive counseling and crisis intervention services, when allowed by regulatory or funding authorities.

Case management/services coordination may be provided by an organization as part of its person-centered planning and delivery, by a department or division within the organization that works with individuals who are internal and/or external to the organization, or by an organization with the sole purpose of providing case management/services coordination. Such programs are typically provided by qualified case managers/coordinators or by case management teams.

Organizations performing case management/ services coordination as a routine function of other services or programs are not required to apply these standards unless they are specifically seeking accreditation for this program.

Applicable Standards

An organization seeking accreditation for a case management/services coordination program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.C. **1. The persons served are linked to services and resources to achieve objectives as identified in their person-centered plan.**

3.C. **2.** **Personnel providing services have a working knowledge of the:**

a. **Services that are appropriate for the needs of the persons served.**

b. **Support systems that are relevant to the lives of the persons served.**

Intent Statements

In order to provide the linkages, coordination, and support needed by the persons served, the case managers are able to demonstrate knowledge of health care, social services, employment, housing, recreational opportunities, and other services and systems available in the community.

3.C. **3.** **Based on the needs of the persons served, case management/services coordination includes:**

a. **Activities carried out in collaboration with the persons served.**

b. **Outreach to encourage the participation of the persons served.**

c. **Coordination of, or assistance with, crisis intervention and stabilization services, as appropriate.**

d. **Assistance with achieving goals as defined by the persons served.**

e. **Optimizing resources and opportunities through:**

(1) **Community linkages.**

(2) **Enhanced social support networks.**

f. **Assistance with:**

(1) **Accessing transportation.**

(2) **Securing safe housing that is reflective of the:**

(a) **Needs of the persons served.**

(b) **Abilities of the persons served.**

(c) **Preferences of the persons served.**

(3) **Exploring employment or other meaningful activities.**

g. **Provision of, or linkage to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:**

(1) **Budgeting.**

(2) **Meal planning.**

(3) **Personal care.**

(4) **Housekeeping and home maintenance.**

(5) **Other identified needs.**

h. **Evidence of linkage with necessary and appropriate:**

(1) **Financial services.**

(2) **Medical or other health care.**

(3) **Other community services.**

Intent Statements

These case management activities are carried out in partnership and collaboration with the persons served. Elements provided are dependent on the needs of persons served and/or funder/regulatory requirements.

3.c. In some programs, such as Healthy Families America, guidelines specify a variety of positive outreach methods and are used to build trust, engage the person served in services, and maintain ongoing involvement.

3.h.(2) Medical or other health care includes the coordination of the health care of the persons served. Often individuals are seeing a variety of health care professionals and using a variety of medications that need to be monitored and coordinated. When working with infants or children, health care includes immunizations.

3.C. **4.** **The organization provides case management activities in locations that meet the needs of the persons served.**

Intent Statements

Services, such as assessment, planning, coordination, and monitoring, can be provided in any setting that provides the best access to the persons served and is preferred by the persons served.

Examples

Such locations may include residences, correctional settings, shelters, community resource sites, hospitals, schools, medical, or other service sites.

3.C. **5. The intensity of case management is based on the needs of the person as identified in his or her person-centered plan.**

Intent Statements

The intensity of case management and the frequency of contact are individualized and clearly defined.

Examples

There is wide variability among types of case management. Many programs provide intensive case management to a small, select group of individuals, and other programs provide services only periodically. However, there is a clear relationship between how often individuals ar served and their specific needs.

Some programs, such as Healthy Families America, have clearly defined criteria for increasing/decreasing the intensity of services.

3.C. **6. When multiple case management providers exist:**
  a. **A primary case manager is identified.**
  b. **There is coordination to:**
     (1) **Facilitate continuity of care.**
     (2) **Reduce duplication of services.**

3.C. **7. With the permission of the persons served, personnel provide advocacy by sharing feedback regarding the services received with the agencies and organizations providing the services.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Person-centered plans for the persons served
- Assessment and documentation of progress toward individual goals

D. Community Housing (CH)

Description

Community housing addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the persons served, regardless of the home in which they live and/or the scope, duration, and intensity of the services they receive. The residences in which services are provided may be owned, rented, leased or operated directly by the organization, or a third party, such as a governmental entity. Providers exercise control over these sites.

Community housing is provided in partnership with individuals. These services are designed to assist the persons served to achieve success in and satisfaction with community living. They may be temporary or long term in nature. The services are focused on home and community integration and engagement in productive activities. Community housing enhances the independence, dignity, personal choice, and privacy of the persons served. For persons in alcohol and other drug programs, these services are focused on providing sober living environments to increase the likelihood of sobriety and abstinence and to decrease the potential for relapse.

Community housing programs may be referred to as recovery homes, transitional housing, sober housing, domestic violence or homeless shelters, safe houses, group homes, or supervised independent living. These programs may be located in rural or urban settings and in houses, apartments, townhouses, or other residential settings owned, rented, leased, or operated by the organization. They may include congregate living facilities and clustered homes/apartments in multiple-unit settings. These residences are often physically integrated into the community, and every effort is made to ensure that they approximate other homes in their neighborhoods in terms of size and number of residents.

Community housing may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living can be offered in apartments or homes, or in congregate settings that may be larger than residences typically found in the community.

- Long-term housing that provides stable, supported community living or assists the persons served to obtain and maintain safe, affordable, accessible, and stable housing.

The residences at which community housing services are provided must be identified in the Intent to Survey. These sites will be visited during the survey process and identified in the survey report and accreditation outcome as a site at which the organization provides a Community Housing program.

Applicable Standards

An organization seeking accreditation for a community housing program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

Note:

- Standards 1.H.11.–1.H.12. (Section 1.H. Health and Safety) are applied to the community housing residence only when the organization owns the home.

- Standard 1.H.13. is not applied to community housing residences.

  If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.

3.D. **1.** Each person served is in a residential setting with his or her own personal space that:
   a. Respects privacy.
   b. Promotes personal security.
   c. Promotes safety.

Intent Statements

Persons served have a right to personal, private space.

Examples

1.a. This standard does not require a separate room for each resident, but it does suggest the provision of a safe, secure, private location that can be thought of by the person served as his or her own.

1.c. Safety needs are determined on the basis of the individuals' strengths and needs. See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

3.D. **2. The organization provides the following community living components:**

    a. Regular meetings between the persons served and staff.

    b. Opportunities to participate in typical home activities.

    c. Appropriate linkage when health-care needs of the persons served are identified.

    d. A personalized setting.

    e. Daily access to nutritious meals and snacks.

    f. The opportunity for expression of choice by the persons served in regard to rooms and housemates.

    g. Based on the choice of the persons served, opportunities to access:

        (1) Community activities.

        (2) Cultural activities.

        (3) Social activities.

        (4) Recreational activities.

        (5) Spiritual activities.

        (6) Employment/income generation activities.

        (7) Necessary transportation.

        (8) Self-help groups.

        (9) Other activities as identified in the person's plan.

    h. Policies related to:

        (1) Visitors or guests.

        (2) Pets.

Intent Statements

Persons served have choice in services/supports.

Examples

2.a. These meetings could be community meetings or meetings for the purpose of collaboratively discussing issues such as:

- Program operations.
- Problems.
- Plans.
- The use of program resources.

2.b. The program encourages all persons served to take increasing responsibility for cooperative operation of the household. Activities may include the preparation of food and the performance of daily household duties.

2.f. Depending on the program structure and the needs of the persons served, there may be procedures for maintaining separate sleeping areas in accordance with the genders, ages, and developmental level of the persons served. Whenever possible, each person served has the choice of a private room or the opportunity to participate in the selection of roommates.

2.g.(8) Activities could include meetings of 12-step and other self-help groups.

3.D. **3. In-home safety needs of persons served are addressed with respect to:**

    a. Environmental risks.

    b. Abuse and/or neglect inflicted by self or others.

    c. Self-protection skills.

    d. Medication management.

Intent Statements

Safety needs are determined on the basis of the individuals' strengths and needs.

Examples

See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

3.D. **4.** **When possible, persons served have options to make changes in their living arrangements:**

  a. **At their request.**
  b. **At the request of their families, when applicable.**
  c. **In transitional living, on a periodic basis when initiated by the organization.**
  d. **Based on informed choice.**

Intent Statements

Residential services and supports are flexible and fluid, as the needs and desires of the persons served change.

Examples

The preference for a different living situation is typically addressed at the person's annual planning meeting.

Knowledge of existing and planned services is important for the persons served so that they can make informed choices about alternative living arrangements. Alternative living arrangements may be provided by the organization or other providers. The term living arrangements refers to the service model and not the residence or home itself.

3.D. **5.** **Based on the needs of persons transitioning to other housing, there are procedures in place to assist them in securing housing that is:**

  a. **Safe.**
  b. **Affordable.**
  c. **Accessible.**
  d. **Acceptable.**

Intent Statements

The safety and security of the living arrangements of the persons served are assessed, risk factors and accessibility issues are identified, and modifications are made to make the housing choices acceptable.

Examples

Successful transition of a person served to safe and affordable housing requires the organization to establish organizational procedures based on

input from a variety of customers and stakeholders. Planning considerations should include the strengths and needs of the persons served, as well as areas of organizational consideration and resources that will need to be addressed. Those areas include accessibility plans and resources budgeted to remove barriers, appropriate review of health and safety factors as defined by local authorities, and the various aspects of risk management, and are all part of the individual services and organizational planning necessary to secure transitional housing.

3.D. **6.** **Each person served receives:**

  a. **Skill development necessary to live as independently as possible.**
  b. **Ongoing support/services as he or she explores changes in his or her living arrangements.**

Intent Statements

The person served has continuous access to services and support. The person's plan is continuously monitored, and modifications are made in the plan as the needs and circumstance of the person served change.

6.b. The person served may need confidence and courage to try alternative living arrangements. It is the responsibility of the provider organization to attempt to minimize risks of trying alternative living arrangements.

Examples

A number of resources can be helpful in planning delivery of services/supports. These include the CARF publication *Using Individual-Centered Planning for Self-Directed Services*, which is available on request from your resource specialist, as well as related standards regarding accessibility, health and safety, and fiscal management found in Section 1 of this manual. Often, the development of a professional team and a circle of support and friends can be helpful in encouraging persons served to try alternative living arrangements.

3.D. **7.** **Personnel are on site based on the needs of the persons served, as identified in their person-centered plans.**

Intent Statements

Personnel have the experience/training needed to effectively deal with the needs of the persons served.

Examples

If the program serves persons with autism, personnel have experience and training in this area.

3.D. **8.** **There is a system for the on-call availability of designated personnel 24 hours a day, 7 days a week.**

3.D. **9.** **In congregate housing, provisions are made to address the need for:**
   a. **Smoking or nonsmoking areas.**
   b. **Quiet areas.**
   c. **Areas for visits.**
   d. **Separate sleeping areas based on:**
      (1) **Age.**
      (2) **Gender.**
      (3) **Developmental need.**
   e. **Other issues, as identified by the residents.**

Intent Statements

When housing is shared by two or more individuals, the program actively addresses the need to designate space for privacy and individual interests.

3.D. **10.** **The organization assists the person served to identify and utilize available modes of transportation.**

Intent Statements

When transportation cannot be accessed independently by the persons served, the organization coordinates transportation to other relevant services and activities.

3.D. **11.** **The organization demonstrates efforts to maintain a person's residence as long as possible during temporary medical, legal, or personal absences.**

3.D. **12.** **The organization provides information to residents that includes:**
   a. **How to access community resources if needed.**
   b. **Safety issues related to the service delivery site.**
   c. **Access to emergency care when it is needed.**
   d. **Specific healthcare procedures and techniques.**
   e. **Contingency plans in case either the support system or the service provider is unable to deliver care.**
   f. **A review of how to deal with emergencies and evacuation from the residence.**

NOTE: *This standard only applies to Community Housing or Supported Living programs provided in apartment-type situations where agency staff do not reside at the site.*

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Documentation of an annual review of the plan for each person served
- A descriptive outline or curriculum for training

E. Community Integration (COI)

Description

Community integration is designed to help persons to optimize their personal, social, and vocational competency in order to live successfully in the community. Activities are determined by the needs of the persons served. The persons served are active partners in all aspects of these programs. Therefore, the settings can be informal in order to reduce barriers between staff members and program participants. In addition to services provided in the home or community, this program may include a psychosocial clubhouse, a drop-in center, an activity center, or a day program.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services based on the identified needs and desires of the persons served. A person may participate in a variety of community life experiences that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

NOTE: *The use of the term* persons served *in Community Integration may include members, attendees, or participants.*

Applicable Standards

An organization seeking accreditation for a community integration program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

If it is a consumer-run program, the organization would apply Section 1; Section 2.E. and 2.F., as applicable; and Section 4.C.

3.E. **1. The persons participating in services/activities move toward:**
   a. **Optimal use of:**
      (1) **Natural supports.**
      (2) **Self-help.**
   b. **Greater self-sufficiency.**
   c. **Greater choice.**
   d. **Greater control of their lives.**
   e. **Increased participation in the community.**

3.E. **2. Services/activities are organized around:**
   a. **The stated goals of the persons served.**
   b. **The identified preferences of the persons served.**
   c. **The identified needs of the persons served.**
   d. **Improving the ability of the persons served to understand their needs.**
   e. **Assisting the persons served to achieve their goals of choice in the following areas:**
      (1) **Community living skill development.**
      (2) **Interpersonal relations.**
      (3) **Recreation or use of leisure time opportunities.**
      (4) **Vocational development or employment.**
      (5) **Educational development.**
      (6) **Self-advocacy.**
      (7) **Access to nondisability related social resources.**

Intent Statements

The organization demonstrates that a range of basic services is provided. These services could be arranged within a psychosocial clubhouse, an activity center, or a day program, but the common services consist of providing assistance with independent living skills and the other activities described in this standard.

2.e.(1) The program assists the person served to develop the skills needed to live as independently as possible in the community.

Examples

2.e.(1) Assistance may be provided to develop or enhance skills related to performing household activities, cooking, grocery shopping, laundry, or money management.

2.e.(3) This may include volunteer activities.

3.E. **3. If work is performed by program participants, legal wage guidelines are observed.**

3.E. **4. Services are provided at times and locations that meet the needs of the persons served.**

Intent Statements

The program's services and hours of operation, including evenings, weekends, and holidays, are evaluated periodically to ensure that the services are available and accessible to meet the needs and interests of the persons served.

3.E. **5. Personnel are available to meet with persons served to discuss matters of mutual interest or concern.**

Examples

These meetings could be community meetings or house meetings for the purpose of collaboratively discussing issues such as:

- Program operations and activities.
- Hours of operation.
- Problems.
- Plans.
- The use of program resources.

3.E. **6. The organization provides information or referral to assist the persons served in securing assistance to meet their basic needs.**

Examples

This may include any of the following based on the needs of the person served:

- Income maintenance.
- Benefits.
- Food, clothing, and household goods.
- Short-term or emergency shelter.
- Housing subsidies, including long-term housing.
- Medical and health care.
- Information on the impact of employment on securing and accessing future benefits.
- Transportation.
- Other community supports.

Other relevant behavioral health services may include therapy, testing, medication management, crisis intervention, and psychiatric assessment.

3.E. **7. The program's outreach to and follow-up procedures for the persons served are directed to:**
   a. Those who drop out of services.
   b. Those who have been admitted to a treatment, institutional, or other setting.

Intent Statements

Each program is encouraged to work cooperatively with other agencies in the community to develop a seamless continuum of services and to reduce all barriers to access. The intent of this standard is to ensure that the program adopt procedures that describe how the program will coordinate services and referrals to reduce disruption of the persons served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Meeting schedules and notes
- House activity schedule
- Menus of meals provided if applicable

F. Court Treatment (CT)

Description

Court Treatment programs provide comprehensive, integrated behavioral health services that work in conjunction with the judicial system. The purpose of court treatment programs is to appropriately respond to the abuse of alcohol and/or other drugs, mental illness, post traumatic stress disorder, family problems, or other concerns and their related criminal and/or civil judicial actions, in order to reduce recidivism and further involvement in the criminal justice system. Court treatment includes services provided to persons referred through various types of problem-solving courts including drug, mental health, veteran's, family dependency, tribal, re-entry, and others.

The treatment team works in collaboration with judges, prosecutors, defense counsel, probation authorities, law enforcement, pretrial services, treatment programs, evaluators, and an array of local service providers. Treatment is usually multi-phased and is typically divided into a stabilization phase, an intensive phase, and a transition phase. During each phase, the treatment team is responsible for assessing the behavioral health needs of the person served within the parameters of the legal sanctions imposed by the court. The treatment team either directly provides or arranges for the provision of screening and assessment, case management, detoxification, intensive outpatient treatment, outpatient, residential treatment, medication use, self-help and advocacy, recovery, health and wellness, relapse prevention, and education regarding factors contributing to the person's court involvement.

A court treatment program may be a judicial or law enforcement organization that provides or contracts for the identified services or may be a direct treatment provider working as part of the court treatment team.

Applicable Standards

An organization seeking accreditation for a court treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

Note: *Court Treatment programs serving juveniles must also apply the standards in Section 4.B. Children and Adolescents (CA) or Section 4.E. Juvenile Justice (JJ).*

3.F. **1.** The court treatment program works:

    a. With the following, as appropriate:

        (1) Prosecutors.

        (2) Defense counsel.

        (3) Court personnel.

        (4) Other criminal justice representatives.

    b. To design policies and procedures for:

        (1) Screening.

        (2) Eligibility.

        (3) Case processing.

3.F. **2.** Participation in a court treatment program is not denied solely on the basis of inability to pay fees, fines, or restitution.

3.F. **3.** The program communicates the need for ongoing judicial interaction to each court treatment participant.

Intent Statements

The assigned clinician or case manager communicates with the participant on a regularly scheduled basis to determine progress and compliance. Status hearings are used to monitor program compliance, participation, and progress for each court participant. The court applies appropriate incentives or sanctions to match treatment progress.

3.F. **4.** A written assessment is conducted for each person served that includes:

    a. A detailed history of the person's criminal behavior, including:

        (1) Arrests.

        (2) Convictions.

        (3) Violations of parole and/or probation.

        (4) Prior incarcerations.

        (5) Pending cases.

    b. Information on the person's participation in organizations or groups that encourage criminal behavior.

    c. The relationship between the person's behavioral health and his or her criminal activity, including, as applicable:

        (1) Alcohol and other drug use.

        (2) Mental illness.

        (3) Post traumatic stress disorder.

        (4) Family concerns.

        (5) Violence.

    d. Risk to self, other persons served, personnel and/or the community.

Intent Statements

In conducting an assessment in a court program, the collection of information related to criminal behavior is emphasized.

3.F. **5.** A court treatment program provides, or ensures the provision of, the following case management services based on the needs of the persons served:

    a. Optimizing of resources and opportunities through community linkages.

    b. Assistance with developing or enhancing social support networks.

    c. Assistance with accessing:

        (1) Transportation services, as needed.

        (2) Safe housing that is reflective of the:

            (a) Abilities of the person served.

(b) Preferences of the person served.

d. Provision of, or linkage to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:

(1) Budgeting.

(2) Meal planning.

(3) Personal hygiene.

(4) Housekeeping.

e. An ongoing assessment of the needs of the persons served to determine appropriateness of services directly provided or accessed.

f. Evidence of linkage with necessary and appropriate services, including, when applicable:

(1) Financial.

(2) Medical or other health care.

(3) Medication use.

(4) Educational.

(5) Employment.

(6) Other community supports.

3.F. **6.** The intensity of case management is based on the needs of the person served.

3.F. **7.** When multiple case management providers exist, linkage is made to:

a. Ensure continuity of care.

b. Reduce duplication of services.

3.F. **8.** The court treatment program provides, or ensures the provision of, the following outpatient services:

a. Individual counseling/therapy.

b. Family counseling/therapy.

c. Group counseling/therapy.

d. Psycho-education.

3.F. **9.** Written procedures specify that the court treatment program provides or arranges for the provision of the following services when needed by the person served:

a. Detoxification.

b. Inpatient treatment.

c. Residential treatment.

d. Intensive outpatient treatment.

3.F. **10.** When applicable, frequent alcohol and other drug testing is used to monitor abstinence.

Intent Statements

The participant is involved in randomly or regularly scheduled alcohol or other drug testing during participation in the program. Abstinence is monitored by drug testing that occurs no less than twice per week. Test results are communicated to the participant and the court.

3.F. **11.** Records of the persons served document, on an ongoing basis, the specific treatment interventions that are provided.

3.F. **12.** Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, criminal justice behavioral health services.

3.F. **13.** All members of the team:

a. Have access to the confidential information that is required for the team members to perform their functions.

b. Are bound by applicable state, federal, or provincial confidentiality laws.

Examples

13.a. Access to clinical records can include access to information such as:

- Person-centered plans.
- Custody records.

3.F. **14. Training:**

    a. Is provided to personnel prior to the delivery of services.

    b. Includes regular interdisciplinary joint cross-training related to clinical and criminal justice issues.

    c. Includes such topics as:

      (1) The requirements imposed on personnel from the criminal justice system who participate on the treatment team.

      (2) Safeguards that are available to personnel.

Intent Statements

14.a. Behavioral health professionals who work in criminal justice settings encounter a unique service delivery system with both opportunities and challenges. The intent of this standard is to ensure that individuals new to this type of setting receive full and complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work.

14.b. *Interdisciplinary cross-training* refers to criminal justice staff members providing criminal justice training to clinical staff members and also to clinical staff members providing clinical training to criminal justice staff members. It also requires that training be conducted jointly with members from both the criminal justice and clinical services participating.

Examples

14.c.(1) May include requirements such as mandatory reporting,

3.F. **15. The treatment team works in a partnership with the judge to:**

    a. Review treatment progress on an ongoing basis.

    b. Respond to the progress and/or noncompliance of each person served.

3.F. **16. The person served is provided with a description of the relationship between the criminal justice entity and the program, including:**

    a. The extent and limitations of confidentiality and sanctions.

    b. The possible implications of having a criminal justice member on the team.

Intent Statements

Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team.

The person served has the option of refusing to have the criminal justice system actively involved in the treatment process and be told of the consequences.

Examples

The team involves a blend of behavioral health providers and criminal justice personnel, such as correctional officers, control agents, guards, and probation and parole officers.

16.b. The staff members of the program might discuss the possible advantages and disadvantages of having a criminal justice member on the team, including such issues as:

- Access to confidential records.
- Action the criminal justice member may be forced to take based on information provided by the team.
- The impact on the therapeutic relationship.

3.F. **17. A review of the person-centered plan for persons served in a court treatment program occurs at least once per month.**

3.F. **18.** If the person served is sanctioned to an external setting for 30 days or more:

 a. An updated transition plan is completed.

 b. His or her status is tracked/ monitored.

3.F. **19.** When the person served is referred to a different level of care in the community, the court treatment program establishes a process to consistently receive information regarding his or her status.

Intent Statements

Case management activities support regular communication and coordination of services with the provider of treatment services delivered outside the court treatment program. Case management services provide ongoing assessment of the participant's progress and needs, provide structure and support for participants who experience difficulties with using services, and ensure communication with the court.

3.F. **20.** When appropriate, and with the consent of the person served, the program coordinates treatment with other services.

3.F. **21.** The person-centered plan for a person receiving education and training services in a court treatment program:

 a. Addresses issues specific to his or her individual needs.

 b. Is consistent with his or her cognitive and learning abilities.

 c. Is consistent with the program's philosophy of treatment.

 d. Addresses:

 (1) Relapse prevention.

 (2) Potential contingency plans.

Intent Statements

21.b. The intent of this standard is to ensure that the assessment has included cognitive and learning abilities and that reading materials, assignments, and the requirements for participation take into consideration the learning abilities of the person served. This standard includes ensuring that reasonable accommodations are available for persons with special educational needs.

21.c. Since many of the criminal justice educational services are provided as part of or within a treatment program, this standard encourages the organization to ensure that the educational plan for each person served is consistent with the philosophy of the treatment program.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Person-centered plans for the persons served
- Assessment and documentation of progress toward individual goals

G. Crisis and Information Call Centers (CIC)

Description

Crisis and information call centers respond to a variety of immediate requests identified by the persons served and may include crisis response, information and referral, or response to other identified human service needs.

Applicable Standards

An organization seeking accreditation for a crisis and information call center program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

3.G. **1.** The program has policies and written procedures for:
  a. Determination of eligibility.
  b. Handling of calls from persons ineligible for services.
  c. Caller identification.
  d. Active rescue.
  e. Follow-up.
  f. Third-party outreach.
  g. Monitoring of calls.
  h. Recording of calls.
  i. Call refusal or termination.
  j. Safety of staff specific to a 24/7 setting.

Examples

1.a. Eligibility may be limited by scope of contract or geographic limitation.

1.i. May address prank, abusive, or sexually inappropriate phone calls.

3.G. **2.** The program provides initial and ongoing training to persons providing services that is guided by:
  a. A written training plan.
  b. A detailed curriculum.
  c. Post-training assessment of competency.
  d. Mechanisms for:
    (1) Modeling.
    (2) Evaluation.
  e. Updating of training to reflect:
    (1) Current community issues or trends.
    (2) Field trends or research.

3.G. **3.** The program provides telephone intervention services.

3.G. **4.** To ensure access during identified hours of operation, the program implements written procedures that:
  a. Identify thresholds for timeliness of response.
  b. Provide for monitoring of attainment of thresholds.
  c. Identify a process for implementing changes in response to:
    (1) Results achieved.
    (2) Changes in demand or capacity.

Intent Statements

The program has procedures in place to match resources (i.e., staffing, call transferring, timeliness, etc.) to anticipated need levels to achieve desired services.

3.G. **5.** The program provides or has procedures for identifying and accessing face-to-face response when indicated.

Intent Statements

Face-to-face response may be provided by the program, or linkages for the provision of face-to-face services are identified in writing.

3.G. 6. Written procedures identify:

   a. The nature of the call.

   b. A screening process that is appropriate to the presenting concern.

   c. Suggested responses based on needs identified by the person calling.

   d. The need to document results of screening.

Intent Statements

6.b. The intent of the standard is to document the collection of an adequate amount of information to provide appropriate and safe services.

3.G. 7. Procedures guide the potential involvement of social support systems, including family members, identified legal representatives, or others, with legal right or the consent of the persons served.

3.G. 8. Individuals providing services demonstrate knowledge and skill of:

   a. Appropriate community resources.

   b. Crisis identification.

   c. Rapport building and positive engagement.

   d. Mandatory reporting requirements.

   e. Other laws and regulations, as applicable.

Intent Statements

Evidence of orientation and training may be documented in personnel records and inservice training logs.

8.a. Information about community resources, such as transportation services, support groups, emergency services, ambulance services, and other information and referral services, is made available to the persons served through program personnel.

8.d. Every state and province has established laws and regulations for individuals who are typically determined to be a threat to themselves or others or who have been involved with a reportable act of abuse.

3.G. 9. In a crisis response program, if the assessment identifies a need for an initial crisis intervention response, it includes:

   a. When applicable, identified immediate need for response to:

   (1) Suicide risk.

   (2) Threatened or actual abuse or violence.

   b. A written statement describing the crisis resolution.

Examples

9.a.(2) May include homicide or physical or sexual abuse.

3.G. 10. A crisis response program provides or has procedures for the provision of services 24 hours a day, 7 days a week.

Intent Statements

The intent of this standard is to ensure the availability of comprehensive crisis intervention services that are directly available at all hours to the population served.

3.G. 11. When a crisis response program uses a secondary provider for roll-over call answering or 24/7 coverage, there is evidence of:

   a. Interagency coordination.

   b. Written agreements.

   c. Identified training requirements.

   d. Service evaluation.

Examples

11.b. May identify requirements for timelines of response.

3.G. 12. In a crisis response program, the individuals providing services have the capability to make appropriate decisions to:

a. Determine an appropriate course of action.

b. Facilitate the stabilization of the situation as quickly as possible.

Intent Statements

The program has personnel, students, or volunteers with adequate training, education, or experience to make appropriate decisions, and records reflect that appropriate decisions are made. Basic components of any crisis response service are the abilities to quickly assess the problem, decide on the appropriate course of action, and bring together the necessary services and providers to stabilize the situation as soon as possible.

3.G. 13. In a crisis response program, the individuals providing services demonstrate competency in:

a. Crisis intervention techniques.

b. Lethality assessment.

c. Problem solving.

d. Recognizing indicators of presenting problems.

Examples

13.c. May include suicide risk, mental illness, abuse, domestic violence, addiction, or homelessness.

3.G. 14. In an information and referral program, written procedures identify the process for:

a. Determining eligibility for inclusion of resources in the community resource database.

b. Regularly updating the database.

c. Tracking requests to identify the community services that are:

(1) Most needed.

(2) Not available.

Intent Statements

The program identifies the criteria and process to be used to add or delete resources from its referral list.

Examples

This may include customer feedback, community history and recognition, proven ability to deliver services, funding resources, etc.

3.G. 15. The information and referral program has a policy defining expectations regarding:

a. Nonendorsement of specific referrals.

b. Fair and equitable caller-driven referrals.

Intent Statements

The referral policy identifies the program's expectations regarding endorsement of select providers when choice exists and expectations relative to referrals that may reflect a potential conflict of interest.

3.G. 16. When applicable, the information and referral program has procedures for:

a. A referral process that provides choice to the caller.

b. Warm transfer.

Examples

16.b. Transferring care from one provider to another involving person-to-person contact as opposed to sending a file.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Policies and written procedures related to the provision and parameters of services

- Written training plan for persons providing services

- Written procedures that match resources to service needs

- Written procedures for screening and responses to calls

- Written statements describing crises resolutions, if applicable

- Written agreements with secondary service providers, if applicable

- Written procedures related to adding/deleting resources from the referral list and tracking requests for community services

- Policy defining expectations regarding nonendorsement of specific referrals and fair and equitable referrals

- Records of the persons served

H. Crisis Intervention (CI)

Description

Crisis intervention programs offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress or in response to acts of domestic violence or abuse/neglect. Crisis intervention services consist of mobile response, walk-in centers, or other means of face-to-face assessments and telephone interventions.

Applicable Standards

An organization seeking accreditation for a crisis intervention program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

3.H. **1. The organization implements an identified written procedure for timely engagement of the person served.**

3.H. **2. The written crisis assessment includes at a minimum:**
   a. **Presenting concerns.**
   b. **Suicide risk.**
   c. **Issues since last stabilization, when applicable.**
   d. **Current living situation.**
   e. **Availability of supports.**
   f. **Risk of harm:**
      (1) **To self or others.**
      (2) **From others.**
   g. **Current medications and compliance.**
   h. **Use of alcohol or drugs.**
   i. **Medical conditions.**
   j. **When applicable, history of previous crises, including response and results.**

3.H. 3. The crisis assessment leads to an initial crisis intervention plan, developed upon contact with each person served, that includes:

  a. Identified immediate response needs.

  b. Identified follow-up when referral is made.

  c. A statement of crisis resolution.

Intent Statements

Since crisis intervention programs consist of immediate and short-term response to the crises, the plan for care may be shorter than the person-centered plan described in Section 2.C. The plan may only address the immediate services needed to respond to the current crisis of the person served and the transition to other services.

3.H. 4. The program provides:

  a. Telephone intervention services.

  b. Face-to-face assessment services.

Intent Statements

At a minimum, a crisis intervention program provides services over the telephone (including TDD when needed) and face-to-face at a treatment location, home, shelter, hospital, or other community site.

4.a. Telephone intervention services are generally shorter in duration, and the information gathered will be minimized because there is less time to access and intervene in the crisis. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

4.b. Although the use of electronic means may be included, it would not suffice in meeting this standard.

3.H. 5. There are procedures for the provision of mobile services.

Intent Statements

Mobile services include the capacity to respond to the site where the individual in crisis is located.

Examples

Mobile services may be provided by the organization, or linkages for the provision of emergency or crisis intervention services may be established through such community organizations as visiting nurse groups, community mental health centers, and case management programs.

3.H. 6. Personnel providing mobile services are trained or certified in first aid and CPR.

3.H. 7. There are written emergency procedures that address:

  a. Screening for medical conditions.

  b. Making referrals to emergency medical services when indicated.

  c. Identifying personnel trained in emergency procedures.

  d. When appropriate, identifying personnel other than physicians who can perform special procedures, including the circumstances under which they can perform these procedures and the degree of supervision required to perform these procedures.

  e. Handling standing orders.

  f. Involuntary hospitalization.

Intent Statements

Often crisis intervention services involve the provision of emergency care. The intent of this standard is to ensure that staff members, resources, and procedures are available to respond to these circumstances. Special procedures may include the provision of medications or other medical services.

3.H. 8. Crisis intervention services are available 24 hours a day, 7 days a week.

Intent Statements

The intent of this standard is to ensure the availability of comprehensive crisis intervention services that are directly available at all hours to the population served.

3.H. 9. Qualified behavioral health practitioners are available 24 hours a day, 7 days a week.

Intent Statements

See the Glossary for the definition of a *qualified behavioral health practitioner*. *Available* may include being on call.

3.H. 10. The program has the capability to make appropriate clinical decisions to:

a. Determine an appropriate course of action.

b. Stabilize the situation as quickly as possible.

Intent Statements

The program has staff with appropriate clinical training, education, or experience to make clinical decisions, and records reflect that clinical decisions are made. Basic components of any crisis intervention service are the ability to quickly assess the problem, decide on the appropriate course of action, and bring together the necessary services and providers to stabilize the situation as soon as possible.

3.H. 11. The program has written procedures to guide access to inpatient services or less restrictive alternatives.

3.H. 12. There are procedures for the involvement of family members, identified legal representatives, or others, with legal right or the consent of the persons served.

Intent Statements

These procedures should follow the legal requirements regarding the confidentiality rights of the persons served.

3.H. 13. Personnel demonstrate knowledge of:

a. The appropriate use of community resources.

b. Crisis intervention techniques.

c. Procedures for involuntary hospitalization.

Intent Statements

Evidence of orientation and training may be documented in personnel records and inservice training logs.

13.a. Information about community resources, such as transportation services, hospital emergency services, ambulance services, and information and referral services, is made available to the persons served through program personnel.

13.c. Every state and province has established laws and regulations for the involuntary hospitalization of individuals who are typically determined to be a threat to themselves or others. The crisis intervention personnel demonstrate knowledge of the laws and procedures for involuntary hospitalization.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written procedure for timely engagement of the person served
- Written crisis assessment
- Initial crisis intervention plans
- Written emergency procedures
- Written procedures to guide access to inpatient services or less restrictive alternative
- Records of the persons served

I. Crisis Stabilization (CS)

Description

Crisis stabilization programs are organized and staffed to provide the availability of overnight residential services 24 hours a day, 7 days a week for a limited duration to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop plans to meet the needs of the persons served. Often crisis stabilization programs are used as a preemptive measure to deter unnecessary inpatient hospitalization.

Applicable Standards

An organization seeking accreditation for a crisis stabilization program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

3.I. **1. The program has the capacity to admit persons served 24 hours a day, 7 days a week.**

3.I. **2. An initial crisis stabilization plan:**
- **a. Is developed upon admission for each person served.**
- **b. Addresses the person-centered plan if one is available.**
- **c. Identifies any directives from the person served and/or legal guardian.**

Intent Statements

Because crisis stabilization programs consist of short lengths of stay in response to crises, the plan for care may be shorter than the person-centered plan described in Section 3.C.

3.I. **3. The program has on-site personnel 24 hours a day, 7 days a week.**

3.I. **4. Licensed medical personnel are available 24 hours a day, 7 days a week.**

Intent Statements

Personnel may include physicians, licensed registered nurses, licensed practical nurses, and licensed physicians' assistants who can be available on site or on call.

3.I. **5. Documented daily therapeutic interventions occur between the persons served and a qualified behavioral health practitioner.**

Intent Statements

Although a particular treatment service is not required, there is daily contact with program staff members, case managers, or other appropriate professionals.

See the Glossary for the definition of a *qualified behavioral health practitioner*.

3.I. **6. The needs of the persons served are continuously evaluated to ensure that appropriate services are provided prior to discharge from crisis stabilization.**

3.I. **7. Appropriate referral and linkage to needed services is conducted at the earliest possible interval in the service provision.**

3.I. **8. The program ensures that transportation arrangements are made for persons served to immediately needed care/service.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Crisis stabilization plans for the persons served
- Staffing pattern chart or schedule

J. Day Treatment (DT)

Description

Day treatment programs are time-limited, medically-monitored programs that offer comprehensive, intensive, individually planned, coordinated, and structured services.

A day treatment program consists of a scheduled series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency in order to assist the persons served in achieving the goals identified in their individual treatment plans. Day treatment programs are offered four or more days per week, typically with some availability in the evenings and on weekends. Such a program functions as a step-down or alternative to inpatient care or partial hospitalization, as transitional care following an inpatient or partial hospitalization stay in order to facilitate return to the community or to prevent or minimize the need for a more intense or restrictive level of treatment. Day treatment programs are more intensive than outpatient treatment and serve persons who need a structured behavioral health setting for daytime activities.

Applicable Standards

An organization seeking accreditation for a day treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.J. **1. The program is available for each person served:**
   a. **At least four days per week.**
   b. **At least three hours per day.**

Intent Statements

While the program is available to the persons served three hours per day, four days per week, individualized plans and variable lengths of stay will determine the degree to which each person actually participates in a day treatment program.

3.J. **2. The program is directed by a qualified behavioral health practitioner.**

Intent Statements

See the Glossary for the definition of a *qualified behavioral health practitioner*.

3.J. **3. The majority of program hours consist of scheduled treatment activities.**

3.J. **4. Treatment activities include at least three of the following:**
   a. **Alcohol and other drug education.**
   b. **Family therapy or counseling.**
   c. **Provision of or linkage with educational activities.**
   d. **Provision of or linkage with vocational activities.**
   e. **Group psychotherapy or counseling.**
   f. **Individual psychotherapy.**
   g. **Medication education.**
   h. **Psychoeducation.**
   i. **Assistance with accessing community supports.**
   j. **Assistance with activities of daily living.**
   k. **Occupational therapy.**

3.J. **5. Additional activities include at least two of the following:**
   a. **Social activities.**
   b. **Leisure/recreational activities.**
   c. **Nutritional activities.**
   d. **Fitness activities.**

Intent Statements

The additional activities listed would need clinical oversight.

3.J. **6. The program:**
   a. **Has consistently assigned personnel.**
   b. **Has consistently scheduled activities.**

Intent Statements

6.a. The program establishes a stable staffing pattern either by assigning the same personnel to the program or by rotating personnel from a

consistent pool to provide the needed intensity of interventions on a consistent basis.

3.J. **7. The program provides:**

    a. Assessment and diagnostic services.

    b. Medication monitoring, when necessary.

3.J. **8. The program's services are provided by a multidisciplinary team.**

Intent Statements

This standard reinforces a team approach to services. There is a team made up of persons from a variety of disciplines who work cooperatively in delivering day treatment services.

3.J. **9. When the persons served have psychiatric needs, psychiatric services:**

    a. Are available to the person served.

    b. Include the availability of a psychiatrist during program hours.

Intent Statements

A psychiatrist can be available either on site or on call.

3.J. **10. Referral is made to alternative services when:**

    a. Medically indicated.

    b. Clinically indicated.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- A program schedule
- Individual program plans for the persons served
- Records of the persons served

K. Detoxification (DTX)

Description

Detoxification programs provide support to the persons served during withdrawal from alcohol and/or other drugs. Services may be provided in a unit of a medical facility, in a freestanding residential or community-based setting, or in the home of the person served. The following types of detoxification may be provided:

- *Outpatient detoxification*: Persons served receiving outpatient detoxification treatment usually are expected to travel to a hospital or other treatment facility daily or on a regular basis for detoxification treatment sessions. Sessions may be scheduled for daytime or evening hours. Outpatient detoxification programs may also be combined with a day program. Outpatient detoxification programs may also include provision of medically monitored medications used in the detoxification process.

- *Social detoxification*: Social detoxification is provided in an organized, residential, non-medical setting delivered by an appropriately trained staff that provides safe, 24-hour medication monitoring, observation, and support in a supervised environment for a person served to achieve initial recovery from the effects of alcohol and/or other drugs. Social detoxification is appropriate for individuals who are able to participate in the daily residential activities and is often used as a less restrictive, nonmedical alternative to inpatient detoxification.

- *Inpatient detoxification*: The inpatient setting offers the advantages of 24-hour medical care and supervision provided by a professional staff and the easy availability of treatment for serious complications. In addition, such a setting prevents persons served access to alcohol and/or other drugs and offers separation from the substance-using environment. Inpatient detoxification is often provided to individuals with co-occurring health conditions that would be impacted by the detoxification process. It is also appropriate

for individuals who need extensive medical monitoring during detoxification.

Applicable Standards

An organization seeking accreditation for a detoxification program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

■ All detoxification programs must apply Standards 1.–10.

■ A detoxification program in an outpatient setting must also apply Standard 3.K.11.

■ An inpatient detoxification program must also apply Standards 3.K.12.–13.

3.K. **1.** **A medical evaluation is obtained prior to or within 24 hours of admission and includes:**

   a. A physical examination.

   b. Orders for appropriate tests.

   c. Face-to-face consultation with a physician.

Intent Statements

Readmission within 30 days would not require a new examination unless specified otherwise by regulation.

1.c. When an admission occurs on a weekend or holiday, face-to-face consultation may not occur until the first working day unless medically required.

When allowed by medical practice boards or other regulation, a physician's assistant or nurse practitioner may be used.

3.K. **2.** **The program ensures:**

   a. The ongoing review of the person-centered plan for detoxification.

   b. That the detoxification process is supervised by medical personnel.

   c. That services provided are consistent with generally accepted standards of practice for detoxification programs.

   d. That medication use services for detoxification are based on medical protocol.

   e. That a health screening is completed for each person admitted that includes:

      (1) The need for medical care.

      (2) The intensity of services needed.

      (3) Laboratory tests, when needed.

Intent Statements

Because physical withdrawal from certain substances can be life threatening, a physical examination or health screening is performed for withdrawal and treatment planning.

When social setting detoxification is provided, medical oversight can substitute for medical supervision.

Examples

2.c. These may include ASAM, AMA, CSAM, CMA, or SAMSHA criteria, and any applicable federal, state, or provincial laws and regulations.

2.e. This refers to the initial admission and not to individuals transferred within the continuum of care in an organization.

3.K. **3.** **Medical personnel are available:**

   a. Twenty-four hours a day, seven days a week.

   b. In accordance with federal, state, or provincial law.

Intent Statements

This standard does not require medical personnel to be on site at all times but rather that medical personnel be on call 24 hours a day, 7 days a week.

3.K. **4.** **Supervision of the detoxification process includes, at a minimum:**

   a. Regular and frequent monitoring of vital signs (pulse, temperature, and respiration).

   b. Face-to-face contact with the person served.

3.K. 5. Detoxification services are provided by qualified personnel 24 hours a day, 7 days a week.

Intent Statements

The detoxification process is the responsibility of qualified professionals, as determined by medical necessity, legal status, and the needs of the persons served.

Examples

Qualified detoxification personnel can include medical personnel, qualified behavioral healthcare practitioners, and healthcare technicians.

NOTE: *In outpatient or in-home programs, detoxification services may not be provided 24 hours a day, 7 days a week, but they are available when needed.*

3.K. 6. Documentation is maintained by qualified personnel regarding each person's condition, including:
  a. Significant indicators as monitored through vital signs.
  b. Symptoms of medical distress.
  c. Actions taken.
  d. Progress of the person served.

Intent Statements

Because detoxification is primarily a medical protocol, clear documentation in the form of treatment plans and progress notes is maintained.

3.K. 7. There is sufficient contact with each person served to monitor his or her progress toward treatment goals.

Intent Statements

The frequency of contact depends on the severity of withdrawal, potential medical complications, and the detoxification setting.

3.K. 8. Referral to another level of care is made during provision of detoxification services or prior to discharge following completion of services.

Examples

Another level of care may mean more intensive medical care if medical complications develop during the detoxification process. *Referral* can involve inpatient, outpatient, or residential treatment.

3.K. 9. The organization implements written procedures addressing transfer to emergency medical services that include:
  a. Steps for dealing with common medical problems.
  b. The process necessary to transfer a person to a hospital or emergency services.
  c. Access to documented services received during absence from the program, including medications prescribed.
  d. Documentation of actions taken when the person served returns from the emergency service provided.

Examples

The written procedures could include a description of the steps for dealing with common medical problems that may arise during withdrawal and the process necessary to transfer a person to a hospital or emergency service.

3.K. 10. The persons served are provided with services designed to motivate them to continue treatment following detoxification.

Intent Statements

It is important to begin the treatment process as soon as possible and to begin intervening at a point when the persons served may be most open to counseling. The intent of this standard is to ensure that when the persons served are being treated for physical withdrawal, they are also engaged in counseling to encourage the continuation of services.

3.K. **11.** **When outpatient detoxification services are provided, medications are prescribed only:**

a. **When the persons served are able to self-manage their medications or when there is evidence of support from families, significant others, and/or members of a social support system.**

b. **When the program maintains sufficient staff resources to provide medication management.**

Intent Statements

Outpatient detoxification typically employs medication that is prescribed and monitored daily by nursing personnel. Individuals come to the program daily and spend the day or part of the day in therapeutic activities.

3.K. **12.** **When inpatient detoxification services are provided, treatment is based on orders authorized by a licensed physician, nurse practitioner, or physician assistant, as permitted by federal, state, or provincial law.**

Intent Statements

This standard does not require a physician, nurse practitioner, or physician assistant to be on site at all times, but a physician, nurse practitioner, or physician assistant should be on call 24 hours a day, 7 days a week. Medically supervised detoxification could be provided in any setting.

3.K. **13.** **When inpatient detoxification services are provided, nursing care is provided:**

a. **Twenty-four hours a day, seven days a week.**

b. **In accordance with federal, state, or provincial law.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Documentation of each person's condition; treatment plans, progress notes
- Medical evaluations of persons served
- Staffing pattern chart or schedule
- Written procedures for transfer to medical emergency services
- Written plan that guides the delivery of services

L.   Diversion (DVN)

Description

Diversion programs may include programs traditionally thought of as intervention that focus on changing outcomes for persons served and targeting antecedents of the problem. Diversion programs utilize strategies designed to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Diversion programs may serve persons on a voluntary and/or involuntary basis. Programs that serve persons on an involuntary basis are designed to implement special strategies for engaging this population.

Diversion programs target persons who are exhibiting early signs of identified problems and are at risk for continued or increased problems. Diversion programs may include programs such as DUI/OWI classes, anger management or domestic violence groups, juvenile justice/court diversion, substance abuse diversion, truancy diversion, report centers, home monitoring, after-school tracking, and building healthy relationships.

Applicable Standards

An organization seeking accreditation for a diversion program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection. If an organization is seeking accreditation for a diversion program for children or adolescents, the standards in Section 4.B. do not apply.

3.L.   **1.   Services are designed by personnel with demonstrated skill and knowledge in current evidence-informed/evidence-based intervention/diversion theory and practice or diversionary alternatives.**

Examples

The program can demonstrate conformance to this standard through staff member interviews and documentation of skills and training in personnel files.

3.L.   **2.   The program collaborates with other programs and stakeholders within the community to:**
   a.   Ensure that agencies are knowledgeable of each others' services.
   b.   Assist with the process of referrals.
   c.   Coordinate community planning and development services.

Intent Statements

The program works collaboratively with other prevention, diversion, intervention, treatment, and community services to coordinate with and avoid overlapping use of community resources.

Examples

Collaboration can be demonstrated by:

- The use of the program's services by other organizations.
- Memberships on planning councils.
- Participation in multiagency United Way and other community organizations or public health activities such as health fairs.
- Participation in communitywide health education activities.

3.L.   **3.   The program provides applicable information in one or more of the following areas:**
   a.   Mental health.
   b.   Alcohol, tobacco, and other drug use.
   c.   Child abuse and neglect.
   d.   Suicide prevention.
   e.   Violence prevention.
   f.   Health and wellness.
   g.   Social and community issues.
   h.   Internet safety.
   i.   Acceptance of cultural diversity.
   j.   Effective parenting.

Examples

Information may be provided through:

- Sponsorship or participation in community events and activities.
- Participation in health fairs.

■ Public service announcements.

■ Community seminars and workshops.

Specific topic areas could include:

■ **3.a.** Stress management education; teen help lines.

■ **3.b.** Education regarding tobacco use, substance reduction, MADD/SADD groups, prescription drug abuse, and drug-free workplace programs.

■ **3.e.** Domestic violence, including interpersonal, family, and intimate partner relationships; bullying, gangs, and school-based violence.

■ **3.f.** Safe sex, sexually transmitted diseases, HIV/AIDS, communicable diseases, teen pregnancy.

■ **3.g.** Spirituality-based programs; dating issues.

3.L. **4.** **Program activities are:**
  a. **Culturally relevant.**
  b. **Age appropriate.**
  c. **Gender appropriate.**
  d. **Targeted toward multiple settings within the community.**

Examples

4.d. The activities can be directed to:

■ Individuals.

■ Families.

■ Organizations.

■ Systems of care.

■ The community and the region.

3.L. **5.** **The program includes two or more of the following strategies:**
  a. **Increasing knowledge and raising awareness.**
  b. **Building skills and competencies.**
  c. **Increasing involvement in healthful alternatives.**
  d. **Increasing access to services.**

e. **Improving early identification of:**
    (1) **Needs.**
    (2) **Referrals.**
  f. **Influencing behavioral change.**
  g. **Reducing incidence of problem behaviors.**
  h. **Changing institutional policies.**
  i. **Influencing how laws are:**
    (1) **Developed.**
    (2) **Interpreted.**
    (3) **Enforced.**
  j. **Building the capacity of collaborative partnerships.**
  k. **Building the capacity of the community to address its needs.**
  l. **Mentoring.**

3.L. **6.** **The program has a plan or written logic model that details:**
  a. **The specific theoretical approaches to be used.**
  b. **The methodological approaches to be used.**
  c. **How the approaches will be applied within the community.**

Intent Statements

The program is able to document that the approach it uses has a sound theoretical foundation.

Examples

Specific theoretical or methodological prevention approaches could include the use of:

■ Health and wellness models.

■ Developmental models.

■ Risk and resiliency models.

■ Public health models.

■ Social competency models.

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3.L. **7. The program:**

    a. Has procedures for referring persons served to other:

        (1) Health services, as needed.

        (2) Social services, as needed.

    b. Demonstrates that personnel are knowledgeable of current community resources.

    c. Conducts evaluation of its:

        (1) Programs/services.

        (2) Training activities.

Intent Statements

7.a. If, as a result of diversion services or activities, individuals identify themselves or are identified by family members, significant others, or personnel as needing treatment, program staff members know how to refer these individuals for appropriate services.

3.L. **8. The program:**

    a. Utilizes a screening or assessment process to identify individuals for participation or enrollment in the program.

    b. Includes a documented plan for individual outcomes.

Intent Statements

While it is important to accurately determine a participant's appropriateness for the diversion program, the screening or assessment may be completed by an external entity.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written plan or logic model that details specific approaches to be used

- Plan for individual outcomes

- Documentation of evaluation of programs/ services and training activities

M. Employee Assistance (EA)

Description

Employee assistance programs are work site focused programs designed to assist:

- Work organizations in addressing productivity issues.

- Employee clients in identifying and resolving personal concerns (including, but not limited to, health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues) that may affect job performance.

Employee Assistance Program Services (EAP Services) may include, but are not limited to, the following:

- Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance and outreach to and education of employees and their family members about availability of EAP services.

- Confidential and timely problem identification and/or assessment services for clients with personal concerns that may affect job performance.

- Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance.

- Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up services.

- Assistance to work organizations in managing provider contracts and in establishing and maintaining relations with service providers, managed care organizations, insurers, and other third-party payers.

- Assistance to work organizations in providing support for employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional behaviors.

■ Identification of the effects of EAP services on the work organization and individual job performance.

Applicable Standards

An organization seeking accreditation for an employee assistance program must apply the standards in Sections 1 and 2 (please consult grid on page 96 for applicability), along with standards in this subsection and 3.H. Crisis Intervention (CI), Standards 7.–13. If only assessment and referral is provided, Section 2.C. Person-Centered Plan does not apply.

3.M. **1. The program:**

    a. Facilitates equal access to services by all segments of the host organization.

    b. Fully discloses to the persons served the conditions that may limit confidentiality.

    c. Protects the host organization's proprietary information with professional discretion and integrity.

    d. Provides consultation regarding:

       (1) The management of employees.

       (2) Referral of employees with job performance and other behavioral problems.

    e. Provides consultation to the host organization's leadership on issues that may impact employees' well-being.

    f. Informs and educates employees.

Intent Statements

1.a. It is not unusual for various employee groups to be excluded from access to employee assistance services or to find such services specifically focused on one occupational group. The intent of this standard is to provide equal access for all groups.

Examples

1.a. Groups that might be excluded from services include:

■ Professional and managerial staff members.

■ Sales staff members or employees off site or in remote locations.

■ Faculty members of educational institutions.

1.f. Methods to educate and inform employees may include:

■ Providing promotional materials.

■ Providing activities that encourage the appropriate use of the program.

■ Providing employee orientation programs.

3.M. **2. The components of the program are based on:**

    a. The agreement with the host organization.

    b. An assessment of employee needs.

    c. Compliance with regulatory and legislative requirements.

Examples

The design of an employee assistance program addresses issues such as:

■ The type of organization.

■ The organization's mission.

■ The number and distribution of work sites.

■ The types of jobs and work products.

■ The size of the workforce.

■ The size of the organization.

■ Collective bargaining agreements.

■ Workforce demographics.

2.c. For example, an employee assistance program that provides counseling in addition to assessment services may be defined as an Employee Retirement Income Security Act (ERISA) program.

3.M. **3.** **The program has a written agreement with the host organization that:**

   a. **Defines the program's relationship to the host organization.**

   b. **States the scope of the program's services.**

   c. **States the limitations of the program's services.**

   d. **Defines the confidentiality guidelines.**

   e. **Defines the limits under which the employee assistance program functions.**

   f. **Describes the appropriate role of the program relative to the host organization's corrective and disciplinary procedures.**

   g. **Delineates the role of the program in all drug-testing programs.**

   h. **Defines the respective responsibilities and relationships of the program and any managed care functions.**

   i. **Identifies the criteria for referral for additional services.**

   j. **Describes the costs of services.**

   k. **Identifies a liaison from the program.**

   l. **Identifies a liaison from the host organization.**

   m. **Delineates the ownership of the program records.**

   n. **Delineates the retention of the program records.**

   o. **Delineates the types of consultation that will be provided.**

Intent Statements

The written agreement includes the issues described and can often be stated in a program policy. However, the policy cannot be confused with operating procedures or other contractual agreements between the host organization and the provider of the employee assistance program. When the written agreement is developed, it is consistent with the host organization's other policies, such as those addressing disciplinary actions, workers' compensation, a drug-free workplace, and the ADA, when applicable.

3.M. **4.** **When the written agreement includes a program advisory process within the host organization, it:**

   a. **Provides for the involvement of all key segments of the workplace.**

   b. **Includes representation from the leadership of:**

      (1) **The host organization.**

      (2) **Labor organizations.**

   c. **Reflects the employee population's:**

      (1) **Genders.**

      (2) **Ethnicity.**

      (3) **Cultural diversity.**

   d. **Describes the program's scope, purpose, and operation.**

   e. **Ensures equal access to services by all segments of the host organization.**

Intent Statements

Program acceptance by the host organization is enhanced by involving the organization's leadership, employees, unions, and other key personnel.

Examples

The advisory process can provide advice regarding:

- Goals and objectives.
- Program design and implementation.
- Outcomes management.
- Use of services.
- Confidentiality issues.
- Issues of diversity.
- Advocacy.

3.M. **5.** **The employee assistance program is provided by an identifiable delivery system that includes provisions for:**

   a. **Making services available in designated areas.**

   b. **Assigning qualified staff members to the program.**

   c. **Using an environment that supports the program philosophy.**

Intent Statements

The intent of this standard is to ensure that employee assistance program services are not delivered through inappropriate channels and do not become integrated into and de-emphasized in either the host organization's system or the health care delivery system. The system for delivering employee assistance program services is distinct from other divisions of the host organization and other systems, such as the organization's department of human resources and the managed care system.

3.M. 6. Each external and consortium program identifies a program liaison from the host organization.

Intent Statements

Employee assistance program staff members who are external to the host organization need one designated individual employed by the host organization to act as the liaison. This individual is often located in the medical or human resources department.

3.M. 7. When considering the addition of new services, the program ensures that the services are consistent with the employee assistance program's goals and objectives.

Intent Statements

Employee assistance professionals and program staff members are most useful to host organizations and their employees when they are proactive in identifying and responding to emerging needs. It is suggested that services designed to meet these emerging needs be incorporated into the employee assistance program as long as they do not reduce the effectiveness or perceived neutrality of the employee assistance professionals or program staff members. The employee assistance professionals may assist in the design and location of services for which a need has been identified.

3.M. 8. All employee assistance program staff members:

a. **Have an understanding of employee assistance program-related functions.**

b. **Have training in employee assistance program-related functions.**

c. **Maintain their skills and abilities.**

Examples

8.b. Such training may include:

- Organizational dynamics.
- Employee assistance program practice.
- Mental health issues.
- Alcohol and drug use assessment and treatment.
- Human resources.
- Labor relations issues.

8.c. Knowledge and skills may be obtained and upgraded through a variety of means, including:

- Formal training.
- Inservice training.
- Participation in professional associations.

3.M. 9. Individuals who provide employee assistance services are:

a. **Certified employee assistance professionals, or**

b. **If not certified, have one of the following:**

   (1) **Supervision by a certified employee assistance professional.**

   (2) **A training plan that demonstrates progress toward the achievement of competencies in employee assistance.**

Intent Statements

The intent of this standard is to ensure that accredited employee assistance programs support individual providers in obtaining and maintaining the unique skills and knowledge base of certified employee assistance professionals.

3.M. **10.** Written procedures describe the type of information the host organization may receive from the program, including:

    a. The circumstances under which information is communicated.

    b. The persons authorized to request or release information.

    c. The need to obtain the consent of the persons served.

    d. The need to adhere to state, provincial, and federal confidentiality guidelines.

Examples

Such information can be included in the written agreement, program policies, contract, or operating procedures of the program.

3.M. **11.** The program is prepared to assist the host organization in the development and implementation of policies regarding:

    a. The threat of workplace violence.

    b. Critical incidents.

    c. Diverse crisis situations.

Intent Statements

If the program staff members do not have training and expertise in these areas, they can contract for these services.

3.M. **12.** When appropriate, with the consent of the person served, communication is maintained with a representative of the host organization throughout the employee assistance process.

Intent Statements

Communication is maintained during all stages, including:

- Assessment.
- Referral.
- Treatment.
- Reintegration.

3.M. **13.** If specified in the written agreement, personnel are trained in:

    a. The scope of the program.

    b. The procedures for referral.

Intent Statements

Personnel include supervisors, management, and union personnel. The intent of training is to encourage supervisors to fulfill their role in early recognition, intervention, and appropriate referral to the employee assistance program. The role of a supervisor is to focus on employees' job performance not on diagnosis of personal problems. Training may be delivered in a variety of ways depending on the host organization's corporate culture and other factors affecting the host organization.

3.M. **14.** If alcohol and other drug services are provided for a host organization, the organization:

    a. Ensures that the individuals performing services comply with the drug testing regulations of the specific governing agencies under which they provide services.

    b. Identifies the relationship between the employee assistance staff person and the alcohol and drug professional.

Intent Statements

Alcohol and drug problems continue to be the major source of personal problems that impact productivity, absenteeism, and employees' health. This area is a critical component of employee assistance program services.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- A written agreement between the host organization and the employee assistance program

- The credentials of individuals providing the employee assistance program services

- Written procedures describing the type of information the host organization may receive

- Policies regarding safety threats

- Documentation of each person's consent

N. Health Home (HH)

Description

Health home is a healthcare delivery approach that focuses on the whole person and provides integrated healthcare coordination that includes primary care and behavioral healthcare. A health home allows for choice and is capable of assessing the various medical and behavioral needs of persons served. The program demonstrates competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders/addictions, and recognize general medical or physical concerns. Programs may also serve persons who have intellectual or other developmental disabilities and medical needs, or those who are at risk for or exhibiting behavioral disorders. Care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served.

A health home serving individuals receiving behavioral healthcare provides screening, evaluation, crisis intervention, medication management, psychosocial treatment and rehabilitation, care management, and community integration and support services designed to assist individuals in addressing their behavioral healthcare needs, and:

- Embodies a recovery-focused model of care that respects and promotes independence and responsibility.

- Promotes healthy lifestyles and provides prevention and education services that focus on wellness and self care.

- Ensures access to and coordinates care across prevention, primary care (including ensuring consumers have a primary care physician), and specialty healthcare services.

- Monitors critical health indicators.

- Supports individuals in the self-management of chronic health conditions.

- Coordinates/monitors emergency room visits and hospitalizations, including participating in transition/discharge planning and follow up.

Using health information technology, a health home collects, aggregates, and analyzes individual healthcare data across the population of persons served by the health home and uses that data and analysis to manage and improve the health outcomes of the population it serves, rather than responding only to each individual concern at each individual visit. Health homes coordinate care and manage multiple diseases both physical and behavioral. If the health home is not the actual provider of a particular healthcare service, it remains responsible for supporting and facilitating desirable and effective outcomes by providing care coordination and disease management supports to outside providers of services for persons served by their health home.

Applicable Standards

An organization seeking accreditation as a health home must apply the standards in Sections 1 and 2 in addition to the standards in this subsection and use the Comprehensive Care field category.

3.N. **1. The written program description clearly defines the following:**

　　a. Population served.

　　b. How primary care and other healthcare services will be:

　　　(1) Provided.

　　　(2) Accessed.

　　　(3) Coordinated.

　　c. Referral procedures for external services needed by persons served.

　　d. The process for providing care coordination and disease management supports for the person served:

　　　(1) Internally.

　　　(2) To external service providers.

3.N. **2. The program is organized and delivered in a manner that ensures:**

　　a. An integrated team approach.

　　b. Inclusion of complementary disciplines needed by the persons served.

Examples

2.b. Complementary disciplines will be determined by the needs of the population served by the health home as well as identified essential health benefits, and could include medical or dental care providers, physical or other therapists, nurse care coordinators, nutritionists, social workers, educational specialists, a variety of behavioral health practitioners, or others.

3.N. **3. When primary care or other healthcare services are provided directly by the health home, support for these services includes:**

　　a. Co-location with appropriate physical space.

　　b. Implemented written procedures regarding:

　　　(1) Access to primary care or other medical services.

　　　(2) Sharing of information.

　　　(3) Coordination of care.

　　c. Cross training for the most common chronic medical and behavioral illnesses prevalent in the population served.

Examples

3.a. May be in a single building, on a single campus, or within close proximity.

3.b. Procedures may identify the following:

- When or under what circumstances face-to-face or other communication will occur with the person served.

- How needs will be communicated and services coordinated.

- How responsibility for care coordination or follow-up will be determined.

3.c. Could include training on common psychiatric diagnoses (symptoms and potential treatments) with medical personnel and basic

training on medical conditions such as heart disease and diabetes with behavioral health personnel.

3.N. 4. The program:

    a. Identifies hours when healthcare services are available.

    b. Ensures the availability of the following during program hours:

        (1) Psychiatrist or psychologist.

        (2) Primary care provider.

        (3) When needed, other professional legally authorized to prescribe.

        (4) Care coordinator.

        (5) Based on the needs of the persons served, other qualified behavioral health practitioner(s).

Intent Statements

The intent of this standard is to provide for the availability of identified licensed staff during program hours and to ensure an ongoing relationship between the health home staff and/or other behavioral health and primary care providers. Equivalent positions identified in this standard may be filled by the same person; e.g., (1) and (3) may both be filled by a psychiatrist, or (3) and (4) may both be filled by a nurse legally authorized to prescribe.

Examples

4.b.(2) May include a variety of primary medical care providers, such as a physician, nurse, etc. May also be met by primary care provider of the person served.

4.b.(3) The program may include others with legal authority to prescribe. Depending on the local regulations, this could include advanced practice nurse or advanced practice psychiatric nurse, registered nurse, nurse practitioner, physician's assistant, or others.

3.N. 5. When neither a psychiatrist nor primary care physician is identified as personnel of the health home, a psychiatrist or primary care physician is available for consultation and/or program oversight during hours of operation.

Intent Statements

This availability could be met via telephonic or electronic means of communication and could be identified through agreement with individuals or institutions.

3.N. 6. When not directly part of the health home, off-site treating psychiatrists or primary care providers are offered care coordination and disease management supports to facilitate and enhance treatment for the persons served in the health home.

Examples

Disease management is the coordination of healthcare interventions and communications for the population served, and supports the practitioner/patient relationship and plan of care.

3.N. 7. The health home team ensures that the following services are provided, as needed, to all persons served:

    a. Health promotion, including education.

    b. Care management, including:

        (1) Outreach.

        (2) Engagement.

    c. Comprehensive care management and care coordination, including, but not limited to:

        (1) Triage based on acuity.

        (2) Assessment of service needs.

        (3) Identification of gaps in treatment.

        (4) Development of an integrated person-centered plan.

        (5) Implementation of the person-centered plan.

        (6) Assignment of health team roles and responsibilities.

        (7) Arranging for and ensuring access to primary care and other needed healthcare services.

(8) Appointment scheduling.

(9) Monitoring of critical chronic disease indicators.

d. Comprehensive transitional care, including:

(1) Ensuring that healthcare and treatment information is appropriately shared with all providers involved in the care of the person served, including:

(a) Treatment history.

(b) Current medications.

(c) Identified treatment needs/ gaps.

(d) Support needed for successful transition between treatment settings.

(2) Providing follow up and medication reconciliation upon discharge from hospitalization.

e. Individual and family support services, including:

(1) Education regarding concerns applicable to the person served.

(2) Education or training in self-management of chronic diseases.

(3) When possible and allowed, interaction with family members and/or significant others to:

(a) Identify any potential impact(s) of disease(s) of the person served on the family unit.

(b) Offer education or training in response to identified concerns.

f. Referral to needed community and social supports.

3.N. **8.** Care coordination includes sharing information:

a. As follows:

(1) Treatment history.

(2) Assessed needs.

(3) Current medications.

(4) Identified goals.

(5) Identified treatment gaps, when applicable.

b. With the following providers involved in the care of the person served, as applicable:

(1) Primary care.

(2) Behavioral health.

(3) Hospital.

(4) Medical specialty.

(5) Others, when applicable.

c. During transitions between:

(1) Inpatient and outpatient care.

(2) Levels of care.

(3) Outpatient care providers.

d. In accordance with applicable laws and authorizations.

Examples

8.b.(5) May include providers of dental care, physical rehabilitation, housing, employment, long-term care, etc.

3.N. **9.** The health home enhances access through the following:

a. Flexible scheduling.

b. Capacity for same or next day visits, excluding weekends or holidays.

c. Staff response to phone calls on the day of receipt.

d. After hours access through coverage that:

(1) Shares necessary data on the person served.

(2) Provides a contact summary to the health home.

(3) Includes a warmline and/or recovery supports.

3.N. **10.** Adequacy of staffing includes:

    a. **Access to a variety of disciplines to respond to the needs of persons served.**

    b. **Coverage that allows for a warm handoff.**

    c. **Identified backup for planned absences.**

Intent Statements

10.b. Warm handoff refers to direct contact between the person served and the receiving provider, either verbally or in person. This is particularly important when there is a concern that the person served may not make a successful self transition.

3.N. **11.** **The program assesses and responds to the needs of the majority of the targeted population served by providing services:**

    a. **In locations that meet their needs.**

    b. **At times to meet their needs.**

3.N. **12.** **The program offers education that:**

    a. **Is understandable to the person served.**

    b. **Includes family members or significant others, as permitted or legally allowed.**

    c. **Includes:**

        (1) **Health promotion, including:**

            (a) **Healthy diet.**

            (b) **Exercise.**

        (2) **Wellness.**

        (3) **Resilience and recovery.**

        (4) **The interaction between mental and physical health.**

        (5) **Prevention/intervention activities, based on the needs of the person served, including:**

            (a) **Smoking cessation.**

            (b) **Substance abuse.**

            (c) **Increased physical activity.**

            (d) **Obesity education.**

            (e) **Chronic disease education as it may relate to:**

                (i) **Heart disease.**

                (ii) **Diabetes.**

                (iii) **Other chronic medical conditions highly prevalent among the population served by the health home.**

        (6) **Self-management of identified:**

            (a) **Medical conditions.**

            (b) **Behavioral health concerns.**

            (c) **Other life issues as identified by the person served.**

        (7) **Medication use.**

Intent Statements

This education includes teaching the person served coordinated information about how to manage his or her condition; how it impacts his or her mental/physical health; and how he or she might best pursue recovery and wellness, including diet, nutrition, and exercise.

Examples

12.c.(1) Health promotion may include metabolic screening.

12.c.(6)(b) When applicable, includes education related to ongoing mental health, substance use or abuse, and/or relapse prevention for psychiatric needs and addictions.

12.c.(7) As part of recovery, education on medication use could include whether the medication has addictive qualities, has mood-altering effects, or interferes with sexual function.

3.N. **13.** **Policies regarding initial consent for treatment identify:**

    a. **How information will be internally shared.**

    b. **How information is shared by collaborating agencies.**

    c. **The ability of the person served to decline health home services.**

    d. **The procedures to be followed if health home services are declined.**

Intent Statements

Consent for treatment includes information on the agency's standard sharing of information for purposes of care coordination with other health care providers. Consent for treatment also allows the person served to decline any or all services offered by the program.

3.N. **14.** **Written screening procedures clearly identify when additional information will be sought in response to the presenting condition of the person served:**

    a. **Including necessary:**

        (1) **Tests.**

        (2) **External assessments.**

    b. **To ensure the identification of underlying health problems or medical conditions.**

    c. **To provide appropriate response to emergency or crisis needs.**

Intent Statements

There needs to be a strongly written protocol on handling the medical issues of persons with mental illness to prevent the possibility of inaccurately identifying a medical issue as a psychiatric issue. The intent of this standard is to identify the additional information or tests that may be called for when certain conditions are present, when external assessments should be considered, and the program's response to emergency or crisis needs identified during a screening process.

Examples

Behavioral health settings could use standard health assessment instrument(s). Primary care services could adopt population-based screening tools (such as PHQ-9, AUDIT-C for SBIRT or other alcohol and other drug screening tools, 5 A's Model for Tobacco Use & Dependence, GAIN-SS for adolescents, CES Depression Scale for Children, or others) rather than relying on other methods to identify those needing behavioral health services. Programs are encouraged to check the following website for additional information: **www.samhsa.gov/healthReform/ healthHomes**.

Where screening tools are in place, a protocol for actions to take is based on scored levels of severity. Screening tools could also be used to remeasure during the course of treatment to determine if the treatment is effective or should be adjusted or augmented ("stepped care").

3.N. **15.** **Health assessment screening:**

    a. **Includes at a minimum:**

        (1) **Suicide risk.**

        (2) **Depression.**

        (3) **Metabolic syndrome screen.**

        (4) **Substance use.**

        (5) **Tobacco use.**

        (6) **Chronic health conditions highly prevalent among the population served by the program.**

        (7) **Chronic disease status, including at least the following:**

            (a) **Diabetes.**

            (b) **Hypertension.**

            (c) **Cardiovascular disease.**

            (d) **Asthma/COPD.**

        (8) **Chronic pain.**

        (9) **Perception of needs from the perspective of the person served.**

    b. **Is conducted or reviewed by a nurse, nurse practitioner, or other equivalent medical personnel.**

    c. **Is completed for all persons enrolled in the health home:**

        (1) **For new enrollees subsequent to contacting the person served and introducing them to health home services.**

        (2) **At the time of the annual assessment.**

Intent Statements

The purpose of the health assessment screening is to guide treatment goals addressing physical health conditions of the persons served in order to promote recovery for the whole person.

Examples

Questions asked during a health assessment screening usually include the following:

■ Health history:

– Does the person have a primary care doctor or other doctor they see for care? If so, have they seen their medical doctor in the past year?

– Has the person had a physical exam in the past year?

– Has the person been hospitalized or gone to the emergency room for psychiatric or medical problems in the past year?

– Is the person experiencing any pain? If so, what is the pain rating scale?

– Request the person's health history of the skin, eyes, ears and throat, respiratory system, circulatory system, endocrine system, GI, elimination, GU, neurological, musculoskeletal, adult sexual development, and surgeries.

– Has the person had a family member with high blood pressure, hepatitis, high cholesterol, heart attack/heart disease, or diabetes?

– Does the person have allergies to medication, foods, or the environment?

– Has the person ever been immunized or vaccinated?

– Does the person have a dentist? Do they have any teeth, gum, or mouth problems?

■ Risk factors:

– Does the person currently smoke or chew tobacco? If so, has the person attempted to stop using in the past?

– To what extent does the person exercise, and are they happy with the amount of exercise they are doing?

– Is the person on a special diet? Have they had unexplained weight gain or loss in the past year?

15.a.(4) May include alcohol or other drugs, including prescription drugs, and drugs used for chronic pain management.

3.N. **16.** **The person-centered plan is an individualized, integrated plan that:**

a. **Includes:**

(1) **Medical needs.**

(2) **Behavioral health needs.**

b. **Is developed with collaboration of:**

(1) **The person served.**

(2) **Other stakeholders, when permitted or legally authorized.**

c. **Is developed with or reviewed by all staff necessary to carry out the plan.**

Intent Statements

The individualized plan is developed with the active involvement of the person served as well as the various disciplines needed to successfully implement the plan. The plan addresses and integrates, in a holistic manner, the medical and behavioral health needs of the person served.

Examples

16.b. Collaboration may include face-to-face contact or communication via telephone or other electronic participation.

16.b.(2) May include family members, significant others, or natural supports with permission of the person served, or other legal representatives of the person served.

3.N. **17.** **Written procedures define a follow-through process in response to the initial assessment that includes:**

a. **Reassessment when appropriate.**

b. **Documented active linkage and/or referral in response to identified concerns.**

c. **Identification of staff member(s) responsible for care coordination.**

d. **Identification of care coordination responsibilities that include contacts for:**

(1) **Self-management planning.**

(2) **Determining availability of needed supports.**

(3) **Medication adherence.**

(4) **Treatment adherence.**

Examples

17.a. May be necessary to assess continuing appropriateness of care level or changes necessary based on changing needs of the person served.

17.d.(2) May include natural supports such as family, community supports such as cultural or spiritual, peer support groups, or paid program supports.

3.N. 18. Written procedures guide ongoing:

    a. Communication among inter-disciplinary team members.

    b. Collaboration with external service providers.

    c. Communication with the person served and family members, when identified and allowed.

    d. Response to limitations on communication when identified by the person served.

    e. Need for documentation of the results of communication and collaboration.

    f. Coordination of individual health-care for the person served.

Intent Statements

Written procedures may define the form and content of communication among interdisciplinary team members on a "need to know" basis, while complying with information and confidentiality requirements of state, federal, or provincial authorities.

Examples

18.e. Documentation of the results of communication and collaboration may occur through case conference notes, progress notes in the records of persons served, team meeting minutes, referral documents, or written correspondence.

3.N. 19. The program uses patient registries and/or electronic health records:

    a. For data:

        (1) Collection.

        (2) Analysis.

    b. To proactively manage the health home population through tracking of the following about the person served:

        (1) Contacts.

        (2) Education.

        (3) Disease status.

        (4) Risk status.

    c. To support a process of:

        (1) Identifying potentially dangerous medication practices.

        (2) Remediating practices identified.

Intent Statements

While health homes are strongly encouraged to develop and use electronic health records to manage their health home program, use of a patient registry would meet the intent of this standard. In its simplest form, a patient registry is a collection of data on persons served who share certain characteristics such as disease status or medication regimen.

3.N. 20. Performance measurement indicators address how service delivery responds to the needs of the persons served in an integrated/holistic manner, and include:

    a. Process measures.

    b. Outcome measures for the persons served that consider:

        (1) Medical status.

        (2) Behavioral status.

    c. Real life functional outcomes for the person served.

    d. Perception of care from the perspective of the person served.

Intent Statements

See related Standards in Section 1.M. for details of measures and areas regarding performance improvement indicators. The intent of this standard is to ensure that the areas of access, effectiveness, efficiency, and satisfaction include indicators specifically related to the provision of integrated care coordination and disease management.

Examples

The performance measurement system can include indicators specific to the following:

- Medical care.
- Behavioral healthcare.
- Medical linkages.
- Evidence of collaborative attention.
- The rate of screening for co-morbid conditions.
- Integrated/holistic practices.
- Wellness and recovery.
- Psycho-education.
- Education regarding interrelationships between medications for physical and psychiatric conditions.
- The relationship between physical medications and addictive disorders.

20.b. Organizations may wish to consider the quality measures endorsed by the National Quality Forum (**www.qualityforum.org**).

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written program description
- Written procedures regarding access to primary care or other medical services, sharing of information, and coordination of care
- Written person-centered plan
- Policies regarding initial consent for treatment
- Written screening procedures
- Written procedures that define the follow-through process in response to the initial assessment
- Documented active linkage and/or referral in response to identified concerns
- Written procedures for communication and collaboration between interdisciplinary team members, external service providers, the person served and family members, when identified, and coordination of individual healthcare
- Documentation of the results of communication and collaboration between team members, external service providers, and the person served and family members, when identified
- Patient registries and/or electronic health records, including records of the persons served
- Performance measurement indicators including process measures and outcome measures for medical and behavioral status

O. Inpatient Treatment (IT)

Description

Inpatient treatment programs provide coordinated and integrated services in freestanding or hospital settings. Inpatient treatment programs include a comprehensive, biopsychosocial approach to service delivery. There are daily therapeutic activities in which the persons served participate. Inpatient treatment is provided 24 hours a day, 7 days a week. The goal of inpatient treatment is to provide a protective environment that includes medical stabilization, support, treatment for psychiatric and/or addictive disorders, and supervision. Such programs operate in designated space that allows for an appropriate medical treatment environment.

Applicable Standards

An organization seeking accreditation for an inpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.O. **1.** A medical evaluation is obtained prior to or within 24 hours of admission and includes:

   a. A physical examination.

   b. Orders for appropriate tests.

   c. Face-to-face consultation with a physician.

Intent Statements

1.c. When an admission occurs on a weekend or holiday, face-to-face consultation may not occur until the first working day unless medically required.

When allowed by law or funding authorities, a physician's assistant or nurse practitioner may be used.

3.O. **2.** Licensed nursing personnel are on site 24 hours a day, 7 days a week.

Intent Statements

Licensed nursing personnel can be registered nurses or licensed practical nurses. *On-site* can be interpreted to mean in the facility or building, not necessarily directly on the unit at all times.

3.O. **3.** Based on the needs of the persons served, services are provided by a coordinated team that includes, at a minimum, the following professionals:

   a. Assigned inpatient staff members or a plan coordinator.

   b. A qualified behavioral health practitioner.

   c. Providers of appropriate medical support services.

3.O. **4.** There is a written daily schedule of activities that contributes to the recovery of the persons served.

Intent Statements

A therapeutic environment promotes the ability of each person served to meet the goals and objectives jointly agreed upon in the development of his or her plan. It is free of unnecessary interruptions and distractions.

3.O. **5.** The program provides space for:

   a. Privacy for:

      (1) Sleeping.

      (2) Personal hygiene.

   b. Meals.

   c. Group interactions.

   d. Recreation.

   e. Therapeutic activities.

   f. Security of personal belongings.

   g. Access to an outdoor setting, if possible.

Intent Statements

The intent of this standard is to ensure that the inpatient treatment program is operated in designated space that allows for an appropriate medical treatment environment.

3.O. **6. Provisions are made to address the need for:**

    a. Cultural and/or spiritual activities.

    b. Quiet areas.

    c. Areas for family or other visits.

3.O. **7. Policies for inpatient treatment include:**

    a. Visitation.

    b. Program-driven administrative discharge.

    c. Transportation for:

        (1) Medical emergencies.

        (2) Psychiatric emergency services.

    d. Provision of a list of key contacts to the persons served that includes, as applicable:

        (1) A patient advocate.

        (2) Other advocacy contacts.

        (3) Support group contacts.

        (4) Legal aid.

        (5) Insurance/financial benefits.

    e. Restrictions pertaining to:

        (1) Receiving mail.

        (2) Sending mail.

        (3) Access to the telephone.

        (4) Access to electronic forms of communication.

        (5) Language.

Intent Statements

7.b. The program-driven administrative discharge policies may include:

- Therapeutic discharges.
- Discharges against medical advice.
- Noncompliance.
- Any unusual discharge.
- Access to electronic forms of communication

3.O. **8. Any restrictions placed on external communication by the persons served are in accordance with federal, state, and provincial legal requirements.**

3.O. **9. The program ensures that the person served has an established appointment and/or sufficient medication upon discharge.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Medical evaluations of persons served
- Daily activities schedules
- Policies for inpatient treatment

P. Integrated Behavioral Health/Primary Care (IBHPC)

Integrated Behavioral Health/Primary Care programs have an identified level of medical supervision and are supported by an "any door is a good door" philosophy. These programs allow for choice and are capable of assessing the various medical and behavioral needs of persons served in an integrated manner. Programs demonstrate competency to identify and treat behavioral health concerns, such as mental illness and substance use disorders, and general medical or physical concerns in an integrated manner. Integration is the extent to which care is coordinated across persons, functions, activities, and sites over time to maximize the value of services delivered to persons served. Programs may also serve persons who have intellectual or other developmental disabilities and medical needs, or those who are at risk for or exhibiting behavioral disorders.

Models may include, but are not limited to, the following: contractual, where two separate, legal entities enter into an agreement to staff and operate a single program either at a location specifically identified for the provision of integrated care or located within another institution (such as a school-based health center); a distinct, integrated program located within a larger entity such as a Veterans Health Administration campus; the colocating of complementary disciplines such as the placement of behavioral staff in a primary care setting (as in a federally qualified health center) or primary care staff in a community mental health center; or a single organization that incorporates both behavioral health and primary care services into an integrated model. Although most integrated models focus on primary care, the standards could also be applied to an integrated system located in specialty care settings such as Ob-Gyn and HIV.

Applicable Standards

An organization seeking accreditation for an integrated behavioral health/primary care program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection, and the Comprehensive Care field category must be used.

3.P. **1.** **The written program description clearly defines the following:**
  a. **Population served.**
  b. **Integrated services that can be provided:**
    (1) **Internally.**
    (2) **Through contracts or other agreements.**
  c. **Referral procedures for other services needed by persons served.**

3.P. **2.** **Integration of identified disciplines is supported by:**
  a. **Colocation and physical space arrangements.**
  b. **Implemented written procedures for:**
    (1) **Colocation.**
    (2) **Coordination.**
  c. **Applicable cross training.**

Examples

2.b. Procedures may identify the following:

■ When or under what circumstances face-to-face or other communication will occur with the person served.

■ How needs will be communicated and services coordinated.

■ How responsibility for care coordination or follow-up will be determined.

3.P. **3. When colocation is not possible, the program is organized and delivered in a manner that ensures an integrated team approach that includes all the complementary disciplines.**

Intent Statements

The organization of the program ensures a behavioral health presence in the primary care facility or a primary care presence when integrated services are provided in a behavioral health facility.

3.P. **4. The program:**

a. **Identifies hours when medical services are available.**

b. **Ensures that one or more of the following medical staff, legally able to independently provide the services offered, is on site during hours in which medical services are offered:**

(1) **Physician.**

(2) **Physician's assistant.**

(3) **Nurse practitioner.**

Intent Statements

The intent of this standard is to provide for the availability of identified licensed medical staff during program hours whose scope of practice as defined under state law allows for the provision of services identified as being available.

3.P. **5. A psychiatrist or psychologist is available for consultation during hours of operation.**

Intent Statements

This availability could be met via telephone or electronic means of communication.

3.P. **6. Behavioral health providers are available on site during identified hours of integrated service operation.**

Intent Statements

Ideally, these individuals are on site during all hours of operation. However, in rural or small sites, it is possible that immediate availability

is only by phone. When services are provided in a large, campus-type setting, behavioral health providers may not be in the specific location of the integrated services, but on call by phone or pager to come immediately to the primary care team area.

Examples

For organizations receiving federal reimbursement, particular attention should be paid to reimbursement requirements. Behavioral health providers may include individuals trained in mental health or addictions, providing services within the scope of state practice acts. Mental health practitioners often include psychiatrists, psychologists, licensed clinical social workers, or other licensed practitioners.

3.P. **7. Adequacy of staffing includes:**

a. **A variety of disciplines to respond to the needs of persons served.**

b. **Staff specifically trained and knowledgeable about the unique aspects of an integrated setting.**

c. **On-site coverage to allow for face-to-face linkage to appropriately trained staff.**

d. **Identified backup for planned absences.**

Intent Statements

Face-to-face linkage is often referred to as a "warm handoff" that includes direct contact between the person served and the receiving discipline.

Examples

Professionals generally included have the skill set to deal with problems such as addictions, behavioral/cognitive interventions, stress reduction, relaxation training, and similar issues. This helps ensure that there is not an over-reliance on psychopharmacology.

3.P. **8. The program assesses and responds to the needs of the majority of its targeted service population by providing services:**

a. **In locations that meet its needs.**

b. **At times that meet its needs.**

3.P. 9. The program offers education that includes:
   a. **Wellness.**
   b. **Resilience and recovery.**
   c. **The interaction between mental and physical health.**
   d. **Self-management of identified:**
      (1) **Medical conditions.**
      (2) **Behavioral health concerns.**

Intent Statements

This education includes teaching the person served coordinated information about how to manage his or her condition; how it impacts his or her mental/physical health; and how he or she might best pursue recovery and wellness, including diet, nutrition, and exercise.

Examples

9.b. As part of recovery, education on medication use could include whether the medication has addictive qualities, has mood-altering effects, or interferes with sexual function.

9.d.(2) When applicable, includes education related to ongoing mental health, substance use or abuse, and/or relapse prevention for both psychiatric needs and addictions.

3.P. 10. Policies regarding initial consent for treatment identify:
   a. **How information will be internally shared.**
   b. **The ability of the person served to decline integrated services.**
   c. **The procedures to be followed if integrated services are declined.**

Intent Statements

Consent for treatment allows the person served to decline any or all services offered by the program.

3.P. 11. Written screening procedures identify additional requirements based on the:
   a. **Specific needs of the population served.**
   b. **Presenting conditions of persons served.**

Intent Statements

There needs to be a very strongly written protocol on handling the medical issues of persons with mental illness to counteract the overwhelming tendency to pathologize a medical issue as a psychiatric issue. The intent of this standard is to identify the additional information or tests that may be called for when certain conditions present, when external assessments should be considered, and the program's response to emergency or crisis needs identified during a screening process.

Examples

Primary care settings could adopt population-based screening tools (such as the PHQ 9) rather than rely on other methods to identify those needing behavioral health services.

Where screening tools are in place, a protocol for actions to take is based on scored levels of severity. Screening tools could also be used to remeasure during the course of treatment to determine if the treatment is effective or should be adjusted or augmented ("stepped care").

3.P. 12. Written procedures provide for an intake assessment to determine:
   a. **An initial level of care.**
   b. **The need for:**
      (1) **Integrated services.**
      (2) **Immediate referral to specific:**
         (a) **Internal services.**
         (b) **External providers.**

3.P. 13. An individualized integrated plan regarding medical and behavioral health needs is developed with collaboration of:
   a. **The person served.**
   b. **All staff necessary to carry out the plan.**

Intent Statements

The individualized plan is developed with the active involvement of the person served as well as the various disciplines needed to successfully implement the plan. The plan addresses and integrates, in a holistic manner, the medical and behavioral health needs of the person served.

Examples

Collaboration may include face-to-face contact or communication via telephone or other electronic participation.

13.a. May include family members, with permission, or other legal representatives of the person served.

3.P. **14.** **Written procedures define a follow-through process in response to the initial assessment that includes:**

   a. **Reassessment when appropriate.**

   b. **Documented active linkage and/or referral in response to identified concerns.**

   c. **Identification of staff member(s) responsible for care coordination.**

   d. **Identification of care coordination responsibilities that include contacts for:**

   (1) **Self management planning.**

   (2) **Determining availability of needed supports.**

   (3) **Medication adherence.**

   (4) **Treatment adherence.**

Examples

14.a. May be necessary to assess continuing appropriateness of care level or changes necessary based on changing needs of the person served.

14.d.(2) May include natural supports such as family, community supports such as cultural or spiritual, peer support groups, or paid program supports.

3.P. **15.** **Written procedures guide ongoing:**

   a. **Communication among inter-disciplinary team members.**

   b. **Collaboration with external service providers.**

   c. **Communication with the person served and family members, when identified.**

   d. **Need for documentation of the results of communication and collaboration.**

Intent Statements

Written procedures may define the form and content of communication among interdisciplinary team members on a "need to know" basis, while complying with information and confidentiality requirements of state, federal, or provincial authorities.

Examples

Documentation of the results of communication and collaboration may occur through case conference notes, progress notes in the records of persons served, team meeting minutes, referral documents or written correspondence.

3.P. **16.** **Performance measurement includes indicators addressing how services delivery responds to the needs of the persons served in an integrated/holistic manner.**

Intent Statements

See related Standards in Section 1.M. for details of measures and areas regarding performance improvement indicators. The intent of this standard is to ensure that the areas of access, effectiveness, efficiency, and satisfaction include indicators specifically related to the provision of integrated care.

Examples

The performance measurement system can include indicators specific to the following:

- Medical care
- Behavioral healthcare
- Medical linkages
- Evidence of collaborative attention
- The rate of screening for comorbid conditions
- Integrated/holistic practices
- Wellness and recovery
- Psychoeducation
- Education regarding interrelationships between medications for physical and psychiatric conditions
- The relationship between physical medications and addictive disorders

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Program plans for the persons served
- Policies and written procedures

Q. Intensive Family-Based Services (IFB)

Description

These intensive services are provided in a supportive and interactive manner and directed toward maintaining or restoring a positive family relationship. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multisystemic approach to treatment and have a goal of keeping families together. The services may include wrap-around and family preservation programs. The program may also provide services directed towards family restoration when a child has been in an out-of-home placement.

Applicable Standards

An organization seeking accreditation for an intensive family-based services program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.Q. **1. A full range of services are designed to prevent out-of-home placement and maintain intact families and include:**

    a. Individual psychotherapy services.

    b. Substance abuse services.

    c. Skill development services, which include the development of:

        (1) Behavior management skills.

        (2) Life skills.

        (3) Conflict resolution skills.

        (4) Problem-solving skills.

        (5) Anger management skills.

        (6) Decision-making skills.

        (7) Crisis management skills.

    d. Family therapy.

    e. School-based services.

    f. Crisis management/stabilization services.

    g. Positive youth development services.

    h. Nutritional and health services.

    i. Service coordination.

j. Medication management/ monitoring services.

Intent Statements

The program provides services designed to meet any area of a family's functioning.

3.Q. **2.** **The program provides a written assessment of how each family functions.**

3.Q. **3.** **Planning is child and family centered.**

3.Q. **4.** **The organization implements a process for identifying, locating, and engaging family members, as appropriate, in services.**

3.Q. **5.** **The organization works with each child/adolescent and family to:**
   a. **Identify the goals of the child/ adolescent and family throughout the treatment process.**
   b. **Monitor the progress of the child/ adolescent toward achievement of the goals.**
   c. **Monitor the progress of the family toward achievement of the goals.**

3.Q. **6.** **The organization has a policy that demonstrates a commitment to having an identified person/team working consistently with the family.**

3.Q. **7.** **The organization provides access to professionals trained in child/adolescent and family care, including:**
   a. **A psychologist.**
   b. **A counselor.**
   c. **A social worker.**
   d. **A psychiatrist.**

e. Medical personnel.

f. Other behavioral health providers as appropriate.

Examples

7.e. May include a nurse, physical therapist, physiotherapist, or speech therapist, based on the need of the child/adolescent served.

7.f. May include a substance abuse counselor.

3.Q. **8.** **A file of current community resources is maintained to be used for appropriate referral of the persons served.**

3.Q. **9.** **The program collaborates appropriately with other programs in planning service delivery.**

3.Q. **10.** **The organization uses a contingency plan for crises that includes:**
   a. **Emergency contact or crisis backup.**
   b. **Respite or supportive parenting.**
   c. **Family crisis plans.**

3.Q. **11.** **The organization provides access to a system for respite care, including 24-hour emergency care services.**

3.Q. **12.** **Services are supervised by a qualified behavioral health practitioner who:**
   a. **Provides clinical oversight.**
   b. **Directs the treatment plan.**

Intent Statements

See the Glossary for the definition of a *qualified behavioral health practitioner*.

❧ **Note:** *Programs in Canada must meet the requirements of their respective provincial government.*

3.Q. **13.** **The organization has a plan for access to qualified professionals 24 hours a day, 7 days a week.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written assessment of family functioning in the home environment
- Policy addressing the importance of maintaining the same individual/team when working with families
- A community resource file
- Contingency plans
- Plan describing clinical supervision
- Plan for access to qualified professionals

R. Intensive Outpatient Treatment (IOP)

Description

Intensive outpatient treatment programs are clearly identified as a separate and distinct program. The intensive outpatient program consists of a scheduled series of sessions appropriate to the person-centered plans of the persons served. These may include services provided during evenings and on weekends or interventions delivered by a variety of service providers in the community. The program can function as a step-down program from partial hospitalization, detoxification, or residential services; may be used to prevent or minimize the need for a more intensive and restrictive level of treatment; and is considered to be more intensive and integrated than traditional outpatient services.

Applicable Standards

An organization seeking accreditation for an intensive outpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.R. **1. In intensive outpatient treatment, at least one of the following occurs, depending on the age of the person served:**

    a. An adult and/or family members are provided with at least nine direct contact hours per week.

    b. A child or adolescent and/or family members are provided with at least six direct contact hours per week.

3.R. **2. Intensive outpatient treatment programs provide two or more of the following services:**

    a. Individual counseling/therapy.

    b. Family counseling/therapy.

    c. Group counseling/therapy.

Intent Statements

Based on the needs of the person served, the outpatient program offers a variety of service modalities that are designed to assist the person served to achieve his or her goals related to areas (such as psychological or social functioning, self-esteem, coping abilities) or external opportunities (such as vocational, educational, or social).

3.R. 3. The intensive outpatient treatment program offers education on wellness and recovery.

Examples

Education on wellness and recovery may include relevant education about the person's disability/disorder or concern, family interactions, community integration, relationships, or importance of living skills.

3.R. 4. The program provides services in locations that meet the needs of the persons served.

Examples

Services are generally provided in traditional offices, but may also be provided in other places in the community.

3.R. 5. When appropriate, and with the consent of the person served, the program coordinates treatment with other services.

Intent Statements

Often a person receiving outpatient treatment is also involved with other services. The intent of this standard is to ensure that the outpatient treatment provided by the organization is coordinated with other services.

Examples

Individuals may be involved with or receiving services in the form of:

- Family counseling.
- Couples counseling.
- Primary healthcare.
- Pastoral counseling.
- Peer support groups.
- Vocational services.

- Medication management.
- Social services.
- Criminal justice agencies.

3.R. 6. The intensive outpatient treatment program is offered at times that maximize the ability of the person served to participate in the program.

3.R. 7. Clinical appropriateness for program admission to an intensive outpatient program is determined by a qualified behavioral health practitioner.

3.R. 8. A review of the individualized plan for persons served in an intensive outpatient program occurs at least once per month.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Individual program plans of persons served
- Documentation of monthly reviews of individual program plans
- Records of persons served

S. Out-of-Home Treatment (OH)

Description

These programs provide treatment services outside of their natural homes to children/adolescents for whom there are documented reports of maltreatment or identified behavioral health needs. Treatment is provided in a safe and supportive setting and may be time limited. The program goal is to reunite the children with their natural families or to provide what is identified as being in the best interest of each child. The program may include foster care, treatment foster care, specialized foster care, therapeutic foster care, therapeutic family services, preadoption placements, care in parent/counselor homes, or group home care.

Applicable Standards

An organization seeking accreditation for an out-of-home treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.S. **1. Planning is child and family centered.**

3.S. **2. When applicable, the organization is responsible for or collaborates in the development of a reunification plan for each child that includes:**
   a. **The involvement of:**
      (1) **The child.**
      (2) **The guardian ad litem when appropriate.**
      (3) **The family.**
      (4) **Significant others.**
      (5) **Other natural supports.**
   b. **A timetable.**
   c. **Identification of the treatment team.**
   d. **Justification for exclusion of the natural family when applicable.**
   e. **Encouraging the family to cooperate with the development of the plan.**

Intent Statements

The reunification plan delineates what needs to occur in order for a child to be placed back with his or her family.

3.S. **3. The organization uses a process for identifying, locating, and engaging family members, as appropriate, in services.**

3.S. **4. The organization documents the status of parental rights.**

3.S. **5. Providers receive training to meet the identified needs of the population served that covers:**
   a. **Attachment theory, including grief and loss.**
   b. **Child growth and development.**
   c. **Behavior management skills.**
   d. **Learning deficits.**
   e. **Cultural competency.**
   f. **The effects of placement on children.**
   g. **Applicable legal issues.**
   h. **Other specific needs.**

Examples

5.h. Additional needs could include issues specific to the person, served such as medical or physical needs or the use of assistive technology.

3.S. **6. The organization documents provider training, including the type, length, and date of training.**

3.S. **7. The organization provides access to professionals trained in child/adolescent and family care, based on the needs of each child/adolescent, including:**
   a. **A psychologist.**
   b. **A counselor.**

c. A social worker.

d. A psychiatrist.

e. Medical personnel.

f. Other behavioral health providers as appropriate.

Examples

7.e. May include a nurse, physical therapist, physiotherapist, or speech therapist, based on the need of the child/adolescent served.

3.S. **8.** The organization provides a broad array of services that form an integrated continuum of care through either referral or direct provision.

3.S. **9.** When the organization provides case management for a child/adolescent served, it assigns one person/team to work consistently with the child/adolescent and the family.

3.S. **10.** A referral network is established for the following:

a. Emergency care.

b. Respite care.

c. Medical care.

d. Other services to meet the needs of the child/adolescent and family.

3.S. **11.** A file of current community resources is maintained and used for appropriate referral and placement of each child/adolescent served.

3.S. **12.** The program provides opportunities for the child/adolescent to access activities as appropriate, including:

a. Community activities.

b. Cultural activities.

c. Recreational activities.

d. Spiritual activities.

3.S. **13.** The program collaborates with other programs in planning service delivery, when appropriate.

Examples

Although this may include local service providers, there may also be situations where legal requirements create the need for collaboration or notification, such as the Indian Child Welfare Act requirements related to foster placement of indigenous children.

3.S. **14.** If the organization selects out-of-home care providers, it demonstrates the following:

a. A comprehensive plan for the selection of out-of-home care providers.

b. A method of placing the child/adolescent served:

(1) At levels of care based on his or her needs.

(2) In an environment that reflects his or her current familiar environment.

(3) In a safe environment that includes security of:

(a) Weapons.

(b) Ammunition.

(c) Pharmaceuticals.

(d) Other items that could prove harmful to the child/adolescent.

c. A written agreement that clearly defines the expectations of:

(1) The organization.

(2) The out-of-home care provider.

d. A broad selection of families to ensure that the needs of each child/adolescent will be met.

Examples

14.b.(3)(d) Other items could include:

■ Sharp items or hazardous materials harmful to a small child or adolescent with cognitive limitations.

■ Items which may be used by a child/
adolescent to harm self or others, such
as knives, razors, or flammables.

3.S. **15.** The organization assists birth/adoptive
families to receive services that promote
reunification, when appropriate.

3.S. **16.** The organization advocates for the
placement of children/adolescents
with their siblings, as appropriate.

3.S. **17.** When placement of children/adolescents
with their siblings is not possible, the
organization advocates that the chil-
dren/adolescents regularly visit with
their siblings, if appropriate.

3.S. **18.** The organization uses a plan to regularly
monitor each foster home placement.

3.S. **19.** If the organization is responsible for
reunification, it provides or arranges
for supervised visits based on identified
permanency goals.

3.S. **20.** When applicable, if reunification is not
feasible, the child/adolescent is referred
for adoption:
    a. In a manner that conforms to all
    applicable laws and regulations.
    b. With ongoing supports provided
    until the adoption or other placement
    is finalized.

3.S. **21.** The program ensures the provision of:
    a. Opportunities to participate in activi-
    ties that would typically be found in a
    home.

    b. Adequate personal space for privacy.
    c. Safeguarding of property.
    d. Evidence of individual possessions
    and decorations.
    e. Daily access to adequate and
    nutritious meals and snacks.
    f. Recognition of special diets.
    g. Involvement in preplacement
    activities whenever possible.
    h. The designation of areas for visits.

3.S. **22.** In a group home setting:
    a. The on-site staffing is adequate,
    based on the needs of the persons
    served.
    b. There are separate sleeping areas
    based on:
        (1) Age.
        (2) Gender.
        (3) Developmental need.

3.S. **23.** The organization has on-call availability
of supervisory staff members to respond
to urgent situations 24 hours a day,
7 days a week.

3.S. **24.** The services of each child/adolescent
served are supervised by a qualified
behavioral health practitioner who
provides clinical oversight and directs
the treatment plan.

Intent Statements

See the Glossary for the definition of a *qualified
behavioral health practitioner*.

3.S. **25.** The organization has a plan for access to
qualified behavioral health practitioners
24 hours a day, 7 days a week.

❧ **NOTE:** *Programs in Canada must meet the require-
ments of their respective provincial government.*

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Development of a reunification plan
- Documentation of parental rights
- Documentation of training
- Community resource file
- Written plan for the selection of out-of-home providers
- Written agreement
- Monitoring plan
- Written plan describing clinical supervision
- Written plan for access to qualified professionals

T. Outpatient Treatment (OT)

Description

Outpatient treatment programs provide services that include, but are not limited to, individual, group, and family counseling and education on recovery and wellness. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, mental health issues, life span issues, psychiatric illnesses, and addictions.

Applicable Standards

An organization seeking accreditation for an outpatient treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.T. **1. Outpatient treatment programs provide one or more of the following services:**
   a. **Individual counseling/therapy.**
   b. **Family counseling/therapy.**
   c. **Group counseling/therapy.**

Intent Statements

Based on the needs of the person served, the outpatient program offers or refers to a variety of service modalities that are designed to assist the person served to achieve his or her goals related to areas (such as psychological or social functioning, self-esteem, coping abilities) or external opportunities (such as vocational, educational, or social).

3.T. **2. The outpatient treatment program offers or refers to a variety of services, based on the needs of the person served.**

3.T. **3. The outpatient treatment program offers education on wellness and recovery.**

Examples

Education on wellness and recovery may include relevant education about the person's disability/disorder or concern, family interactions, community integration, relationships, or importance of living skills. Education may be provided through the provision of literature, videos, links to online resources, or professional presentations.

3.T. **4. The program provides services in locations that meet the needs of the persons served.**

Examples

Locations may include traditional offices, residences, schools, correctional settings, shelters, community resource sites, hospitals, nursing homes, and medical and behavioral health sites.

3.T. **5. When appropriate, and with the consent of the person served, the program coordinates treatment with other services.**

Intent Statements

Often a person receiving outpatient treatment is also involved with other services. The intent of this standard is to ensure that the outpatient treatment provided by the organization is coordinated with other services.

Examples

Individuals may be involved with or receiving services in the form of:

- Family counseling.
- Couples counseling.
- Primary health care.
- Pastoral counseling.
- Peer support groups.
- Vocational services.
- Medication management.
- Social services.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Program plans for the persons served

U. Partial Hospitalization (PH)

Description

Partial hospitalization programs are time limited, medically supervised programs that offer comprehensive, therapeutically intensive, coordinated, and structured clinical services. Partial hospitalization programs are available at least five days per week but may also offer half-day, weekend, or evening hours. Partial hospitalization programs may be freestanding or part of a broader system but should be identifiable as a distinct and separately organized unit.

A partial hospitalization program consists of a series of structured, face-to-face therapeutic sessions organized at various levels of intensity and frequency. Partial hospitalization programs are typically designed for persons who are experiencing increased symptomatology, disturbances in behavior, or other conditions that negatively impact the mental or behavioral health of the person served. The program must be able to address the presenting problems in a setting that is not residential or inpatient. Given this, the persons served in partial hospitalization do not pose an immediate risk to themselves or others. Services are provided for the purpose of diagnostic evaluation; active treatment of a person's condition; or to prevent relapse, hospitalization, or incarceration. Such a program functions as an alternative to inpatient care, as transitional care following an inpatient stay in lieu of continued hospitalization, as a step-down service, or when the severity of symptoms is such that success in a less acute level of care is tenuous.

Applicable Standards

An organization seeking accreditation for a partial hospitalization program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.U. **1. The program is provided under the direction of a clinical director.**

Intent Statements

The clinical (or medical) director is a physician.

3.U. **2. The program:**
   a. **Is available to the persons served at least five days per week.**
   b. **Includes a minimum of three hours of therapeutic services per day.**

Intent Statements

Although the program is capable of providing a multidisciplinary program of medical and therapeutic services to the persons served three hours per day, five days per week, individualized plans and variable lengths of stay will determine the degree to which each person actually participates in a given week.

3.U. **3. The therapeutic environment includes:**
   a. **Consistently assigned personnel.**
   b. **Scheduled activities.**
   c. **Sufficient professional staff to:**
      (1) **Conduct clinical assessments.**
      (2) **Develop appropriate person-centered plans.**
      (3) **Provide therapeutic interventions.**
      (4) **Review goals/objectives on a biweekly basis.**

Intent Statements

The environment achieves a stable staffing pattern either by assigning the same personnel to the program or by rotating personnel from a consistent pool to provide the needed intensity of interventions on a consistent basis.

3.U. **4. The program's services are provided by a multidisciplinary team.**

Intent Statements

This standard reinforces a team approach to services. There is a team made up of persons from a variety of disciplines who work cooperatively in delivering partial hospitalization services. The various disciplines included are based on the needs of the person served.

3.U. **5.** **Qualified behavioral health practitioners are on site during program hours to:**
   a. **Supervise personnel.**
   b. **Direct services.**
   c. **Provide direct clinical treatment services, as appropriate.**
   d. **Provide interventions, as necessary.**

Intent Statements

See the Glossary for the definition of a *qualified behavioral health practitioner*.

5.b. Some services, such as education and training and therapeutic activities, may be provided by personnel who are not qualified behavioral health practitioners, but are qualified to deliver the services, specifically trained to work with the population being served, and supervised by qualified behavioral health practitioners.

5.c. Clinical treatment services are provided by qualified behavioral health practitioners within the scope of their licenses and clinical privileges.

3.U. **6.** **A registered nurse, trained and competent in the delivery of behavioral health services, is available on site during program hours to provide necessary:**
   a. **Nursing care.**
   b. **Psychiatric nursing care.**

Intent Statements

Nursing care may also include supervision of ancillary staff members (such as nursing aides or technicians) who provide supportive medically related services, as allowed by law or regulation.

In a partial hospitalization program where either the specific needs of the persons served or the program's regulatory authorities and funding sources do not require continuous on-site nursing coverage, this standard may be met through an on-call system or clearly identified process for accessing nursing care when needed.

3.U. **7.** **Psychiatric services are provided to the persons served as deemed clinically necessary.**

3.U. **8.** **When applicable, based on the needs of the persons served, a psychiatrist is available 24 hours a day, 7 days a week.**

Intent Statements

A psychiatrist can be available either on site or on call, but is available at all times when the program is providing services to persons with psychiatric disorders.

3.U. **9.** **An initial medical and/or psychological necessity determination, establishing the need for partial hospitalization, is received upon admission and certifies:**
   a. **Inpatient care would be necessary if partial hospitalization was not provided.**
   b. **Services will be provided under the care of a physician.**
   c. **Services are provided under a written plan of care.**

Intent Statements

In some situations, it is required that a physician certify that the person served would require inpatient care if the partial hospitalizations services were not provided.

9.b. Face-to-face assessment and services can be provided when necessary.

Examples

Medical and/or psychological necessity may include the following:

- Identified need for crisis stabilization or treatment of partially stabilized mental health disorders.

- Evidence of psychiatric symptoms that cause significant impairment in day-to-day social, vocational, and/or educational functioning.

- Indication of the person's physical and intellectual capacity to actively participate in all aspects of the therapeutic program.

- Inability to achieve sufficient clinical gains within an outpatient setting. Severity of presenting symptoms is such that success in outpatient treatment is doubtful.

■ Readiness for discharge from an inpatient setting, but needing daily monitoring, support, and ongoing therapeutic interventions.

3.U. 10. **Eligibility for admission is:**

    a. **Determined by qualified behavioral health practitioners as identified by law or regulations.**

    b. **Determined following:**

        (1) **A medical assessment.**

        (2) **A behavioral health assessment.**

3.U. 11. **An initial assessment of the person served:**

    a. **Includes:**

        (1) **A physical examination:**

            (a) **Completed within 24 hours of admission.**

            (b) **Completed by a qualified licensed health care practitioner.**

        (2) **A mental health evaluation.**

        (3) **A nursing assessment.**

        (4) **A skills assessment conducted by an activity, occupational, or rehabilitation therapist.**

    b. **Is conducted within 24 hours of admission.**

3.U. 12. **The person-centered plan is:**

    a. **Completed within seven days of admission.**

    b. **Reviewed:**

        (1) **When major changes occur in treatment.**

        (2) **At least every two weeks.**

        (3) **Periodically by a physician.**

3.U. 13. **Access to primary medical care is available as needed.**

3.U. 14. **The majority of scheduled program hours consist of therapeutic services.**

Intent Statements

Therapeutic services may vary according to the age, needs, or individual development or comprehension level of each person served.

3.U. 15. **Therapeutic services include at least three of the following:**

    a. **Individual psychotherapy.**

    b. **Family therapy or counseling.**

    c. **Alcohol and other drug education.**

    d. **Occupational therapy.**

    e. **Diagnostic services.**

    f. **Medication education.**

    g. **Psychoeducation.**

    h. **Activity therapy.**

    i. **Provision of community supports.**

3.U. 16. **Case management services are integrated in the partial hospitalization continuum of care or are provided by external case managers.**

3.U. 17. **If case managers are external to the partial hospitalization program, there are weekly meetings with the persons served, members of the partial hospitalization treatment team, and the case manager.**

3.U. 18. **Case management services assist with arrangements for:**

    a. **Financial support, if needed.**

    b. **Housing, if needed.**

    c. **Transportation to services, as needed.**

    d. **Maintenance of activities of daily living.**

3.U. **19. Crisis management services are available 24 hours a day, 7 days a week for the persons served.**

3.U. **20. Therapeutic activities include:**
   a. Family members, when appropriate.
   b. The community, when appropriate.

Examples

Such therapeutic activities could include activities designed to incorporate family and community involvement and assist the person served to move to a greater level of personal independence. The provision of therapeutic activities may be limited by specific funding sources to exclude those activities that are primarily recreational and diversionary or provide only a level of functional support that does not treat the serious presenting psychiatric symptoms that are currently placing the person served at risk.

3.U. **21. Referral to another level of service is made when:**
   a. Medically indicated.
   b. Clinically indicated.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ A program schedule

■ Treatment plans

■ Case records

V. Prevention (P)

Description

Prevention programs are proactive and evidence-based/evidence-informed, striving to reduce individual, family, and environmental risk factors, increase resiliency, enhance protective factors, and achieve individual and comprehensive community wellness through a team or collaborative approach. Prevention programs utilize strategies designed to keep individuals, families, groups, and communities healthy and free from the problems related to alcohol or other drug use, mental health disorders, physical illness, parent/child conflict, abuse or neglect, exposure to or experience of violence in the home and community; to inform the general public of problems associated with those issues, thereby raising awareness; or to intervene with at-risk individuals to reduce or eliminate identified concerns. Programs may be provided in the community, school, home, workplace, or other settings.

Organizations may provide one or more of the following types of prevention programs, categorized according to the population for which they are designed:

■ *Universal* programs target the general population and seek to increase overall well-being and reduce the overall prevalence of problem behaviors, and include comprehensive, well-coordinated components for individuals, families, schools, communities, and organizations. Universal prevention programs promote positive behavior and include social marketing and other public information efforts.

■ *Selected* programs target groups that are exposed to factors that place them at a greater than average risk for the problem. These programs are tailored to reduce identified risk factors and strengthen protective factors.

Examples of prevention programs include pregnancy prevention, drop-out prevention, Strengthening Families, substance abuse prevention, violence prevention, HIV

prevention, smoking prevention, child abuse prevention, and suicide prevention.

- *Training* programs provide curriculum-based instruction to active or future personnel in human services programs.

  Examples of training programs include caseworker training, child welfare supervisory training, foster parent training, leadership training, guardian/guardian ad-litem training, and childcare assistant training.

Applicable Standards

An organization seeking accreditation for a prevention program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

If the program is strictly a training program and no direct services to persons served are provided, Standard 6. is not applicable.

If an organization is seeking accreditation for a prevention program for children or adolescents, the standards in Section 4.B. do not apply.

3.V. **1. Services are designed by personnel with demonstrated skill and knowledge in current evidence-informed/evidence-based prevention theory and practice.**

Examples

The program can demonstrate conformance to this standard through staff member interviews and documentation of skills and training in personnel files.

3.V. **2. The program includes efforts to increase public awareness in one or more of the following areas:**
  a. **Mental health.**
  b. **Alcohol, tobacco, and other drug use.**
  c. **Child abuse and neglect.**
  d. **Suicide prevention.**
  e. **Violence prevention.**
  f. **Health and wellness.**

  g. **Social/community issues.**
  h. **Internet safety.**
  i. **Acceptance of cultural diversity.**
  j. **Effective parenting.**

Intent Statements

For training programs, efforts are targeted to prepare personnel to provide services in one or more of the areas identified.

Examples

Public awareness efforts may include:

- Sponsorship of or participation in community events.
- Participation in health fairs.
- Public service announcements.
- Community seminars and workshops.

Specific topic areas could include:

- **2.a.** Stress management education; teen help lines.
- **2.b.** Education regarding tobacco use, substance reduction, MADD/SADD groups, prescription drug abuse, and drug-free workplace programs.
- **2.e.** Domestic violence, including interpersonal, family, and intimate partner relationships; bullying, gangs, and 0school-based violence.
- **2.f.** Safe sex, sexually transmitted diseases, HIV/AIDS, communicable diseases, teen pregnancy.
- **2.g.** Spirituality-based programs; dating issues.

3.V. **3. Program activities are:**
  a. **Culturally relevant.**
  b. **Age appropriate.**
  c. **Gender appropriate.**
  d. **Targeted toward multiple settings within the community.**

Examples

3.d. The activities can be directed to:

- Individuals.
- Families.
- Organizations.

- Systems of care.
- The community and the region.

3.V. **4.** **Universal and selected programs include two or more, and training programs include a.–g., of the following strategies:**

  a. **Increasing knowledge and raising awareness.**

  b. **Building skills and competencies.**

  c. **Increasing awareness of healthy alternatives.**

  d. **Increasing awareness of available services.**

  e. **Improving early identification of:**
     (1) **Needs.**
     (2) **Referrals.**

  f. **Influencing behavioral change.**

  g. **Reducing incidence of problem behaviors.**

  h. **Changing institutional policies.**

  i. **Influencing how laws are:**
     (1) **Developed.**
     (2) **Interpreted.**
     (3) **Enforced.**

  j. **Building the capacity of collaborative partnerships.**

  k. **Building the capacity of the community to address its needs.**

Intent Statements

Prevention, consultation, education, and training services typically employ a variety of strategies.

Examples

4.i. Programs may work to influence development or enforcement of laws such as curfews or laws related to use of seat belts or bicycle helmets.

3.V. **5.** **The program has a plan or written logic model that details:**

  a. **The specific theoretical approaches to be used.**

  b. **The methodological approaches to be used.**

  c. **How the approaches will be applied within the community.**

Intent Statements

The program is able to document that the approach it uses has a sound theoretical foundation.

Examples

Specific theoretical or methodological prevention approaches could include the use of:

- Health and wellness models.
- Developmental models.
- Risk and resiliency models.
- Public health models.
- Social competency models.

3.V. **6.** **The program:**

  a. **Has procedures for referring persons served to other:**
     (1) **Health services, as needed.**
     (2) **Social services, as needed.**

  b. **Demonstrates that personnel are knowledgeable of current community resources.**

  c. **Conducts evaluation of its:**
     (1) **Programs/services.**
     (2) **Training activities.**

Intent Statements

6.a. If, as a result of education and awareness activities, individuals identify themselves or are identified by family members or significant others as needing treatment, program staff members know how to refer these individuals for appropriate services.

3.V. **7.** **Training programs document a written comprehensive curriculum for each course offered that guides the training and includes:**

  a. **The course philosophy.**

  b. **The course outline.**

  c. **Competency-based objectives.**

  d. **Instructional methods and materials.**

  e. **The sequence and hours of instruction.**

  f. **Clinical/practicum expectations, if applicable.**

g. A revision schedule and methodology.

Examples

7.g. The course is reviewed and revised on an annual basis through the use of course evaluation feedback, trainees' successful completion rate, and subject matter content changes.

3.V. **8. Training programs:**

a. **Utilize an expert advisory committee.**

b. **Satisfy regulatory requirements leading to certification, as applicable.**

c. **Focus on the care of the persons served.**

d. **Identify educational and other prerequisite requirements.**

e. **Utilize consistent evaluation.**

f. **Provide a coordinated, logical learning experience.**

Intent Statements

8.c. The focus and emphasis of the training is to provide instruction and tools to the trainees so they will provide quality care to the persons served.

Examples

8.a. A recognized expert/teacher in the field who is external to the program, an external administrator, and an external service provider meet biannually to review the curriculum and the program's policies and procedures in order to support utilization of the latest research and accepted practices.

8.f. The program provides the theoretical basis of the curriculum prior to teaching the application of that knowledge in a practical, hands-on manner. The trainee learns the stages of grieving and methods of counseling before applying these skills to a person served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written plan or logic model that details specific approaches to be used
- Documentation of evaluation of programs/services and training activities

W. Residential Treatment (RT)

Description

Residential treatment programs are organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, 7 days a week for persons with behavioral health disabilities or co-occurring disabilities, including intellectual or developmental disability. Residential treatment services are organized to provide environments in which the persons reside and receive services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems. Residential treatment may be provided in freestanding, nonhospital-based facilities or in clearly identified units of larger entities, such as a wing of a hospital. Residential treatment programs may include domestic violence treatment homes, nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Applicable Standards

An organization seeking accreditation for a residential treatment program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.W. **1. The program provides treatment at least four hours a day, seven days a week, which consists of three or more of the following:**
   a. **Therapeutic activities such as individual and group counseling.**
   b. **Educational activities.**
   c. **Training activities.**
   d. **Crisis intervention.**
   e. **Development of community living skills.**
   f. **Family support with the approval of the person served.**
   g. **Linkages to community resources.**

   h. **Advocacy.**
   i. **Education on wellness and recovery.**
   j. **Development of a social support network.**
   k. **Development of vocational skills.**
   l. **Education/training in selection and maintenance of housing that is safe, decent, affordable, and accessible.**
   m. **Development of recreational and leisure skills.**
   n. **Medical care and/or therapies.**

Intent Statements

Not all listed services must be provided. Some services may be provided off site.

Because developing the skills and functioning necessary to live independently is a key goal of community reintegration programs, such programs demonstrate their efforts to assist persons to live independently and to help them find appropriate housing.

Examples

1.c. Training may address:
- Community integration goals and activities
- Identification of target symptoms
- Behavior management and interview practices
- Factors impacting the persons served, such as:
  - Communication skills
  - Degree of support and supervision required
  - Guardianship issues
  - Special needs
  - Medications
  - General health considerations
  - Religious beliefs
  - Literacy
- Functional skills
- Housekeeping/maintenance skills
- Human sexuality
- Incident reporting
- Menu planning and meal preparation
- Cultural competency and relevance
- Sanitation and infection control

- Safety procedures
- Scheduling of:
  - Menu planning and meal preparation
  - Cleaning and maintenance of appliances
  - Daily routines
- Maintenance of adaptive equipment
- Special dietary requirements
- Recreation
- Wellness

1.h. Advocacy may address self-advocacy activities for the person served as well as the organization's advocacy efforts.

3.W. **2.** **Based on the needs of the persons served, services are provided by a coordinated treatment team that includes, at a minimum, the following professionals:**
   a. **Assigned residential staff members or a plan coordinator.**
   b. **A qualified behavioral health practitioner.**
   c. **Providers of appropriate medical support services.**

Intent Statements

Because residential treatment programs serve persons with varying needs, the specific qualifications and credentials of staff members are determined based on the specific needs of the persons served and the structure of the residential treatment program.

2.b. See the Glossary for the definition of *qualified behavioral health practitioner*.

2.c. May be provided by consulting or contracted professionals.

3.W. **3.** **The program provides staff support 24 hours a day, 7 days a week.**

Intent Statements

Staff members should be on the same campus and have the ability to respond to emergencies quickly. Some services or support may be provided by organizations outside of the program, such as in a correctional setting. If the program

serves children or adolescents, staff members are on site 24 hours a day, 7 days a week.

3.W. **4.** **The program provides the following community living components:**
   a. **A written daily schedule of activities.**
   b. **Regular meetings between the persons served and program personnel.**
   c. **Opportunities to participate in activities that would be found in a home.**
   d. **Adequate personal space for privacy.**
   e. **Security of property.**
   f. **A homelike and comfortable setting.**
   g. **Evidence of individual possessions and decorations.**
   h. **Daily access to nutritious meals and snacks.**
   i. **Separate sleeping areas for the persons served based on:**
      (1) **Gender.**
      (2) **Age.**
      (3) **Needs.**

Intent Statements

4.a. A written daily schedule would describe the activities offered.

4.c. The program encourages all persons served to take increasing responsibility for cooperative operation of the house-hold.

4.f. This standard may not be possible, and therefore not applicable in correctional settings.

4.g. These items are consistent with the personal choices and needs of the persons served, except for items contra-indicated by their person-centered plans.

4.i. Separation based on gender does not need to occur when parents and children sleep in the same area. When serving children or adolescents, needs includes developmental level.

Examples

4.b. These meetings could be community meetings or house meetings for the purpose of collaboratively discussing issues such as:

- Program operations.
- Problems.
- Plans.
- The use of program resources.

4.c. These activities may include the preparation of food and the performance of routine household duties.

3.W. **5.** **The program provides or ensures the provision of:**
   a. **Medical services.**
   b. **Pharmaceutical services.**

Intent Statements

For persons in long-term residential programs, medical services include regular health monitoring and prompt, ongoing follow-up on any identified problems.

3.W. **6.** **The program has at least one personnel member immediately available at all times who is trained in:**
   a. **First aid.**
   b. **Cardiopulmonary resuscitation (CPR).**
   c. **The use of emergency equipment.**

3.W. **7.** **Provisions are made to address the need for:**
   a. **Cultural and/or spiritual activities.**
   b. **Quiet areas.**
   c. **Areas for family or other visits.**

3.W. **8.** **There is at least a quarterly review of each person's:**
   a. **Plan of services.**
   b. **Goals.**
   c. **Progress toward goals.**

Intent Statements

The intent of this standard is to ensure that the person-centered plan is reviewed frequently enough to track the progress made toward identified goals and to note any new needs or interests.

3.W. **9.** **Persons served are given opportunities to participate in:**
   a. **Community activities.**
   b. **Social activities.**
   c. **Recreational activities.**
   d. **Spiritual activities.**

Examples

The program could provide a listing of activities in the community that persons served may participate in at no cost, such as local church services, city parks, advocacy groups, or local festivals.

3.W. **10.** **The program establishes collaborative relationships to facilitate community opportunities for the persons served.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- A written daily schedule of activities
- Documentation of a quarterly review of the person-centered plan

X. Student Counseling (SC)

Description

Student counseling programs serve as the primary behavioral health resource for higher education campus communities and their students. Services are designed to provide students with an opportunity to develop personal insight, identify and solve problems, and implement positive strategies to better manage their lives both academically and personally. Services include individual, family, and/or group counseling, prevention, education, and outreach. In addition to working directly with students, program goals are realized through outreach, partnerships, and consultation initiatives with faculty, staff, parents, students' internships sites, or other educational entities or community partners.

Applicable Standards

An organization seeking accreditation for a student counseling program must apply the standards in Section 1. In addition, Section 2 (please consult grid on page 96 for applicability of standards in this section) must be applied along with standards from this subsection.

3.X. **1. For each person served, a written person-centered plan:**
   a. **Is developed with the active participation of the person served.**
   b. **Is prepared using the following information relative to the person served:**
      (1) **Relevant medical history.**
      (2) **Relevant behavioral health information.**
      (3) **Relevant social information.**
      (4) **Information on current and previous direct services and supports.**
      (5) **Other applicable information.**
   c. **Is based on the person's:**
      (1) **Strengths.**
      (2) **Needs.**
      (3) **Abilities.**
      (4) **Preferences.**
   d. **Is reflective of the person's:**
      (1) **Desired outcomes.**
      (2) **Cultural background and diversity.**
      (3) **Other issues important to the person served.**
   e. **Identifies:**
      (1) **Overall goals defined in the words of the person served.**
      (2) **Specific objectives that are:**
         (a) **Measurable.**
         (b) **Time limited.**
      (3) **Methods/techniques to be used to achieve the objectives.**
      (4) **Those responsible for implementation.**
      (5) **Barriers to the individual's goals.**
      (6) **Strengths, supports, or solutions to overcome barriers.**
      (7) **Transitional needs.**
   f. **Is reviewed with respect to expected outcomes:**
      (1) **With the person served.**
      (2) **On a regular basis.**
   g. **Is revised, as appropriate:**
      (1) **Based on the satisfaction of the person served.**
      (2) **To remain meaningful to the person served.**
      (3) **Based on the changing needs of the person served.**

Examples

The person-centered plan may vary in size and complexity based on the type of services needed. In a short-term crisis response, the plan may address only the immediate needs of the person served.

3.X. **2.** The goals and objectives in the person-centered plan are communicated in a manner that is understandable:

  a. To the person served.

  b. To the person(s) responsible for implementing the plan.

3.X. **3.** The student counseling program provides one or more of the following services:

  a. Individual counseling.

  b. Family counseling.

  c. Group counseling.

3.X. **4.** The program provides or refers to a variety of services, based on the needs of the person served.

3.X. **5.** The program offers education on wellness and recovery.

3.X. **6.** Individuals providing student counseling services demonstrate:

  a. Knowledge of:

    (1) Appropriate community resources.

    (2) Mandatory reporting requirements.

    (3) Other laws and regulations, as applicable.

  b. Competency in:

    (1) Crisis identification.

    (2) Rapport building.

    (3) Positive engagement.

    (4) Counseling skills.

3.X. **7.** The program provides services:

  a. In locations that meet the needs of the persons served.

  b. At times that are responsive to the needs of the persons served.

3.X. **8.** When the need is identified, and with the consent of the person served, the program coordinates services with other educational or service providers.

3.X. **9.** When a person is transferred or discharged, the program identifies:

  a. A process to ensure coordination.

  b. The person responsible for coordinating the transfer or discharge.

3.X. **10.** A discharge summary is prepared for each person served who leaves the program.

3.X. **11.** A complete record is maintained for each person served.

3.X. **12.** Written procedures guide ongoing communication and collaboration with relevant stakeholders within the educational organization.

Examples

Stakeholders may include health services, student affairs, guidance departments, student life centers, student housing, and public safety. Procedures may guide how referrals are made, communication expectations with or without permission of the person served, or identification of expected collaboration relative to cross training, etc.

3.X. **13. A plan and written procedures:**

 a. Guide the program's response when a potential threat to personal or campus safety is identified.

 b. Determine the level of risk for each identified potential threat.

 c. Define immediate actions to be taken.

 d. Identify to whom information will be communicated.

Intent Statements

It is important to identify a clear expectation and resultant process that would occur if a threat is identified by the student counseling services, whether the threat is directed towards them, an individual, or the campus.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written individual person-centered plans
- Written discharge summaries
- Records of the persons served
- Written procedures concerning communication and collaboration with relevant stakeholders within the educational organization

Y. Supported Living (SL)

Description

Supported living addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of persons living in their own homes (apartments, townhouses, or other residential settings). Supported living services are generally long term in nature, but may change in scope, duration, intensity, or location as the needs and preferences o individuals change over time.

Supported living refers to the support services provided to the person served, not the residence in which these services are provided. A sampling of these sites will be visited as part of the interview process of the person served. Although the residence will generally be owned, rented, or leased by the person who lives there, the organization may occasionally rent or lease an apartment when the person served is unable to do so. Typically, in this situation the organization would cosign or in other ways guarantee the lease or rental agreement; however, the person served would be identified as the tenant. The home or individual apartment of the person served, even when the organization holds the lease or rental agreement on behalf of the person served, is not included in the intent to survey or identified as a site on the accreditation outcome.

NOTE: *The term* home *is used in the following standards to refer to the dwelling of the person served; however, CARF accreditation is awarded based on the services provided. This is not intended to be certification, licensing, or inspection of a site.*

Applicable Standards

An organization seeking accreditation for a supported living program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.Y. **1. Based on the needs of the persons served, assistance is offered in securing or maintaining housing that is:**

 a. Safe.

 b. Affordable.

c. Accessible.

d. Chosen by the individual.

Intent Statements

Although these services are provided to persons in their own homes, it may or may not be necessary for the provider to offer assistance in locating an appropriate location.

3.Y. **2. In-home safety needs of persons served are addressed with respect to:**

a. **Environmental risks.**

b. **Abuse and/or neglect inflicted by self or others.**

c. **Self-protection skills.**

d. **Medication management.**

Intent Statements

Health and safety risks may be greater in this type of residential support service. This standard amplifies those in Section 1.H. and should be considered in their context.

3.Y. **3. Persons served have input into:**

a. **Where they live.**

b. **With whom they live.**

Intent Statements

These elements of interdependence and self-determination are fundamental to the concepts of supported living and will enhance satisfaction results for the persons served.

3.Y. **4. Persons served determine the décor in their homes.**

3.Y. **5. Support personnel are available based on the needs of the person served, as identified in the person-centered plan.**

Intent Statements

Supported living services may be up to 24/7/365 support, depending on local regulatory requirements and definitions. This is individualized to each person's specific needs.

3.Y. **6. Support personnel collaborate with the person's support network, as directed by the person served.**

Intent Statements

This standard defines the amount of control the person served has over the living supports.

3.Y. **7. A system is in place to provide access to needed services 24 hours a day, 7 days a week.**

Intent Statements

Refer to Standard 5. above. The extent of service support is determined by the needs of the individual and based on the program plans, local definitions, and regulations.

3.Y. **8. Based on the needs and desires of the person served, support is offered in the following areas:**

a. **Healthy lifestyles.**

b. **Personal care.**

c. **Home maintenance.**

d. **His or her role as a tenant, when applicable.**

e. **Effective self-advocacy and decision making.**

f. **Family contact, if desired.**

g. **Social life and friendships/ relationships.**

h. **Community membership and social networks.**

i. **Financial stability.**

j. **Other identified needs.**

Intent Statements

Supported living services may be more inclusive of life needs than traditional residential support for basic food and shelter requirements.

Examples

8.b. This may include assistance with daily needs, personal hygiene, shopping, meal preparation, selection of wardrobe, and/or personal belongings.

3.Y. 9. Persons served are provided opportunities to choose and access:

   a. **Community activities.**

   b. **Cultural activities.**

   c. **Social activities.**

   d. **Recreational activities.**

   e. **Spiritual activities.**

   f. **Employment/income generation activities.**

   g. **Transportation, when necessary.**

   h. **Other.**

3.Y. 10. The organization provides information to residents that includes:

   a. **How to access community resources if needed.**

   b. **Safety issues related to the service delivery site.**

   c. **Access to emergency care when it is needed.**

   d. **Specific healthcare procedures and techniques.**

   e. **Contingency plans in case either the support system or the service provider is unable to deliver care.**

   f. **A review of how to deal with emergencies and evacuation from the residence.**

   NOTE: *Standard 10. only applies to Community Housing or Supported Living programs provided in apartment-type situations where agency staff do not reside at the site.*

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served

- Person-centered plans

- Progress notes

- Health and safety information

- Procedures manual

Z. Therapeutic Communities (TC)

Description

Therapeutic communities are highly structured residential environments or continuums of care in which the primary goals are the treatment of substance abuse or other behavioral health needs and the fostering of personal growth leading to personal accountability. The program addresses the broad range of needs identified by the person served. The therapeutic community employs community-imposed consequences and earned privileges as part of the recovery and growth process. In addition to daily seminars, group counseling, and individual activities, the persons served are assigned responsibilities within the therapeutic community setting. Participants and staff members act as facilitators, emphasizing personal responsibility for one's own life and self-improvement. The therapeutic community emphasizes the integration of an individual within his or her community, and progress is measured within the context of that therapeutic community's expectation.

Applicable Standards

An organization seeking accreditation for a therapeutic community program must apply the standards in Sections 1 and 2 in addition to the standards in this subsection.

3.Z. 1. The therapeutic community model views the community as the modality for individual change—i.e., the community as the healer. The program's written plan identifies the therapeutic community model through:

   a. **Use of the mutual-help principle.**

   b. **Program structure.**

   c. **Rules.**

   d. **Schedules.**

   e. **Responsibilities.**

   f. **Behavioral expectations.**

   g. **Role modeling.**

h. Feedback mechanisms.

i. Therapeutic learning interventions.

j. Therapeutic work assignments.

Intent Statements

The treatment community itself is viewed as the modality for individual change. All members of the community, including staff members and peers, role model appropriate behaviors for other community members in program functions and activities.

1.a. Mutual help, also known as self-help or peer support, requires the person served to actively participate in his or her own treatment and the treatment of others using the community as the method.

3.Z. **2. The program demonstrates use of the mutual-help principle through evidence of the following:**

a. **Adherence to program rules.**

b. **Adherence to existing schedules.**

c. **Adherence to behavioral expectations of the community.**

d. **Acceptance of responsibility for:**

(1) **Self.**

(2) **Applicable others.**

(3) **The health of the community itself.**

e. **Positively influencing other members of the community by teaching and by role modeling appropriate behaviors in:**

(1) **Program functions.**

(2) **Activities.**

(3) **The community itself.**

f. **Providing honest feedback and guidance to other members of the community that leads to interventions occurring in a community forum.**

g. **Demonstration of empathy and genuine concern for other members of the community.**

Intent Statements

This standard relates to the active involvement of the persons served in their treatment process and in that of their peers. An individual's growth and change are the product of his or her own motivation and commitment, with help from others engaged in the same process.

3.Z. **3. The program's hours of operation meet the needs of the persons served.**

Intent Statements

In a correction setting, the hours of operation may be determined and limited by institutional rules.

3.Z. **4. The treatment environment is conducive to and supportive of recovery.**

3.Z. **5. When a program is provided in a residential setting, there is qualified personnel available to respond 24 hours a day, 7 days a week.**

Intent Statements

Personnel should be on the same campus and have the ability to respond to emergencies quickly. If the program serves children or adolescents, personnel are on site 24 hours a day, 7 days a week. In a correctional setting, services or support outside of program hours may be provided by personnel outside of the organization or program seeking accreditation or may be provided by institutional staff.

3.Z. **6. Whenever possible, peer mentors are used as credible role models in the program.**

Examples

In a correctional setting, this may include inmates who have completed the correctional therapeutic community and are used as peer mentors to teach, facilitate, and role model for newer participants in the therapeutic community.

3.Z. 7. Based on the needs of the person served, the program provides, either directly or through referral, services that seek to assist the person served with:

a. Substance abuse issues.

b. Criminal issues, including:

(1) Attitudes.

(2) Beliefs.

(3) Behaviors.

c. Mental health issues.

d. Medical needs.

e. Family issues, where appropriate.

f. Cognitive functioning.

g. Emotional functioning.

h. Building of self-esteem and self-concepts.

i. Improvement of coping abilities.

j. Development of responsible decision-making skills.

k. Educational opportunities.

l. Vocational development and/or employment.

m. Social functioning.

n. Use of leisure time.

o. Relapse prevention or support strategies.

p. Community living skills.

q. Spirituality.

r. Family reunification.

s. Violence reduction.

t. Permanent and stable housing.

u. Financial skills, including applicable restitution.

Intent Statements

The therapeutic community treatment model is distinguished by a view of substance abuse as a disorder of the whole person, involving problems with behavior, attitudes, and management of emotions. This comprehensive approach utilizes a continuum of services and allows for individualized treatment planning in response to the needs of the persons served.

Examples

7.e. Family issues may include parenting classes.

3.Z. 8. The organization implements a process to ensure that personnel providing direct services demonstrate skill in the application of the therapeutic community core competencies that include an understanding of:

a. Practicing positive role modeling.

b. Promoting mutual help.

c. Practicing the concept of "acting as if."

d. Minimizing the dichotomy of "we versus they."

e. Promoting a system of earned privileges and graduated responsibilities.

f. Social learning.

g. Utilizing the relationship between belonging and individuality.

h. Creating a belief system in the community.

i. Facilitating group process.

j. Positive boundaries in the following areas:

(1) Clinical.

(2) Ethical.

(3) Security (in correctional settings).

Intent Statements

8.b. Mutual help emphasizes personal responsibility and de-emphasizes the concept of "patients" being serviced by "experts."

8.c. This is a cognitive technique that emphasizes the creating of a positive atmosphere. This technique is important because of the therapeutic community belief that acting positively, despite feeling negatively, will eventually lead to feeling positively.

8.d. To the greatest extent possible, staff members should remove all barriers between the persons served and staff members so that both are viewed as facilitating the treatment process. In a correctional setting, this must be consistent with institutional rules and regulations and practices, which are designed to ensure institutional security and staff safety. This can be achieved in correctional settings via role modeling of community techniques, such as challenging and confronting behaviors and demonstrating prosocial or right-living behaviors.

8.f. Social learning includes role modeling, peer feedback, and learning by experience.

8.g. The initial priority of the therapeutic community is to promote a strong feeling of inclusion within and bonding with the community itself, which promotes feelings of belonging and commitment. Individuality and self-realization are stressed in later phases of treatment. Balancing belonging and individualism is integral to treatment success.

3.Z. **9.** When the therapeutic community is in a correctional facility, security personnel are trained on the therapeutic community model.

3.Z. **10.** The program completes, at a minimum, a quarterly review of each person's:
   a. Plan of services.
   b. Goals.
   c. Objectives.
   d. Progress toward goals.

3.Z. **11.** The program provides treatment throughout the day consisting of the following, based on the needs of the persons served:
   a. A written schedule that includes:
      (1) Community activities.
      (2) Cultural activities.
      (3) Recreational activities.
      (4) Spiritual activities.
   b. Assignment of therapeutic duties and work assignments.
   c. Daily access to nutritious meals and snacks.
   d. Therapeutic activities, such as individual and group counseling.
   e. Educational activities.
   f. Training activities.
   g. Crisis intervention.
   h. Development of community living skills.

   i. Family support, with the approval of the persons served.
   j. Linkages to community resources.
   k. Development of:
      (1) Social skills.
      (2) Prosocial behavior.
      (3) Responsible concern for others.
   l. Development of a social support network.
   m. Development of vocational skills.
   n. Community building activities that use therapeutic community tools and methodology.
   o. Assistance in securing housing that is safe, decent, affordable, and accessible for the persons served.

Examples

11.c. In a correctional setting, these are provided by the institution.

11.f. Training may include budgeting, money management, literacy skills, or GED preparation.

11.n. In a correctional setting, this may be linkage to continuing care.

3.Z. **12.** In a noncorrectional residential setting, the following community living components are provided:
   a. Opportunities to participate in activities that would be found in a home.
   b. Adequate personal space for privacy.
   c. A homelike and comfortable setting.
   d. Evidence of individual possessions and decoration, when clinically appropriate.

3.Z. **13.** In a residential setting, there are separate sleeping areas for the persons served based on:
   a. Gender.
   b. Age.
   c. Needs.

Intent Statements

When parent-child treatment is provided, the same sleeping areas may be appropriate.

13.a. The organization must be able to clearly delineate male and female designated areas (separate wings, buildings, etc.)

13.c. When serving children or adolescents, needs includes developmental level.

3.Z. 14. **The program demonstrates that therapeutic learning interventions:**

a. **Are consistent with the treatment goals.**

b. **Relate to the attitudes or behaviors leading to implementation.**

c. **Are understood by personnel and persons served.**

d. **Are used to the greatest extent possible within the treatment environment.**

e. **Are consistent with the principle of using the community as the primary instrument of facilitating change.**

Intent Statements

Therapeutic learning interventions are a part of the treatment process and are linked to the treatment goals of the persons served.

Examples

They may be communicated through such means as orientation manuals, seminars, peer interactions, or staff instruction and may be applied by the community as well as personnel, particularly in a correctional setting.

14.d. Within a correctional setting, therapeutic community learning interventions are used as the primary intervention in all situations where rule violations do not automatically trigger correctional sanctions.

3.Z. 15. **The program demonstrates that the use of therapeutic duty assignments:**

a. **Is consistent with the treatment plan of the persons served.**

b. **Responds to the needs and abilities of the persons served.**

c. **Includes documentation of:**

(1) **Progress.**

(2) **Supervision.**

Intent Statements

Assignments are utilized to promote community membership, social functioning, daily living skills, individual self-esteem, responsibility, vocational development, and/or employability. Under the supervision of staff, persons served perform assignments integral to the running of the community. New persons served are assigned entry-level therapeutic duty assignments as a way to signify the start of their contribution to the community. Persons served assume greater responsibility based on treatment progress, performance, behavior, and attitude. Persons served gain valuable experience through therapeutic duty assignments and may internalize a work ethic as well as a strong sense of responsibility for the community.

3.Z. 16. **Provisions are made to address the need for:**

a. **Cultural and/or spiritual activities.**

b. **Quiet areas.**

c. **Areas for visits.**

Intent Statements

In a correctional setting, this results from agreements between program and correctional personnel.

16.a. In a correctional setting, this is based on institutional policy.

16.c. In a correctional setting, this is designated by the institution and is based on institutional security needs and program integrity and efficacy needs.

3.Z. **17.** **In a correctional setting, the therapeutic community is provided in a designated space that allows for an appropriate treatment environment.**

Intent Statements

This would include sufficient segregation from the general population to ensure a prosocial environment for the treatment program, as well as housing and employment, to the extent possible.

3.Z. **18.** **In a correctional setting, efforts are made to accept persons served into the therapeutic community at a time that will allow for transition from the treatment program into applicable community-based treatment in a timely manner.**

Intent Statements

In order to best support long-term treatment gains and recovery, organizations promote treatment as close as possible to the time that the individual will be released.

3.Z. **19.** **In a correctional setting, personnel:**

a. **Have training or experience in the treatment of addictions as well as expertise in working with the criminal justice population.**

b. **Reflect the unique knowledge and experience of persons who are in recovery or are ex-offenders.**

3.Z. **20.** **In a correctional setting, a written procedure exists for review of rule infractions that:**

a. **Includes:**

(1) **Informal review.**

(2) **Formal review.**

b. **Clarifies roles and responsibilities of program and correctional personnel.**

c. **Considers the relationship between the safety of the institution and the value of the therapeutic intervention.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ A written program plan

■ A quarterly review of the plan for services, goals, and progress made

■ A written schedule of activities

■ Documentation of therapeutic duty assignments

SECTION 4

Behavioral Health Specific Population Designation Standards

Guidelines for Organizations Seeking a Specific Population Designation

If an organization is required or chooses to add one of the following Specific Population Designations to a core program(s) being surveyed, the standards for these designations will be applied at the time of the survey in addition to the core program standards. See Sections 4.B.–F. for applicable standards.

The Specific Population Designations available are:

■ 4.B. Children and Adolescents (CA) (May be required—see following note.)

■ 4.C. Consumer-Run (CR)

■ 4.D. Criminal Justice (CJ) (May be required—see following note.)

■ 4.E. Juvenile Justice (JJ) (May be required—see following note.)

■ 4.F. Medically Complex (MC) (May be required; includes Medically Complex for Children/Adolescents (MCCA)—see following note.)

■ 4.G. Eating Disorders (ED) (includes Eating Disorders for Children/Adolescents (EDCA—see following note.)

NOTE: *If children or adolescents (up to age 18) are served in any behavioral health core program (except Prevention or Diversion) for which the organization is seeking accreditation, the standards in Section 4.B. Children and Adolescents (CA) <u>or</u> 4.E. Juvenile Justice (JJ) must be applied.*

An organization seeking accreditation for an Eating Disorders program for Children/Adolescents (EDCA) must apply the standards in Sections 4.B. and 4.G.

If an organization is seeking accreditation for a Prevention program that serves youths under 18 years of age, it is not necessary to apply the standards in Section 4.B. or 4.E., as they are intended for treatment-oriented programs that admit or enroll the persons served.

If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the standards in Section 4.D. Criminal Justice (CJ) [or 4.E. Juvenile Justice (JJ), for populations under 18 not tried as adults] must be applied.

If a core program for which the organization is seeking accreditation is designed primarily to serve persons who meet the definition of medically complex, or the program serves only this target population, the medically complex standards must be applied.

Organizations seeking accreditation for a core program for children/adolescents who meet the definition of medically complex (MCCA) must apply the standards in Sections 4.B. and 4.F.

For Opioid Treatment Programs Outside of the United States

■ 4.A. Addictions Pharmacotherapy (AP) can be applied as a specific population designation for opioid treatment programs located outside of the United States.

■ An Addictions Pharmacotherapy program that serves children/adolescents (APCA) must apply the standards in Sections 4.A. and 4.B.

■ Opioid Treatment Programs within the United States must use the *Opioid Treatment Program Standards Manual*. Contact CARF for further assistance if necessary.

A. Addictions Pharmacotherapy (AP)

Description

🍁 **NOTE:** *The standards in this section are applicable only to opioid treatment programs located outside of the United States. For example, opioid treatment programs in Canada can apply these standards to the specific core programs they want designated as addictions pharmacotherapy programs. Opioid treatment programs located in the United States must use the CARF Opioid Treatment Program Standards Manual.*

Addictions pharmacotherapy programs provide support for persons with narcotic or opiate dependence. The duration of the support is based on the needs of the persons served and takes into consideration the benefits of medication. The medications used to achieve treatment goals may include such drugs as methadone or opioid replacement medications.

These programs outside of the United States offer comprehensive, coordinated, defined services that may include, but are not limited to, medical services; individual, group, and family counseling; psychosocial educational classes; vocational planning; and case management.

The services of addictions pharmacotherapy programs may vary in intensity and are generally offered in outpatient settings. These services may also be offered in inpatient, detoxification, criminal justice, or residential settings.

Applicable Standards

If an organization selects an addictions pharmacotherapy designation, it must apply the standards in Sections 1 and 2 and seek accreditation in at least one core program area in Section 3 in addition to the standards in this subsection. An organization cannot be accredited for addictions pharmacotherapy alone but rather must select a core program(s) to which it wants this designation applied.

NOTE: *An organization seeking accreditation for an addictions pharmacotherapy program for children/ adolescents (APCA) must apply the standards in Section 4.B. as well as the standards in this section.*

4.A. **1. An addictions pharmacotherapy program has policies and written procedures related to:**

   a. **The administration of medications, including:**

   (1) **The role of physicians concerning:**

   (a) **Admission to the program.**

   (b) **The prescription of dosages.**

   (2) **The responsibility of the medical director or other physicians for the medical practices of the organization.**

   b. **The establishment of the dosage for each individual, including:**

   (1) **Establishing the initial dosage.**

   (2) **Adjusting the dosage to ensure stable functioning.**

   (3) **Establishing the maintenance dosage.**

   c. **Visits to the program site.**

   d. **Unsupervised, off-site self-administration.**

   e. **The responsibility of each person served concerning drug safety issues, including:**

   (1) **The individual's responsibility to inform program personnel of changes in drug use.**

   (2) **The individual's responsibility to report his or her status as a participant in an addictions pharmacotherapy program to other medical service providers from whom services are received.**

   (3) **Safe practices for storage of medications for the purpose of unsupervised, off-site self-administration.**

Intent Statements

1.a.(2) The medical director is responsible for writing a prescription for each person served prior to establishing the initial dosage. The medical director or other physicians are responsible for:

■ Physical examinations.

- Participation in the treatment planning.
- Determination of the frequency of program attendance.

1.b.(1) Factors to be considered in determining the dosage include:

- The history of narcotic dependence.
- Current standards of practice.

1.b.(2) Factors to be considered in adjusting the dosage include:

- The dosage required for stable functioning.
- An evaluation of continued unauthorized drug use.
- Detoxification.
- The use of prescribed medications.

1.e.(1) *Drug use* relates to:

- Prescriptions.
- Over-the-counter medications.
- Illegal substances.

1.e.(2) Methods employed to notify the person served of his or her responsibility may include:

- Posted notification.
- Orientation.
- Individual and group counseling sessions.
- Educational sessions.

4.A. **2. Policies and procedures address drug-screening practices, including:**

a. **The frequency of drug screening.**

b. **Provisions for the individualization of drug screening.**

c. **An interpretation of the results of drug screening.**

d. **Actions to be taken based on the results of drug screening.**

e. **The collection and processing of urine samples, including:**

(1) **Minimizing falsification during urine sample collection.**

(2) **Ensuring respect for the persons served during urine sample collection.**

(3) **Defining observation practices.**

(4) **Using of urinalysis reports.**

(5) **Distributing of urinalysis reports.**

(6) **Continuing education of staff members concerning urinalysis practices.**

(7) **Establishing chain-of-custody procedures.**

f. **Other laboratory procedures.**

g. **Education for personnel.**

h. **Individuals who have co-occurring health issues, including:**

(1) **Medical problems.**

(2) **Mental health problems.**

(3) **The use or abuse of multiple drugs.**

(4) **The use or abuse of alcohol.**

(5) **HIV or other sexually transmitted diseases.**

(6) **Infectious diseases.**

(7) **Pregnancy and prenatal care.**

i. **Referrals to treatment for persons with:**

(1) **Medical problems.**

(2) **Mental health problems.**

j. **Administrative discharge, including:**

(1) **The circumstances under which administrative discharges may be initiated.**

(2) **Interdisciplinary team review of administrative discharges.**

(3) **Education of the persons served as to the procedures for grievances or due process.**

k. **Emergency services procedures.**

Intent Statements

2.f. The policies and procedures relate to the purposes, rationale, and use of the laboratory procedures.

Examples

2.k. Emergency services procedures may include methods of handling:

- Persons who fail to follow their treatment plans.
- Violence or threats of violence.
- Behavior disruptive to program functioning.

4.A. **3.** **The duration of addictions pharmaco-therapy is based on:**

    a. **The needs of each person served.**

    b. **The benefits of the medication.**

Intent Statements

A variety of factors are considered when anticipating the duration of a person's treatment. Such factors include:

- The severity of the addiction.
- The length of the addiction.
- Previous treatment received.
- Medical complications.

4.A. **4.** **The services conform to accepted medical practices when a person served is taking medications during pregnancy.**

4.A. **5.** **A physician is available for medical consultation 24 hours a day, 7 days a week.**

Intent Statements

This standard does not require a physician to be on site at all times, but rather to be available on call.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Addictions pharmacotherapy policies and procedures.
- Policies addressing drug screening practices

B. Children and Adolescents (CA)

Description

Programs for children and adolescents consist of an array of behavioral health services designed specifically to address the treatment needs of children and adolescents. Such programs tailor their services to the particular needs and preferences of children and adolescents and are provided in a setting that is both relevant to and comfortable for this population.

Applicable Standards

If children or adolescents (up to age 18 unless legally emancipated) are served in any core program other than Diversion or Prevention, the standards in this section or Section 4.E. Juvenile Justice (JJ) *must* be applied in addition to the standards in Sections 1 and 2 and the core program standards in which the organization is seeking accreditation. An organization cannot be accredited for children and adolescents alone, but rather must select a core program(s) to which it wants this designation applied.

NOTE: *Legal emancipation generally occurs through marriage, a court order, or specific rules of the Indian Child Welfare Act.*

4.B. **1.** **Assessments of each child or adolescent served include information on his or her:**

    a. **Developmental history, such as developmental age factors, motor development, and functioning.**

    b. **Medical or physical health history.**

    c. **Culture/ethnicity.**

    d. **Treatment history.**

    e. **School history.**

    f. **Language functioning, including:**

        (1) **Speech functioning.**

        (2) **Hearing functioning.**

    g. **Visual functioning.**

    h. **Immunization record.**

    i. **Learning ability.**

j. Intellectual functioning.

k. Family relationships.

l. Interactions with peers.

m. Environmental surroundings.

n. Prenatal exposure to alcohol, tobacco, or other substances.

o. History of use of alcohol, tobacco, or other substances.

p. Parental/guardian custodial status.

q. When applicable, parents'/guardians':

(1) Ability/willingness to participate in services.

(2) Strengths.

(3) Preferences.

Intent Statements

In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, or Detoxification), the amount of information collected may be limited by time or the condition of the person served. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

1.f.–g. Speech, hearing, and visual functioning are often included in yearly physical exams and/or in schools. Source documents are not required; however, any identified needs of the child/youth should consider whether language and/or visual functioning is a contributing factor.

1.h. The assessment includes a determination of the status of the child's immunization. A copy of the immunization record is not required. Organizations can note when children and adolescents are enrolled in school settings where verification of immunization is legally required.

1.k. Information about family relationships includes siblings as well as extended family. Family relationship information would also document changes in the family constellation and persons moving into or out of the home.

1.m. Environmental surroundings include family moves and changes in placements for children placed out of the home.

4.B. **2.** The assessments are appropriate with respect to the child's or adolescent's:

a. Age.

b. Development.

c. Culture.

d. Education.

4.B. **3.** When the services disrupt the child's or adolescent's day-to-day educational environment, the program provides or make arrangements for the continuity of his or her education.

Examples

Arrangements could include:

- Use of a facility-based school.
- Use of a private school at the organization.
- Use of on-site educators from a local school system.
- Coordination with home school services.
- Coordination and monitoring of assignments.
- Coordination with the community school to facilitate reintegration.

4.B. **4.** Based on the needs of each child or adolescent, or as required by law, an educational specialist is a member of the team.

Intent Statements

When applicable, the educational specialist assists in the planning, implementing, and evaluating of the child's or adolescent's educational activities.

The educational specialist can be available when needed and is not required to attend all team meetings. Please refer to Standard 2.A.20. for the functions of the team.

4.B. 5. If educational services are provided, they:

    a. Are appropriate to the person served.

    b. Meet applicable federal, provincial, and state requirements.

    c. Include provisions for:

        (1) Evaluation.

        (2) Group instruction.

        (3) Individual instruction.

Intent Statements

Educational services should be appropriate to the developmental and clinical needs of each child and adolescent served.

4.B. 6. Based on the needs of the children or adolescents served, the program includes the development of:

    a. Community living skills.

    b. Social skills.

    c. Social supports.

    d. Vocational skills.

4.B. 7. The environment is configured appropriately to meet the needs of children and adolescents, including:

    a. The physical plant.

    b. The furniture.

    c. The equipment.

Intent Statements

The location in which services are provided reflects the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the children or adolescents served.

Examples

Considerations include the provision of:

- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and video equipment.

4.B. 8. The organization implements a policy and procedures for obtaining criminal background checks on all persons providing direct services to children or adolescents.

Intent Statements

Background checks may include fingerprinting and FBI criminal history checks. Persons providing direct services include personnel, students, interns, volunteers, or contracted providers of direct services. The provision of direct services includes transportation.

🍁 In Canada, depending on provincial/territorial/tribal requirements, a criminal record check and a child welfare information system check would be required to meet this standard.

Examples

Background checks may be conducted prior to employment for new personnel, at the time of job change when beginning to work with children or adolescents, or prior to an accreditation survey for existing personnel.

4.B. 9. For residential services provided in congregate facilities or sites that are owned, rented, or leased by the organization, staff support is available on site 24 hours a day, 7 days per week.

Intent Statements

Residential services may include group homes, residential treatment, child caring institutions, inpatient facilities, or residential detoxification programs. Treatment or therapeutic foster care that is provided in facilities that are owned, rented, or leased by the organization is also included. Staff members are in the residential facility around the clock and able to respond to emergencies quickly. If there are times when no persons are served in the facility (such as during off-site school attendance), staff may be off site, but need to be available.

4.B. **10.** **If residential services are provided, the program provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:**

   a. **Family members and significant others.**

   b. **Peers.**

4.B. **11.** **The program does not exclude children or adolescents from services solely on the basis of their juvenile justice status.**

Intent Statements

Although specific behaviors may be identified by a program as exclusionary admission criteria, children and adolescents cannot be excluded from services solely because they are involved in the juvenile justice system.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Assessments of the children or adolescents served

■ Filed, current information on law pertaining to educational specialists and educational services

■ Staffing pattern chart for residential, or 24/7 programs

■ Policy related to background checks on all personnel

C. Consumer-Run (CR)

Description

Improvement of the quality of an individual's situation requires a focus on the person served and his or her identified strengths, abilities, needs, and preferences. The program is designed around the identified needs and desires of the persons served, is responsive to their expectations, and is relevant to their maximum participation in the environments of their choice.

The person served participates in decision making and planning that affects his or her life. Efforts to include the person served in the direction of the program or delivery of applicable services are evident. The service environment reflects identified cultural needs and diversity. The person served is given information about the purposes of the program.

Applicable Standards

These standards would be applied to consumer-run programs in place of the current standards in Sections 2.A.–D., G., and H.

4.C. **1.** **The program's policies and procedures for membership or acceptance into services identify:**

   a. **Criteria for the order of acceptance of any person awaiting service.**

   b. **The position or entity responsible for making acceptance decisions.**

   c. **Opportunities for individuals to learn about the program and its services.**

Intent Statements

These policies may be established based on local referral policies and the mission of the program. These policies and procedures reduce the possibility that subjective judgment will be used to determine if the program is applicable to a person's needs. They ensure fair access for all applicants and referrals, in keeping with the program's commitment to be accessible. The intent is to provide information for persons to make informed choices.

4.C. **2. The membership/acceptance criteria are presented in an understandable manner.**

Intent Statements

It is important to consider the comprehension levels and language skills of those applying.

Examples

Written materials in the person's primary language, large-print written materials, videotapes, and face-to-face presentation are some of the ways to present information in an understandable manner.

4.C. **3. When a person is found ineligible:**
   a. The person is informed as to the reason(s).
   b. The referral source is informed as to the reason(s).
   c. The person is given information about potential alternative services.
   d. The program maintains documentation of these actions.

Intent Statements

Reasons for ineligibility may be provided verbally or in writing.

3.d. The program gathers data on persons found ineligible for services. Through the program's performance improvement system, this information is used to strategically position the program to identify and develop services to meet the needs of unserved or underserved populations in the community.

4.C. **4. Prior to participation in the program, the program ensures that all persons involved are aware of their responsibilities regarding services/activities.**

Intent Statements

The persons accepted for services, their family members, staff members, funders, and others, as appropriate, are given information about their rights and responsibilities.

4.C. **5. As required by funding sources and for legal reasons, signed informed consent for services is:**
   a. Obtained.
   b. Retained.

Intent Statements

Programs are encouraged to check with local authorities regarding legal requirements to determine when signed informed consent is required. Signed informed consent is documented. Staff members are familiar and comply with informed consent procedures and requirements.

4.C. **6. The persons participating in activities or receiving services are given information about:**
   a. Planning of the services to be delivered or activities in which to participate.
   b. Setting their individual service goals, when applicable.
   c. How progress on service goals will be communicated with the persons served.

Intent Statements

The result is that the persons served are knowledgeable about the person-centered planning process and their active role in or possible direction of the process, including the sharing of information on progress toward and/or achievement of goals.

4.C. **7. As appropriate, the following needs are addressed:**
   a. Assistive technology.
   b. Reasonable accommodations.
   c. Identified health risks.
   d. Identified safety risks.

Intent Statements

Reasonable accommodations are necessary to fully access services and enable the person served to participate in the program. Technology needs are addressed in the person-centered plan.

The program considers reasonable accommodations and uses assistive technology to convey information about services.

As part of a program's risk management, any health or safety risks identified during the planning process should be addressed to limit an individual's exposure to adverse consequences.

Examples

The program may provide assistive technology, or it may be provided by referral to other local resources.

Accommodations and technology may entail the use of communication devices, videotapes and audiotapes, pictures, and materials in each person's primary language.

4.C. **8. If a person participating in activities or receiving services needs services that are not available through the program, referrals to other providers are suggested.**

Intent Statements

The program may not be able to provide all services a person may want or need. If this is the case, the program refers the person to other services outside the program and coordinates these services with those provided by the program.

Examples

The program may maintain listings or demonstrate knowledge of agencies and programs to which it can refer individuals, if so requested or needed. As a good practice, a program should have a procedure in place to ensure that individuals are satisfied with the services they receive elsewhere as a result of these referrals and that the agencies and programs receiving its referrals are quality driven and person centered.

4.C. **9. Persons served are given opportunities to enhance their advocacy skills through:**
   a. **Training.**
   b. **Support for systems advocacy activities.**
   c. **Support for self-advocacy activities.**
   d. **Linkage with self-advocacy programs.**
   e. **Other appropriate means, if applicable.**

Examples

Support for advocacy activities may be provided within the program through support for participation in activities, such as consumer-councils, in the community through support for participation in activities sponsored by advocacy groups, or through support for self-advocacy to access benefits and/or services.

Applicable Standards

The following six standards (Standards 4.C.10.–15.) do not apply in a drop-in center or consumer-run program that does not provide direct services.

4.C. **10. The following information is used in the development of the person-centered plan:**
   a. **Relevant medical history.**
   b. **Relevant psychological information.**
   c. **Relevant social information.**
   d. **Information on current and previous direct services and supports.**
   e. **Other issues, as necessary.**

Intent Statements

This standard does not require that each person have a physical or psychological evaluation. The program has a procedure in place to determine relevancy based on the individual's situation and services provided by the program. The person-centered plans demonstrate that this information has been considered in development of the person-centered plans.

4.C. **11. A coordinated person-centered plan is based on the person's:**
   a. **Strengths.**
   b. **Needs.**
   c. **Abilities.**
   d. **Preferences.**
   e. **Desired outcomes.**
   f. **Cultural background and diversity.**
   g. **Other issues important to the person served.**

Intent Statements

The program may use consumer self-assessments and/or person-centered planning to obtain this information. Person-centered plans may be under the authority of a referral agency. In these cases, the program demonstrates how it accesses these plans and how it uses them to achieve individualized services and person-focused outcomes.

Plans are highly individualized, reflecting the diversity of the persons served.

4.C. **12.** **A coordinated person-centered plan:**
   a. **Is developed with the input of the person served.**
   b. **Identifies:**
      (1) **Overall goals.**
      (2) **Specific measurable objectives.**
      (3) **Methods/techniques to be used to achieve the objectives.**
      (4) **Those responsible for implementation.**
      (5) **Barriers to an individual's goals.**
      (6) **Strengths, supports, or solutions to overcome barriers.**
   c. **Is reviewed on a regular basis with respect to expected outcomes.**
   d. **Is revised, as appropriate:**
      (1) **Based on the satisfaction of the person served.**
      (2) **To remain meaningful to the person served.**
      (3) **Based on the changing needs of the persons served.**

Intent Statements

The program includes the person served as an active participant giving direction in all aspects of the planning and revision processes. Reasonable efforts and accommodations are made to obtain the active participation and understanding of the person served, including the inclusion of an advocate or family member if the person prefers or if it is necessary to interpret the person's desires. Objectives reflect the desires and dreams of the persons within the mission and values of the program and are written using their language. A program may choose to include

documentation in the plan of decisions made by the individual.

The program establishes a schedule for periodic review of the plan. The plan focuses on outcomes and results, and regular review is essential to ensure that goals are achievable and remain meaningful to the person served. Plans are essential for all members of the team to perform their functions and to ensure continuity of services when new staff members are hired.

4.C. **13.** **The goals and objectives of the person-centered plan are communicated in a manner that is understandable:**
   a. **To the person served.**
   b. **To the person(s) responsible for implementing the plan.**

Intent Statements

The program ensures that all persons involved understand the plans and their own involvement in achieving the goals and objectives.

Examples

Understanding by the persons served may be demonstrated through interviews, records, or checklists.

4.C. **14.** **A discharge summary is prepared for each person served who leaves a program.**

Intent Statements

A discharge summary typically describes the person's progress toward or achievement of goals, as identified in his or her person-centered plan, the services provided, and the reasons for discharge. The summary also lists recommendations for services or supports needed to assist the person served to achieve his or her identified goals and may suggest referrals to other services.

4.C. **15.** **A complete record is maintained for each person served.**

Intent Statements

The program determines which information should be kept in the records of the persons served. The record communicates information that is complete, clear, and current. Funders and referral agencies may require that certain

information be maintained. The program also complies with its own service delivery design for the development of the record. Electronic records are acceptable.

Examples

The record may include demographic data; names of personal representatives, such as parents, guardians, and advocates; referral reports; functional abilities; medical information, such as medications taken and name of physician; person-centered plans; release forms; consent forms; follow-up reports; exit summaries; progress reports; and referrals to other resources.

The program may find it helpful to keep an orientation checklist in each person's record so that documentation can be made when items are shared with the individual, such as rights and responsibilities, setting goals and planning services, and securing/retaining benefits.

Working files can be used if security of files is maintained.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons receiving services
- Acceptance policies and procedures
- Entrance criteria
- Criteria for the order of acceptance
- Information regarding referrals of persons who are ineligible
- Handbook and information regarding responsibilities in services
- Information regarding basic entitlements
- Orientation checklist, information, etc.
- Person-centered plans
- Information regarding reasonable accommodations and assistive technology used, if applicable
- Release-of-information forms
- Informed consent information
- Documentation of advocacy training or curriculum
- Referral information
- Discharge summary report

D. Criminal Justice (CJ)

Description

Criminal justice programs serve special populations comprised of accused or adjudicated individuals referred from within the criminal justice system who are experiencing behavioral health needs, including alcohol or other drug abuse or addiction, or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, in community-based or institutional settings, or in sex offender programs. Institutional settings may include jails, prisons, and detention centers. The services are designed to maximize the person's ability to function effectively in the community. The criminal justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

Criminal justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/DWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Applicable Standards

If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the Criminal Justice (or Juvenile Justice, for populations under 18 not tried as adults) standards must be applied.

Organizations seeking accreditation in Criminal Justice must apply the standards in Sections 1 and 2 and one or more of the service-specific core programs in Section 3 as well as these standards. For example, a criminal justice program providing treatment through a therapeutic community model would apply the standards in Sections 1 and 2 as well as

3.Z. Therapeutic Communities (TC) and 4.D. Criminal Justice (CJ).

4.D. **1. Treatment programs within a correctional setting include:**
   a. **Partnering with correctional personnel who have decision-making authority.**
   b. **Identification of personnel assigned as liaison for ongoing communication.**

4.D. **2. Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, criminal justice behavioral health services.**

Intent Statements

In addition to the standards in Section 2 related to the team providing services, this standard provides more specific guidance as to the competencies of team members providing services in a criminal justice setting who are directly involved in the participatory process of defining, refining, and assisting a person served in meeting his or her goals.

4.D. **3. All members of the team:**
   a. **Have access to the confidential information that is required for the team members to perform their function.**
   b. **Are bound by applicable state, federal, and provincial confidentiality laws.**

Intent Statements

The intent is for all parties to engage in collaborative information sharing to the greatest extent possible within identified laws, rules, and regulations.

4.D. **4. The person served is provided with a description of the relationship between the criminal justice entity and the program, including:**
   a. **The extent and limitations of confidentiality and sanctions.**

b. The possible implications of having a criminal justice member on the team.

Intent Statements

The team involves a blend of behavioral health providers and criminal justice personnel, such as correctional officers, control agents, guards, and probation and parole officers. Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team. Although exceptions may exist in a correctional setting, the person served has the option of refusing to have the criminal justice system actively involved in the treatment process.

Examples

4.b. The staff members of the program might discuss such issues as:

■ Access to confidential records.

■ Action the criminal justice member may be forced to take based on information provided by the team.

■ The impact on the therapeutic relationship.

4.D. **5.** Training:

a. Is provided to personnel prior to the delivery of services.

b. Includes regular interdisciplinary cross-training related to clinical and criminal justice issues.

c. Includes such topics as:

(1) The requirements imposed on personnel from the criminal justice system who participate on the treatment team.

(2) Safeguards that are available to workers.

(3) Safety and security practices specific to the setting.

(4) Clinical boundaries.

(5) Correctional boundaries.

(6) Specialized clinical needs, including dual diagnoses.

(7) Therapeutic community practices and methodologies, when that core program is provided.

Intent Statements

5.a. Behavioral health professionals who work in criminal justice settings encounter a unique service delivery system with both opportunities and challenges. The intent of this standard is to ensure that individuals new to this type of setting receive full and complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work.

5.b. *Interdisciplinary cross-training* refers to criminal justice staff members providing criminal justice training to clinical staff members and also to clinical staff members providing clinical training to criminal justice staff members.

4.D. **6. The criminal justice program conducts or obtains a timely assessment for each person served that includes:**

a. A detailed history of the person's criminal behavior, including:

(1) Arrests.

(2) Convictions.

(3) Violations of parole and/or probation.

(4) Prior incarcerations.

(5) Pending cases.

b. Information on the person's participation in organizations or groups that encourage criminal behavior.

c. The relationship between the person's behavioral health and his or her criminal activity.

d. Risk to self, other persons served, personnel, and/or community.

e. Risk for reoffending.

f. Triggers for recidivism.

Intent Statements

In conducting an assessment in a criminal justice setting, a program emphasizes the collection of information related to criminal behavior.

4.D. 7. When applicable and/or permitted, family members and/or significant others are:

a. **Identified.**

b. **Located.**

c. **Contacted.**

d. **Offered and, when possible, engaged in services.**

Intent Statements

Family members include children, when applicable. In certain situations, such as under specific contracts for service, contact with family members may not be permitted.

4.D. 8. The person-centered plan of the person served includes:

a. **A discussion of the impact of his or her behavior on:**

(1) **Applicable victims.**

(2) **Family members, including children.**

(3) **Friends or significant others.**

(4) **The community.**

(5) **The person served.**

b. **Goals that address the responsibility of the person served to engage in activities that help to restore or repair damage done to individuals or the larger community when he or she committed criminal acts.**

4.D. 9. When a criminal justice program provides behavioral health services in a prison or jail setting, it provides or advocates for access to a full range of services based on the person's:

a. **Strengths.**

b. **Needs, including risk of:**

(1) **Recidivism.**

(2) **Relapse.**

c. **Preferences.**

Intent Statements

The intent of this standard is to ensure access to treatment-related services for individuals incarcerated in correctional settings. The services used will depend on the needs and preferences of the persons served.

Examples

The services could include:

- Screening and assessment.
- Crisis intervention.
- Case management, including referral to other services needed.
- Crisis stabilization.
- Outpatient treatment.
- Day treatment.
- Medication management.
- Inpatient and/or residential treatment.
- Aftercare.

4.D. 10. When the program provides behavioral health services in a prison or jail setting, the transition plan refers the person served for:

a. **Reentry services within the other correctional systems when appropriate.**

b. **Identified continuing care in the community in which he or she will reside when released from custody.**

c. **In-prison continuing care or aftercare maintenance services, when available.**

Examples

10.b. Continuing care may include connecting the person served with ongoing treatment services, as needed, or support groups (such as AA/NA) to assist with successful transition. Following treatment in a therapeutic community provided in a correctional facility, transition to a community-based therapeutic community is the treatment of choice, when available.

4.D. **11.** Predischarge transition plans are:

 a. Developed:

  (1) With the active involvement of the person served.

  (2) Cooperatively by treatment program and correctional institution staff.

 b. Based on a comprehensive needs and risk assessment.

 c. Written at least 30 days prior to discharge.

 d. When applicable, effectively communicated to continuing care providers.

4.D. **12.** The predischarge plan addresses:

 a. The personal restoration plan of the person served.

 b. A transition that offers continuity of care.

 c. Transition for the person served to a level of care congruent with his or her:

  (1) Current treatment program.

  (2) Specific needs, including:

   (a) Level of criminality/threat to the safety of the larger community.

   (b) Risk of relapse/recidivism.

  (3) Available resources.

 d. Continuation of needed treatment upon discharge.

 e. Expectations regarding ongoing legal requirements.

Applicable Standards

If an organization has a criminal justice educational component in its program, Standards 13.–14. also apply.

4.D. **13.** The curriculum-based program component for each person served:

 a. Addresses issues specific to his or her individual needs.

 b. Is consistent with his or her cognitive and learning abilities.

 c. Is consistent with the program's philosophy of treatment.

 d. Includes provisions for:

  (1) Evaluation.

  (2) Group instruction.

  (3) Individual instruction.

 e. Meets applicable federal, provincial, and state requirements.

Intent Statements

13.b. The intent of this standard is to ensure that the assessment has included cognitive, behavioral, and learning abilities and that reading materials, assignments, and the requirements for participation take into consideration the learning abilities and styles of the person served. This standard includes ensuring that reasonable accommodations are available for persons with special educational needs.

13.c. Because many of the criminal justice educational services are provided as part of or within a treatment program, this standard encourages the organization to ensure that the educational plan for each person served is consistent with the philosophy of the treatment program.

Examples

Based on the needs of the persons served and the resources available, the organization is encouraged to include the following topics in its educational programs:

- Substance abuse treatment, relapse prevention, and recovery.
- Physical health issues or consequences and communicable diseases.
- Community resources and community integration.
- The possible relationship between substance abuse and/or mental illness and criminal behavior.
- Violence prevention.

- Family reunification.
- Parenting skills, when applicable.
- Culture-specific issues.
- Interpersonal and relationship skills.
- Communication skills.
- Life-skills training.
- Job readiness.
- Problem solving.
- Conflict resolution.
- Anger management.

4.D. **14. Based on the needs of the person served, the educational program addresses the development of:**
   a. **Community living skills.**
   b. **Social skills.**
   c. **Social supports.**
   d. **Vocational skills.**

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Written assessments for each person served
- Written individual person-centered plans
- Written service agreements
- Transition or discharge plans
- Curriculum for or records of staff training
- Educational plans for the person served

E.   Juvenile Justice (JJ)

Description

Juvenile justice programs serve special populations comprised of accused or adjudicated juveniles referred from within the juvenile justice system who are experiencing behavioral health needs including alcohol or other drug abuse or addiction or psychiatric disabilities or disorders. Services can be provided through courts, through probation and parole agencies, or in community-based or institutional settings. Institutional settings may include juvenile detention centers, jails, prisons, or other delinquency-focused settings. The services are designed to maximize the person's ability to function effectively in the community. The juvenile justice mandates include community safety needs in all judicial decisions and require that behavioral health programs are aware of the safety requirements of not only the individual, program staff members, and peers, but also the community at large.

Juvenile justice educational programs may include either community-based or institution-based educational and training services. Such programs may include personal and interpersonal skills training, conflict resolution, anger management, DUI/OWI education, mental health education, education about alcohol and other drugs, information on criminal thinking patterns, or traditional academic education.

Applicable Standards

If a behavioral health core program for which the organization is seeking accreditation is primarily provided in a correctional facility, the Juvenile Justice standards must be applied.

Organizations seeking accreditation in Juvenile Justice must apply the standards in Sections 1 and 2 and one or more of the service-specific core programs in Section 3 as well as these standards. For example, a juvenile justice program providing treatment through a therapeutic community model would apply the standards in Sections 1 and 2 as well as 3.Z. Therapeutic Communities (TC) and 4.E. Juvenile Justice (JJ).

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4.E. **1.** **Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, juvenile justice behavioral health services.**

Intent Statements

In addition to Standard 2.A.20. related to the team providing services, this standard provides more specific guidance as to the competencies of team members providing services in a juvenile justice setting who are directly involved in the participatory process of defining, refining, and assisting a person served in meeting his or her goals.

4.E. **2.** **All members of the team:**
   a. **Have access to the confidential information that is required for the team members to perform their function.**
   b. **Are bound by applicable state, federal, and provincial confidentiality laws.**

Intent Statements

2.a. Access to clinical records can include access to information such as:
- Person-centered plans.
- Custody records.

4.E. **3.** **The person served is provided with a description of the relationship between the juvenile justice entity and the program, including:**
   a. **The extent and limitations of confidentiality and sanctions.**
   b. **The possible implications of having a juvenile justice member on the team.**

Intent Statements

The team involves a blend of behavioral health providers and juvenile justice personnel, such as detention officers, control agents, guards, and probation and parole officers. Those individuals who play a significant role in the treatment, education, and incarceration of the person served work cooperatively and collaboratively as a team.

The person served has the option of refusing to have the juvenile justice system actively involved in the treatment process.

Examples

3.b. The staff members of the program might discuss such issues as:
- Access to confidential records.
- Action the juvenile justice member may be forced to take based on information provided by the team.
- The impact on the therapeutic relationship.

4.E. **4.** **Training:**
   a. **Is provided to personnel prior to the delivery of services.**
   b. **Includes regular interdisciplinary cross-training related to clinical and juvenile justice issues.**
   c. **Includes such topics as:**
      (1) **The requirements imposed on personnel from the juvenile justice system who participate on the treatment team.**
      (2) **Safeguards that are available to workers.**
      (3) **Safety practices specific to the setting.**

Intent Statements

4.a. Behavioral health professionals who work in juvenile justice settings encounter a unique service delivery system with both opportunities and challenges. The intent of this standard is to ensure that individuals new to this type of setting receive full and complete training prior to the delivery of services, and throughout their employment, to ensure that they are familiar with the unique procedures and characteristics of the environment in which they work.

4.b. *Interdisciplinary cross-training* refers to juvenile justice staff members providing juvenile justice training to clinical staff members and also to clinical staff members providing clinical training to juvenile justice staff members.

4.E. 5. The juvenile justice program conducts a timely assessment for each person served that includes:

a. A detailed history of the person's criminal behavior, including:

(1) **Arrests.**

(2) **Convictions.**

(3) **Violations of parole and/or probation.**

(4) **Prior incarcerations.**

(5) **Pending cases.**

b. Information on the person's participation in organizations or groups that encourage criminal behavior.

c. The relationship between the person's behavioral health and his or her criminal activity.

d. Risk to self, other persons served, personnel, and/or community.

Intent Statements

In conducting an assessment in a juvenile justice setting, a program emphasizes the collection of information related to delinquent or criminal behavior.

4.E. 6. Assessments include information on each juvenile's:

a. Developmental history, such as developmental age factors, motor development, and functioning.

b. Medical or physical health history.

c. Culture.

d. Treatment history.

e. School history.

f. Language functioning, including:

(1) **Speech functioning.**

(2) **Hearing functioning.**

g. Visual functioning.

h. Immunization record.

i. Learning ability.

j. Intellectual functioning.

k. Family relationships.

l. Interactions with peers.

m. Environmental surroundings.

n. Prenatal exposure to alcohol, tobacco, or other drugs.

o. History of use of alcohol, tobacco, or other drugs.

p. Parental/guardian custodial status.

q. Ability/willingness of parent(s)/ guardian to participate in services.

Intent Statements

In short-term programs (such as Assessment and Referral, Crisis Intervention, Crisis Stabilization, or Detoxification), the amount of information collected may be limited by time or the condition of the person served. The intent of the standard is to collect an adequate amount of information to provide appropriate and safe services.

6.h. The assessment includes a determination of the status of the juvenile's immunization. A copy of the immunization record is not required. Organizations can note when juveniles are enrolled in school settings where verification of immunization is legally required.

4.E. 7. The assessments are appropriate with respect to the juvenile's:

a. Age.

b. Development.

c. Culture.

d. Education.

4.E. 8. When applicable and/or permitted, family members and/or significant others are:

a. Identified.

b. Located.

c. Engaged in services.

4.E. 9. When a juvenile justice program provides behavioral health services in a correctional setting, it provides or advocates for access to a full range of services based on the person's:

a. Needs.

b. Preferences.

Intent Statements

The intent of this standard is to ensure access to treatment-related services for individuals placed in detention or other correctional settings. The services used will depend on the needs and preferences of the persons served.

Examples

The services could include:

■ Screening and assessment.

■ Crisis intervention.

■ Case management, including referral to other services needed.

■ Crisis stabilization.

■ Outpatient treatment.

■ Medication management.

■ Inpatient and/or residential treatment.

■ Aftercare.

4.E. 10. **When the program provides behavioral health services in a correctional setting, the transition plan refers the person served for:**

   a. Transitional services within the other juvenile justice systems when appropriate.

   b. Continuing care in the community in which he or she will reside when released from custody.

4.E. 11. **Predischarge transition plans are:**

   a. Developed:

      (1) With the active involvement of the person served.

      (2) Cooperatively by treatment program and correctional institution staff.

   b. Based on a comprehensive needs assessment.

   c. Written at least 30 days prior to discharge.

4.E. 12. **Based on the needs of each child or adolescent, or as required by law, an educational specialist is a member of the team.**

Intent Statements

The educational specialist can be available when needed and is not required to attend all team meetings. Please refer to Standard 2.A.20. for the functions of the team.

4.E. 13. **When the services disrupt the juvenile's day-to-day educational environment, the program provides or makes arrangements for the continuity of his or her education.**

Examples

Arrangements could include:

■ Use of a facility-based school.

■ Use of a private school at the organization.

■ Use of on-site educators from a local school system.

■ Coordination with home school services.

■ Coordination and monitoring of assignments.

■ Coordination with the community school to facilitate reintegration.

4.E. 14. **The curriculum-based program component for each person served:**

   a. Addresses issues specific to his or her individual needs.

   b. Is consistent with his or her cognitive and learning abilities.

   c. Is consistent with the program's philosophy of treatment.

   d. Includes provisions for:

      (1) Evaluation.

      (2) Group instruction.

      (3) Individual instruction.

   e. Meets applicable federal, provincial, and state requirements.

Intent Statements

14.b. The intent of this standard is to ensure that the assessment has included cognitive and learning abilities and that reading materials,

assignments, and the requirements for participation take into consideration the learning abilities of the person served. This standard includes ensuring that reasonable accommodations are available for persons with special educational needs.

14.c. Because many of the juvenile justice educational services are provided as part of or within a treatment program, this standard encourages the organization to ensure that the educational plan for each person served is consistent with the philosophy of the treatment program.

Examples

The organization is encouraged to include the following topics in its educational programs:

- Substance abuse treatment, relapse prevention, and recovery.
- Physical health issues or consequences and communicable diseases.
- Community resources and community integration.
- Violence prevention.
- Culture-specific issues.
- Interpersonal and relationship skills.
- Life-skills training.
- Problem solving.
- Conflict or anger management.

4.E. **15.** **Based on the needs of the person served, the educational program addresses the development of:**
   a. **Community living skills.**
   b. **Social skills.**
   c. **Social supports.**
   d. **Vocational skills.**

4.E. **16.** **For residential services provided in congregate facilities or sites that are owned, rented, or leased by the organization, staff support is available on site 24 hours a day, 7 days a week.**

Intent Statements

Staff members are in the facility around the clock and are able to respond to emergencies quickly.

In detention or correctional settings, staff support may be provided by an organization other than the one providing the behavioral health services.

4.E. **17.** **If residential services are provided, the program provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:**
   a. **Family members and/or significant others.**
   b. **Peers.**
   c. **Others.**

4.E. **18.** **The environment is configured to meet the needs of juveniles, including:**
   a. **The physical plant.**
   b. **The furniture.**
   c. **The equipment.**

Examples

Considerations include the provision of:

- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and video equipment.

4.E. **19.** **The organization implements a policy(ies) and procedures for:**
   a. **Obtaining criminal background checks on all persons providing direct services to juveniles.**
   b. **Acting on the results of the background checks.**

Intent Statements

Background checks may include fingerprinting and FBI criminal history checks. Persons providing direct services include personnel, students, interns, volunteers, or contracted providers of direct service. The provision of direct services includes transportation.

Examples

Background checks may be conducted prior to employment for new personnel, at the time of job change when beginning to work with

children or adolescents, or prior to an accreditation survey for existing personnel.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Curriculum for or records of staff training
- Written service agreements
- Transition or discharge plans
- Person-centered plans
- Educational plans for the person served
- Assessments of the children or adolescents served
- Filed, current information on law pertaining to educational specialists and educational services
- Staffing pattern chart for residential, or 24/7 programs
- Policies related to background checks on all personnel

F. Medically Complex (MC)

Description

Medically complex standards are applied to programs that serve a specific population of persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to his or her health status.

These standards consider the individual's overall medical condition, including acuity, stability, impairments, activity limitations, participation restrictions, psychological status, behavioral status, placement, and long-term outcomes expectations. Appropriate medical consultation occurs specific to each person served in addition to medical consultation related to policies and procedures.

Services to persons with medically complex conditions can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. The services within the program are designed based on the needs, desires, and expectations of the persons served and their legal guardian/caregivers to maximize the ability to function effectively within their family (or placement), school, and/or community environments and to achieve and maintain an optimal state of health to enhance their quality of life. The services provided also consider any culturally specific issues relevant

to the individual and his or her family/caregivers as appropriate. The service plan supports all transitions in the person's life and is changed as necessary to meet his or her identified needs as well as the needs of the family/caregivers.

Some examples of the quality results desired by the different stakeholders of these services include:

- Development of an effective and efficient network of community support services including access to therapies, medical supports, and guidance.

- Satisfying and meaningful relationships.

- Achievement of goals in health, education, and activities of daily living.

- Being able to choose and pursue meaningful activities in the least restrictive environment possible to achieve personal satisfaction in life activities.

- Maintenance of health and well-being.

- Restored or improved functioning.

- Enhanced quality of life.

- Personal and family development.

- Transitions between levels of care or transition to independence.

- End-of-life services and supports for the person, his or her family/caregiver, legal guardian, and/or other significant persons in the individual's life to assist with meaningful closures.

Applicable Standards

If a core program for which the organization is seeking accreditation is designed primarily to serve persons who meet the definition of medically complex, or the program serves only this target population, the medically complex standards must be applied in addition to the standards in Sections 1 and 2 and one or more service-specific core program standards in Section 3.

Organizations

NOTE: *An organization seeking accreditation for a core program for children/adolescents who meet the definition of medically complex (MCCA) must apply the standards in Sections 4.B. and 4.F.*

4.F. **1. The program description of services available for this population includes the following, as applicable:**
   a. **Medical acuity issues.**
   b. **Medical stability issues.**
   c. **Psychological issues.**
   d. **Behavioral issues.**
   e. **Activity limitations.**
   f. **Participation restrictions.**
   g. **Long-term planning criteria.**
   h. **Intended discharge environments.**
   i. **Environmental modifications.**
   j. **Adaptive equipment.**
   k. **Respite.**

Intent Statements

1.a. Medical acuity issues refers to the services that are considered urgent and require immediate attention.

1.b. Medical stability issues refers to the overall medical condition of the person served at a given point in time.

4.F. **2. The program collaborates with:**
   a. **Healthcare providers who provide specialized medical, psychological/ behavioral, and other therapeutic care to the person served.**
   b. **Other providers who provide specialized care to the person served.**

Examples

2.b. Other providers may include child care, recreation, and education.

4.F. **3. Services are managed by an individual who has:**
   a. **The education, training, and experience needed to meet the needs of persons with medically complex needs.**
   b. **The competencies needed to manage the services.**

Intent Statements

The program identifies the background and competencies required based on the scope of services provided.

Examples

Based on the services provided, the individual's education, training, and experience may be in areas such as healthcare or nursing, health advocacy, health aspects of disabilities, health problems commonly co-occurring with developmental or medical disabilities, palliative care, or medication management.

Job descriptions identify qualifications needed and ensure compliance with applicable guidelines and legal requirements. Applicable laws and national/professional organizations may be excellent resources for establishing qualifications.

4.F. **4.** **The program informs the primary care physician(s) of the progress of each person served toward his or her individual goals regarding:**
   a. **Assessments.**
   b. **Significant changes.**
   c. **Discharge/transition.**

Intent Statements

Communication with primary care physicians is critical when providing services to persons with medically complex needs, especially when the primary care physician is not directly involved with the services provided.

The physician(s) to be notified are identified by the person served and/or by a residential facility.

Examples

4.b. Examples of significant changes in the status of the person served include an acute illness that precipitates transfer to another level of care, a fall that results in significant injury, or death.

4.F. **5.** **The service delivery team includes specialists, as appropriate.**

Intent Statements

In addition to the primary care physician, there may be an array of other professionals or specialists that would be included on the service delivery team.

Examples

The survey team will look for conformance to this standard through review of records (documentation of input into team decisions, attendance at team meetings, and phone conversations) and interviews with persons served, families, personnel, and payers.

Team member involvement can be accomplished by a variety of methods such as conference calls; sharing information via fax, messenger, or mail; and ongoing conversations between team members.

Additional individuals on the service delivery team could include:

- An audiologist.
- A behavior analyst. (A behavior analyst is a psychologist in the distinct specialty of applied behavior analysis. A behavior analyst conducts functional assessments and analyses of behavior and its environmental influences. This individual designs and implements programs using the principles of learning and motivation to effect the acquisition of desired instrumental and social behaviors.)
- A case manager/care coordinator, internal or external.
- A spiritual advisor.
- A child life specialist. (A child life specialist has competence in the areas of growth and development, family dynamics, play and activities, interpersonal communication, developmental observation and assessment, the learning process, the group process, behavior management, the reactions of children to hospitalization and to illness, interventions to prevent emotional trauma, collaboration with other healthcare professionals, a basic understanding of child/youth illnesses and medical terminology, and supervisory skills.)
- A child psychologist.
- A creative arts therapist. (Includes music therapists, art therapists, dance therapists, drama therapists, and poetry therapists.)
- A developmental specialist. (An individual who is competent in child/youth development and could include, but is not limited to, a

pediatrician, child psychologist, social worker, special educator, or child life specialist.)

- A driving instructor.
- An educational specialist. (A special or regular education teacher.)
- A neuropsychologist.
- An occupational therapist.
- An orthotist.
- A pediatric nurse practitioner.
- A pediatric physiatrist.
- A pharmacist.
- A physical therapist.
- A physiotherapist/physical therapist.
- A primary care physician.
- A physician extender (assistant).
- A prosthetist.
- A qualified alcoholism and other drug abuse counselor. (An individual with experience and training in the treatment of alcoholism and other drug abuse.)
- A registered dietitian.
- A registered nurse. (May include a registered nurse with rehabilitation experience.)
- A rehabilitation engineer.
- A rehabilitation nurse.
- A rehabilitation physician.
- A respiratory therapist.
- A school guidance counselor.
- A social worker.
- A speech-language pathologist.
- A therapeutic recreation specialist.
- A vocational specialist.

4.F. **6. Personnel demonstrate competencies in the following areas:**
   a. **Developmental stages.**
   b. **Physical impairments.**
   c. **Behavioral needs.**
   d. **Day-to-day needs.**
   e. **Grief and end-of-life support concerns.**

Examples

6.d. May include nutritional needs or medication administration.

4.F. **7. The program promotes a positive, therapeutic approach to behavior management, as applicable, that addresses:**
   a. **Instruction and guidance to the person regarding desired behaviors that:**
      (1) **Build on current strengths.**
      (2) **Promote resiliency.**
   b. **Environmental factors to enhance the desired behaviors of the person.**
   c. **Environmental modifications.**
   d. **Use of medications.**

Examples

7.c. Environmental modifications might include the use of noise-reduction materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and doorbells; limiting or controlling where and when people may visit persons served; reducing noxious stimuli such as bright sunlight or odors; and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

4.F. **8. As appropriate to the scope of the program, end-of-life planning:**
   a. **Is directed by the wishes/desires of the person served and/or legal guardian.**
   b. **Includes advocacy of hospice, palliative care, or other end-of-life choices as needed.**
   c. **Includes spiritual or religious elements, if desired by the person served and/or legal guardian.**
   d. **Includes the guidance of a medical professional, if desired by the person served and/or legal guardian.**
   e. **Is communicated to applicable service providers in the required format, if applicable.**

Intent Statements

Persons served, families/support systems, and personnel have opportunities to talk about end-of-life issues and participate in planning the memorial service and creating end-of-life protocols.

Examples

Families/support systems should be involved in the development of advance directives and in identifying the extent to which medical intervention is to be administered.

Whenever possible, no one dies alone. Support and presence are planned for each individual served so that he or she does not die alone.

The person served and his or her family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do-not-resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to an individual's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or family/support systems.

Some organizations do not choose to have a memorial service, but they may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

4.F. **9.** **The program has a written philosophy of health and wellness for the persons served that:**
   a. **Is designed to:**
      (1) **Meet their interests.**
      (2) **Align with their cognitive capabilities.**
      (3) **Reflect their choices.**
      (4) **Promote their personal growth.**

(5) **Enhance their self-image.**
(6) **Improve or maintain their functional levels whenever possible.**
   b. **Is implemented to:**
      (1) **Address:**
         (a) **Function.**
         (b) **Quality of life.**
      (2) **Promote healthy aging and well-being.**
   c. **Addresses aging in place.**
   d. **Is shared with:**
      (1) **The persons served.**
      (2) **Families/support systems.**
      (3) **Personnel.**

Examples

A program's philosophy may be documented separately or included in other documents such as a program plan or marketing materials. An emphasis might be placed on:

- Maximizing or maintaining independence of persons served.

- How changing acuity needs will be addressed.

9.b.(1)(a)–(b) A program's philosophy addresses how it intends to provide services that promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the persons served.

4.F. **10.** **The primary assessment for each person served in the program includes the identification of:**
   a. **Presenting health risks.**
   b. **Health goals.**
   c. **Expected health benefits.**

4.F. **11.** **Based on the initial and ongoing assessments, the person-centered plan of care addresses needs in the following areas, as appropriate:**
   a. **Adjustment of the person to activity limitations.**
   b. **Adjustment of the family to activity limitations.**

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c. Advance directives.

d. Assistive technology.

e. Bereavement.

f. Communication.

g. Community reintegration.

h. Environmental modifications.

i. Growth and development.

j. Sexuality.

k. Wellness.

Examples

11.c. Advance directives may relate to organ donation and orders not to resuscitate. Considerations include religion, legal parameters, how orders should be documented, and who is responsible for making a DNR decision.

4.F. **12.** The person-centered plan of care:

a. Specifically addresses how services will be provided in a manner that ensures the safety of the person served.

b. Identifies the services provided by skilled healthcare providers.

4.F. **13.** Wellness for the person served is promoted through activities that:

a. Are purposeful.

b. Include daily:

(1) Structured activities.

(2) Unstructured activities.

c. Are designed to:

(1) Meet their interests.

(2) Align with their cognitive capabilities.

(3) Reflect their choices.

(4) Promote their personal growth.

(5) Enhance their self-image.

(6) Improve or maintain their functional levels whenever possible.

d. Allow for group interaction.

e. Allow for autonomy, as applicable.

f. Include opportunities for community integration.

g. Are evident in the person-centered plan for each person served.

4.F. **14.** The environment where services are provided addresses the behavioral and cognitive needs of the person served in terms of:

a. Agitation.

b. Cueing.

c. Distractibility.

d. Elopement risks.

e. Equipment safety.

f. Level of responsiveness.

g. Orientation.

h. Physical safety.

i. Physically aggressive behaviors.

j. Self-injurious behaviors.

k. Sexual behaviors.

4.F. **15.** The environment where services are provided supports:

a. Wellness activities.

b. Initiation of the wellness/health services.

c. Transition from the wellness/health services.

Intent Statements

The environment where services are provided includes adequate resources, materials, and space to allow for health and wellness activities. The program identifies how persons served are included or removed from those activities.

4.F. **16.** When applicable, the living environment provided for the person served is:

a. Developed based on input from the person served and family/guardian.

b. Modified as needed based on input from the person served and family/guardian.

c. Inclusive.

d. Integrated into the community.

e. Physically supportive to meet the needs of the persons living in the residence.

f. Psychologically supportive to meet the:

(1) Emotional needs of the person served.

(2) Social needs of the person served.

4.F. **17.** When applicable, individual possessions and decorations reflecting the choices by the person served are evident in his or her living environment.

4.F. **18.** As appropriate based on scheduling, the program provides:

a. Daily access to at least three nutritious meals (or equivalent per doctor/dietician) or enteral feedings in a program that provides 24-hour care.

b. Access to snacks consistent with personal choice and timing, unless contraindicated by the person-centered plan or medical condition.

4.F. **19.** The education and training program for the person served:

a. Is:

(1) Developmentally appropriate.

(2) Age appropriate.

b. Includes:

(1) Knowledge of:

(a) Ability.

(b) Activity.

(c) Participation.

(2) Ability to describe and discuss any activity limitations in an age-appropriate fashion.

(3) Conflict resolution.

(4) Negotiation skills.

(5) Assertiveness training.

(6) Advocacy training.

(7) Preparation for adolescence/adulthood.

(8) Outcomes of decisions.

4.F. **20.** When a person served dies, opportunities are provided to other persons in the program, family/support systems, and personnel to:

a. Express grief and remembrance.

b. Develop and participate in:

(1) Memorial services.

(2) Memorial rituals.

(3) Other forms of grief expression, as desired.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Written program description of services

■ Documentation of end-of-life planning, as appropriate

■ Written philosophy of health and wellness for the persons served

■ Assessments for the persons served

■ Written individual person-centered plans

G. Eating Disorders (ED)

Description

Standards for residential and inpatient eating disorder programs apply to programs that offer treatment to patients 24 hours per day, 7 days per week, under the supervision of a licensed health-care professional who has access to a licensed physician. Patients served in these facilities have been diagnosed with eating disorders according to the current DSM and ICD-9, including Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified. Symptom management and interruption requires an intensity of service delivery that is beyond an outpatient and partial hospitalization level of care.

The standards consider the individual's bio-psychosocial needs and strengths as well as the needs and strengths of family members. Services maximize the person's ability to function effectively within their family, school, and community environment and to achieve and maintain an optimal state of health to enhance their quality of life. Services provided also consider any culturally specific issues relevant to the individual and his or her family/caregivers as appropriate. Services to persons with eating disorders can be provided in a variety of settings and are not necessarily exclusive programs that serve only this particular population. However, programs serving persons with eating disorders within larger general medical or psychiatric units, similar to exclusive programs, must demonstrate programming that is specialty- and evidence-based and demonstrate that staff are specialty-trained and competent to provide eating disorder inpatient or residential treatment. Exclusive programs and programs within larger general psychiatric or medical units must also demonstrate that services are designed based on the needs and expectations of the persons served and their legal guardians/caregivers. For example, they can be informed by the World Wide Charter on Action for Eating Disorders (**www.aedweb.org/source/ charter/documents/WWCharter4.pdf**). The

charter describes the following rights of persons with eating disorders and carers:

- Right to communication and partnership with healthcare professionals
- Right to comprehensive assessment and treatment planning
- Right to accessible, high-quality, fully funded specialized care
- Right to respectful, fully informed, age-appropriate, safe levels of care
- Right of carer(s) to be informed, valued, and respected as a treatment resource
- Right of carer(s) to accessible, appropriate support and education resources

Some examples of the quality results desired by different stakeholders of these services include:

- Replacing the person's connection with the eating disorder with satisfying, supportive and meaningful relationships and the use of healthy coping strategies.
- Effective transitions between levels of care or transition to community living.
- Development of an effective and efficient network of community support services including access to therapies, medical supports, and other school, work, and community-based resources.
- Achievement of goals in health, education, work, and activities of daily living.
- Personal and family development.
- Maintenance of recovery and improved functioning.

The eating disorders residential and inpatient treatment program standards were developed using the Clinical Practice Recommendations for Residential and Inpatient Eating Disorder Programs created by the Academy for Eating Disorders Credentialing Task Force, which can be found at **www.aedweb.org/ AED_Inpatient_Standards.htm**. The Task Force is a collaboration of the Academy for Eating Disorders, the National Eating Disorders Association, and the International Association of Eating Disorder Professionals. The AED Credentialing Task Force established these recommendations to inform standards

development for residential and inpatient eating disorder program accreditation to: (a) safeguard patients and families who seek eating disorder residential and inpatient treatment; (b) review and improve the quality of care offered by residential and inpatient treatment programs; and (c) provide a quality of care benchmark for third party payers to consider as they collaborate with health care providers in the development of comprehensive models of care and its reimbursement. Many aspects of the Task Force recommendations are embraced in the CARF ASPIRE to Excellence and Behavioral Health General and Specific Program standards. The following specific population designation standards identify additional guidelines deemed important by the Task Force to help create a foundation for quality services. Eating disorder treatment programs seeking CARF accreditation are encouraged to use both the CARF standards and the Clinical Practice Recommendations for Residential and Inpatient Eating Disorders Programs developed by the AED Credentialing Task Force.

Applicable Standards

Organizations seeking accreditation as an Eating Disorders program must apply the standards in Sections 1 and 2, the core program standards in either Inpatient Treatment (3.O.) or Residential Treatment (3.W.), and the standards in this section.

NOTE: *An organization seeking accreditation for an Eating Disorders program for Children/Adolescents (EDCA) must also apply the standards in Section 4.B.*

4.G. **1.** **Screening (an initial assessment) is conducted:**

  a. **Within 48 hours of initial contact.**

  b. **By an individual knowledgeable about eating disorder symptoms.**

  c. **And includes:**

  (1) **Evaluation of medical stability:**

    (a) **Provided by a medical clinician.**

    (b) **Including, but not limited to:**

      (i) **A physical examination.**

      (ii) **Necessary laboratory testing.**

      (iii) **EKG.**

  (2) **Mental health screening using the DSM or ICD classification of Mental Disorders.**

  (3) **Past and current treatment, including current provider contact information, when applicable.**

  (4) **Nutritional screening that includes:**

    (a) **Eating disorder behaviors.**

    (b) **Nutritional status.**

  (5) **Special needs, including, but not limited to:**

    (a) **Physical challenges.**

    (b) **Language barriers.**

    (c) **Communicable disease requiring isolation.**

  (6) **Assessment of impact of illness on patient and family in relation to:**

    (a) **Role impairment.**

    (b) **Quality of life.**

    (c) **Burden of care.**

4.G. **2.** An initial assessment (admission process):

  a. Is completed within 72 hours.

  b. Includes:

   (1) A comprehensive medical assessment provided by a medical clinician.

   (2) A multi-axial diagnostic assessment.

   (3) A psychiatric evaluation.

   (4) A nutritional assessment.

   (5) Based on the needs of the person served, evaluations by professionals in the following areas:

    (a) Medical/nursing.

    (b) Psychiatric.

    (c) Psychological.

    (d) Nutritional.

4.G. **3.** A comprehensive assessment is completed within seven days.

4.G. **4.** The person-centered plan:

  a. Is developed within the following timeframes:

   (1) An initial within 72 hours of admission.

   (2) A complete within seven days.

  b. Includes a diagnosis according to the current DSM and ICD-9.

  c. Is signed by the:

   (1) Person served or his or her legal representative.

   (2) Treatment team.

  d. Is reviewed by the treatment team at least every seven days.

4.G. **5.** The transition plan:

  a. Includes identification of the recommended level of care based on current risk assessment.

  b. Is provided to after-care providers:

   (1) With written consent of the person served.

   (2) Initially, either verbally or in writing, within 48 hours to:

    (a) The primary care provider of the person served.

    (b) Receiving mental health therapists or programs.

   (3) In written form within two weeks of discharge.

4.G. **6.** The provision of services includes:

  a. Care delivered by licensed professionals in each of the following four core areas:

   (1) Psychological.

   (2) Medical/nursing.

   (3) Nutritional.

   (4) Psychiatric.

  b. At a minimum, weekly delivery of the following core care components to each person served:

   (1) Individual therapy.

   (2) Group therapy.

   (3) Family therapy.

   (4) Medical monitoring.

   (5) Medication monitoring, as applicable.

   (6) Milieu therapy.

  c. Nutritional counseling provided by a registered dietician trained and experienced in eating disorders for the applicable age group.

  d. Services provided by staff with a minimum of six continuing education hours per year devoted to eating disorders.

Intent Statements

6.a. Care is delivered by persons knowledgeable or experienced in the area of working with persons with eating disorders.

Examples

Current evidence in eating disorder research supports the use of cognitive-behavioral treatment (CBT) and interpersonal therapy (IPT) for adults with bulimia nervosa, and family-based treatment for adolescents (under 19 years of age with less than three years duration of illness) with anorexia nervosa and bulimia nervosa, as well as the use of the principles of CBT and supportive clinical management (SCM) for adults.

6.b.(6) Milieu therapy includes day-to-day milieu management and support.

4.G. **7.** **The program implements nutritional practices that:**

   a. **Promote growth and development in the applicable age group(s) of the person served.**

   b. **Support regular and consistent weight gain (or loss, when applicable).**

   c. **Measure improvement in symptomatic eating behavior and/or urges.**

   d. **Include:**

      (1) **A physician to prescribe the diet.**

      (2) **A registered dietician to:**

         (a) **Provide the following:**

             (i) **Assessment.**

             (ii) **Education.**

             (iii) **Counseling.**

         (b) **Design, implement and manage safe and effective nutrition-related strategies to:**

             (i) **Enhance growth and development.**

             (ii) **Promote recovery from disordered eating.**

             (iii) **Reduce disturbances in body image.**

             (iv) **Promote lifelong health.**

Examples

7.b. Weight loss may be applicable when the person served has concurrent obesity.

7.c. May include restricting, binge eating, purging, etc.

4.G. **8.** **Based on the needs of the persons served, the program's outcome measures include the following:**

   a. **Regular and consistent weight gain (or loss, when applicable).**

   b. **Measurable improvement in symptomatic eating behavior and/or urges.**

   c. **Eating disorder diagnostic symptoms regarding preoccupation with:**

      (1) **Weight.**

      (2) **Shape.**

      (3) **Body image.**

   d. **Improvement as measured by the standardized eating disorder assessments chosen to record admission and discharge status.**

   e. **When possible, measurement of outcomes at twelve months post-discharge.**

Examples

8.b. Restricting, binging, purging.

8.d. Eating Disorder Examination Questionnaire (EDEQ)-6 and Eating Disorder Quality of Life. Programs are encouraged to routinely include additional measures of mood and other co-morbid symptoms, such as the Beck Depression Inventory, at admission and discharge.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Records of persons served

■ Screening forms or procedures

■ Assessment forms or procedures

■ Individual plans of persons served

■ Evidence of service provision by professionals with appropriate licenses/credentials

■ Nutritional guidelines and diets

■ Transition plans of persons served

■ Outcomes measures used

■ Procedures for gathering outcomes information

Section 5

Community and Employment Services Standards

A. Program/Service Structure

Description

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

5.A. **1.** Each program/service:
   a. Documents the following parameters regarding its scope of services:
      (1) Population(s) served.
      (2) Settings.
      (3) Hours of services.
      (4) Days of services.
      (5) Frequency of services.
      (6) Payer sources.
      (7) Fees.
      (8) Referral sources.
      (9) The specific services offered, including whether the services are provided directly or by referral.
   b. Shares information about the scope of services with:
      (1) The persons served.
      (2) Families/support systems, in accordance with the choices of the persons served.
      (3) Referral sources.
      (4) Payers and funding sources.
      (5) Other relevant stakeholders.
      (6) The general public.
   c. Reviews the scope of services at least annually and updates it as necessary.

Intent Statements

The scope is defined at the level of the program/service and provides the persons served, families/support systems, referral sources, payers, and other relevant stakeholders with information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.

Resources

1.b. Resources/links for creating printed materials in language that can be understood by persons served include:

- www.ric.org/cror/healthliteracy.aspx
- www.ahrq.gov/populations/sahlsatool.htm
- www.who.int/classifications/icf/training/icfbeginnersguide.pdf
- www.cpha.ca/en/portals/h-l/resources.aspx
- www.noslangues-ourlanguages.gc.ca/
- www.cpha.ca/uploads/portals/h-l/directory_e.pdf
- www.literacybc.ca/Info/clear_language.pdf
- www.nald.ca/litweb/other/other.htm
- www.literacy.ca/?q=literacy/clearwriting

5.A. **2.** The organization provides the resources needed to support the overall scope of each program/service.

Intent Statements

The ability to provide the program/services defined in the scope statement is evidenced by adequate materials, equipment, supplies, space, finances, training, and human resources.

5.A. 3. Based on the scope of each program/service provided, the organization documents its:

    a. Entry criteria.

    b. Transition criteria.

    c. Exit criteria.

Intent Statements

The organization determines which persons it is qualified and able to serve and identifies conditions/time/events for transition and/or exit. This includes transitions to other levels of care/services as well as transitions within a program/service. Transition criteria may also address continuing stay criteria.

5.A. 4. When a person served is found ineligible for services:

    a. The person served is informed as to the reasons.

    b. In accordance with the choice of the person served:

        (1) The family/support system is informed as to the reasons.

        (2) The referral source is informed as to the reasons.

    c. Recommendations are made for alternative services.

5.A. 5. Each program/service implements procedures that address unanticipated service modification, reduction, or exits/transitions precipitated by funding or other resource issues.

Intent Statements

The program/service demonstrates its knowledge of funding sources and their expectations and time frames for discontinuing or changing the program/service. While funding issues impact entry and exit decisions, the program/service consistently advocates for needs of the persons served.

5.A. 6. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.

Intent Statements

The service delivery model and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes.

5.A. 7. To facilitate integrated service delivery, each program/service implements communication mechanisms regarding the person served that:

    a. Address:

        (1) Emergent issues.

        (2) Ongoing issues.

        (3) Continuity of services, including:

            (a) Contingency planning.

            (b) Future planning.

        (4) Decisions concerning the person served.

    b. Ensure the exchange of information regarding the person-centered plan.

Intent Statements

This standard addresses the need for timely communication to ensure services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples

Communication and collaboration may occur in the program/service through written or oral communication, such as electronic formats, log books, face-to-face meetings, progress notes, specialized communication devices, facilitative communication, handheld devices and computers, videos, audio recordings, one-on-one teaching, etc.

5.A. **8. The organization's policies and procedures for acceptance into services identify:**

   a. **The process and order of acceptance when any person is awaiting service.**

   b. **The position or entity responsible for making acceptance decisions.**

Intent Statements

These policies and procedures reduce the possibility that subjective judgment will be used to determine if a service is applicable to a person's needs and desired outcomes. They ensure fair access to services for all applicants and referrals, in keeping with the organization's commitment to provide accessible services, as identified in Section 1.L. As appropriate, assistive technology is considered.

Examples

8.a. These policies may be established based on local referral policies and the mission of the organization.

Written materials in the person's primary language, pictures, large-print written materials, and videos are some of the ways to present information in an understandable manner.

5.A. **9. Information about the organization provided to the persons inquiring about services:**

   a. **Includes:**

      (1) **Its values and mission statement.**

      (2) **Expected results or outcomes of services.**

      (3) **Services availability, including possible wait time for services.**

      (4) **Options for persons served to direct their service design and delivery.**

      (5) **Organizational certifications, if any, and if applicable to services.**

   b. **Is provided in an understandable format.**

   c. **Is updated as necessary to reflect changes in information provided.**

Intent Statements

To be informed, make choices, and be involved, the persons served should be able to get accurate and current information about the organization's potential to deliver services relevant to their needs and desires.

Information is provided about the variety of service options available or support approaches to a service need and the volume of services an organization can support, which may be number of persons, geographical coverage, etc.

Examples

This standard is part of the organization's public information activity. This information may be provided by electronic means, printed brochures, checklists, handbooks, etc.

Organizations have the responsibility to respond to all requests from the public about their accredited services. This responsibility includes providing information defined by some of the CARF standards, information defined by the organization as important, and information in response to questions that may come from the public.

Further guidance can be found in Section 1.N. Standard 3., which encourages sharing useful performance information, and in Section 1.I. Standard 4., which supports current and knowledgeable staff.

5.A. **10. A complete record is maintained for each person served.**

Intent Statements

The organization determines what information should be kept in the records of the persons served. The record communicates information that is complete, clear, and current. Funders and referral agencies may require that certain information be maintained. The organization also complies with its own service delivery design for the development of the record. Electronic records are acceptable.

Examples

The record may include demographic data; names of personal representatives, such as parents, guardians, and advocates; intake information; initial orientation to services

and rights; referral reports; functional abilities; medical information, such as medications taken and name of physician (Standard 5.E.1.); Do Not Resuscitate (DNR) protocols; individual plans (Standards 5.B.3.–7.); release forms (Standard 5.A.11.); follow-up reports; exit summaries (Standard 5.B.10.); progress reports; and referrals to other resources (Standard 5.B.9.).

The organization may find it helpful to keep an orientation checklist in each person's record so that documentation can be made when items are shared with the individual, such as responsibilities (Standard 5.B.5.), setting goals and planning services (Standard 5.B.2.), and securing/retaining benefits (Standard 5.B.8.).

Working files can be used if security of files is maintained.

During a survey, surveyors will randomly select a representative sample of files for review from the different programs and sites.

5.A. **11. Any release of confidential information:**
   a. **Is authorized by the person served and/or his or her legal representative.**
   b. **Is limited to the specific information identified.**
   c. **Has a time limitation.**
   d. **Conforms to the guidelines of funders and/or referral sources.**
   e. **Conforms to applicable laws.**

Intent Statements

Guidelines are in place and followed regarding the sharing of any confidential information about a person served. The procedure complies with all legal regulations governing such release of information [Standard 1.K.2.e.(2)]. The time-limitation is specific and not open-ended.

Examples

The records contain signed releases that are specific to the information released and the duration of the release. This does not mean that there must be a separate release for every instance (every phone call, conversation, etc., to the same agency) in which information is released. One release per agency, person, etc., with a time limitation may be sufficient.

This standard does not relate solely to printed information released. The same level of confidentiality should also be observed with regard to verbal information and photographs or video of the person served.

A good resource is to "mirror" the guidelines of local funding and referral sources.

Employee orientation and training reinforce the meaning and importance of confidentiality and the organization's codes of ethical conduct reinforce it as well (Standard 1.A.6.a.).

5.A. **12. If behavioral change approaches are used, positive behavior interventions:**
   a. **Are implemented prior to the use of restrictive procedures.**
   b. **Continue to be used in conjunction with any restrictive procedures.**

Intent Statements

The organization demonstrates a commitment to a system that nurtures personal growth and dignity, and it supports the use of positive approaches and supports.

Examples

This commitment is emphasized during orientation and ongoing staff training. The organization's policies, procedures, and staff members deal with maladaptive or inappropriate behaviors without undue force that could lead to the injury of a person served. Even when a restrictive procedure is used when other approaches have not been successful, positive interventions constitute the main approach.

5.A. **13. Personnel are trained in the use of positive interventions:**
   a. **Initially.**
   b. **Annually.**

Intent Statements

The use of positive interventions is emphasized in policies and procedures and through regular provision of training.

Examples

In providing training on positive interventions, organizations also typically provide training to clarify and recognize actions that constitute

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restrictions on rights and any prohibited practices (such as the use of squirt bottles, use of noxious stimulants, splints, mitts, time out procedures, etc.)

5.A. **14.** **If restrictions are placed on the rights of a person served:**

   a. **The organization ensures that its policies are in compliance with funding guidelines and governmental regulations.**

   b. **The organization follows its policies and written procedures.**

   c. **Prior to implementation:**

      (1) **The organization obtains informed consent of the person served.**

      (2) **Staff members are trained in the use of restrictive procedures.**

   d. **The organization:**

      (1) **Implements methods to reinstate rights as soon as possible.**

      (2) **Monitors the effectiveness of these methods to reduce rights restrictions.**

Intent Statements

Policies and procedures are in place and staff is trained to ensure that informed consent is obtained prior to any restrictions and that rights are reinstated as soon as possible.

Examples

Legal guidelines are carefully followed regarding the use of rights restrictions.

Specific measurable objectives, methods, and techniques should be identified, as called for in Standard 5.B.5.b.(2)–(3). A good practice is for an organization to develop its own human rights committee involving community members outside the organization as a quality element. Agencies such as Protection and Advocacy may also perform this function.

When rights are restricted, informed consent of the persons served is evident.

The individual planning process and the procedures used reflect the integration of methods to remove restrictions on rights. A good practice is

for the organization to ensure that any restriction on a person's rights is subject to frequent and planned reviews by advocates. The method used should ensure that rights are reinstated as soon as possible in all cases.

5.A. **15.** **If any part of the services for which the organization is seeking accreditation is provided by another organization or person, these contracted services are:**

   a. **Provided under a written agreement.**

   b. **Monitored by the organization to ensure that performance effectively meets responsibilities as identified in the individual plans of the persons served.**

   c. **Evaluated at least annually:**

      (1) **For cost-effectiveness.**

      (2) **To ensure the health and safety of persons served.**

Intent Statements

This refers to contracted services related to persons served and not to clerical-type services. Contracted service provision is included in the survey only when it is part of a service for which the organization is seeking accreditation. Quality is maintained in the service whether provided directly or contracted.

Examples

The interpretation of *contracted services*, for purposes of this standard, must include some direct service relationship, such as when the organization shares personnel or direct service delivery with another agency or service provider. It implies a relationship that may include personnel, direct service efforts, sharing of facilities and resources, or sharing of case records/individual planning, etc., and is not just a financial contract for funding.

Written agreements detail responsibilities, applicable policies and procedures, etc. These annual evaluations allow the organization to review the continuing appropriateness and/or cost-effectiveness of the contracted services and to ensure that contractual requirements are followed. Regular review also helps to ensure the quality of the

services/supports which are being provided. See the Glossary for the definition of *regular*.

Contracts may be written to reference appropriate CARF standards.

5.A. 16. When services are provided to identified criminal offenders:

a. **Information is provided to the person served concerning the relationship between the criminal justice entity and the organization.**

b. **A detailed history of the person's criminal history is maintained, as required by state, provincial, and/or local government authorities.**

c. **Services are coordinated with other systems, as needed and/or required.**

Intent Statements

The organization follows the specific requirements it must meet in providing services to this population. This standard applies only to persons who are in an active relationship with a court system or other criminal justice entity.

Examples

Before providing such services, it is suggested an organization would check with governmental and legal authorities so it can establish procedures to ensure that it is in compliance with all regulations. The information provided to the person served is an important extension of informed consent and should be given before services begin.

5.A. 17. The organization has a policy that identifies whether or not it has any role related to medications that are used by the persons served in the programs seeking accreditation, including whether or not it directly provides:

a. **Prescribing.**

b. **Dispensing.**

c. **Administering.**

d. **Physical control of medications self-administered by the persons served.**

Intent Statements

If an organization's policy has identified a role related to medications used by persons served in the program seeking accreditation, Section 2.C. Medication Monitoring and Management, must be applied.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Documented scope of services for each program
- Records of the persons served
- Acceptance policies and procedures
- Entrance, transition, and exit criteria
- Policy for the order of acceptance
- Individual service plans
- Release-of-information forms
- Referral information
- Exit summary report
- Policies and written procedures regarding the use of positive interventions and limitations on use of restrictive procedures
- Documentation of staff training regarding the use of positive interventions and limitations on use of restrictive procedures
- Policy on whether the organization has any role related to medications in the program seeking accreditation (if Standard 5.A.17. is identified as applicable to the program)

B. Individual-Centered Service Planning, Design, and Delivery

Description

Improvement of the quality of an individual's services/supports requires a focus on the person and/or family served and their identified strengths, abilities, needs, and preferences. The organization's services are designed around the identified needs and desires of the persons served, are responsive to their expectations and desired outcomes from services, and are relevant to their maximum participation in the environments of their choice.

The person served participates in decision making, directing, and planning that affects his or her life. Efforts to include the person served in the direction or delivery of those services/supports are evident.

NOTE: *Throughout this section reference is to the person/persons served. Please refer to the Glossary definition of* person served *for understanding of when this might include other individuals acting on behalf of the primary consumer, such as family members.*

5.B.   **1.   Prior to the planning of services, information is gathered from a new person entering services about his or her desired outcomes from services.**

Intent Statements

Before actual planning of services, an informal discussion with persons about goals or outcomes they desire from services gives guidance to personnel regarding service planning. This standard does not require the use of a formal assessment document or instrument.

Examples

Information may be gathered from face-to-face meetings, telephone interviews, or by other technological means.

There may be instances where the information gathered indicates an immediate goal for which only minor assistance is needed and

that therefore does not require development of an individualized plan. Some examples of this would be:

■   The person wants assistance with developing a résumé for job seeking.

■   The person wants to be able to conduct job search on a computer and simply needs access or a basic orientation to doing so.

5.B.   **2.   The persons served are given information about:**
   a.   Their role in setting their individual service goals.
   b.   How planning the services/supports to be delivered is conducted.
   c.   Requirements for their continued participation in services.

Intent Statements

The result is that the persons served are knowledgeable about the individual service-planning process and their active role in or direction, if desired, of the process.

Examples

Services demonstrate a focus on the importance of input from the persons served throughout the planning process and the importance of their role in making decisions. The persons and/or families served participate in making decisions about their services including:

■   The expected results of the services for the individuals.

■   How the design of the services meets their identified needs.

■   How the services will be delivered.

■   The expected duration of the services, if applicable.

■   Possible alternatives for services within the organization and in the community.

■   How results will be evaluated.

■   Futures planning.

Surveyors will want to verify this by talking with persons served. Some questions may be asked of persons about satisfaction with their involvement in the process.

Information might be presented to persons in a handbook or video and also be included as an orientation item. As required by funding sources and for legal reasons, signed informed consent for services may be obtained and retained, but this is not required by CARF. Organizations are encouraged to check with local authorities regarding legal requirements to determine when signed informed consent is required. Staff members are familiar with and comply with informed consent procedures and requirements when this is required.

For example, in an employment program the person served is involved in making informed employment-related decisions, including the expected outcome for services and his or her role and responsibilities related to achieving desired employment outcomes. Informed choice is reflected in the individual planning process through full disclosure of the capabilities of the organization to meet the person's outcomes expectations, the person's needs, and the person's understanding of his/her responsibilities. Decision making based on informed choice may be reflected in:

■ The scope, duration, and expected outcomes of the employment services.

■ Employment choices, plans, and options, including:

  – Paid or unpaid work.

  – Work settings.

  – Career development and/or training activities.

  – Career advancement opportunities.

2.c. Requirements for continued participation in services at this point of orientation to services are likely generalized and not specific to individual plans, because these have not been developed yet. Examples of requirements or expectations for participation in services might be:

■ Regular attendance.

■ Punctuality.

■ Appropriate clothing for work or function.

■ Good personal hygiene.

5.B. 3. An individualized service plan is developed based on the person's:

  a. Strengths.

  b. Abilities.

  c. Preferences.

  d. Desired outcomes.

  e. Other issues, as identified by the person served.

Intent Statements

Plans are highly individualized, reflecting the diversity of the persons served.

Examples

When indicated through discussion with the person served that his or her desired outcomes of services are such that an individualized service plan is appropriate, plan development is begun.

The organization may use consumer self-assessments and/or person-centered planning as ways to obtain this information. Individual service plans may be under the authority of a referral agency. In these cases, the organization demonstrates how it accesses these plans and how it uses them to achieve individualized services and person-focused outcomes.

Staff notes and progress reviews indicate involvement of and direction by the person served. Objectives reflect the desires and dreams of the persons, within the mission and values of the organization, and are written using their language. A good practice is to write individual plans using "I" language and to quote the person in the plan.

3.e. Other issues to be considered in service planning may include, as identified by the specific individual, the person's cultural background, spiritual beliefs, and faith/religious background.

5.B. 4. As appropriate to the persons served and the services provided, the following information is considered for service planning:

  a. Relevant medical history.

  b. Relevant psychological information.

  c. Relevant social information.

d. **Available information on previous direct services and supports.**

e. **Other relevant assessments, when available.**

Intent Statements

In developing an individual service plan, all relevant information is considered.

Examples

This standard does not require that each person have a physical or psychological evaluation. The organization has a procedure in place to determine relevancy based on the individual's situation and services provided by the organization. The information may be obtained from a previous provider, a family member, or self-reported by an individual. The individual plans demonstrate that when relevant this information has been considered in the planning process.

It is critical to understand the person's skills, likes and dislikes, and desired outcomes. When those have been identified, it is helpful to understand the areas described above to ensure that there are no inherent conflicts with the services and outcomes desired by the individual.

See Standard 5.B.5., which relates to the individual's plan.

5.B. **5. A coordinated individualized service plan:**

a. **Is developed with the active involvement of the person served.**

b. **Identifies:**

   (1) **The person's overall goals.**

   (2) **Specific measurable objectives.**

   (3) **Methods/techniques to be used to achieve the objectives.**

   (4) **Those responsible for implementation.**

   (5) **How and when progress on objectives will be regularly reviewed.**

c. **Is communicated in a manner that is understandable:**

   (1) **To the person served.**

   (2) **To the persons responsible for implementing the plan.**

d. **Is reviewed on a regular basis with respect to expected outcomes.**

e. **Is revised as appropriate based on the:**

   (1) **Changing needs of the person served.**

   (2) **Satisfaction of the person served.**

f. **Reflects timely transition planning when a person served moves:**

   (1) **From one level of services/supports or program to another within the organization.**

   (2) **Externally to another provider.**

Intent Statements

The person served is an active participant giving direction in all aspects of the planning and revision processes.

Examples

Reasonable efforts and accommodations are made to obtain the active participation and understanding of the person served, including the inclusion of an advocate if the person prefers, or if it is necessary to interpret the person's desires. An organization may choose to include documentation in the plan of decisions made by the individual. The organization establishes a schedule for periodic review of the plan. The plan focuses on outcomes and results, and regular review is essential to ensure goals are achievable and remain meaningful to the person served.

Plans are essential for all members of the team to perform their functions and to ensure continuity of services/supports when new staff members are hired. The organization ensures that all persons involved understand the plans and their own involvement in achieving the outcomes.

Based on the scope of services, formalized service planning may be less in-depth and less individualized. For example, in a program that offers drop-in center services or senior centers, the plan may take the form of a more generic agreement such as a membership agreement, registration form, etc. Often these may be accredited as a Community Integration program.

Active participation of the persons served in setting goals and planning services may be

demonstrated through interviews, records, checklists, etc. Persons served understand what is written in their plans and can communicate what it means. A good practice an organization may follow is to provide copies of the service plan to the persons served and others who are responsible for implementing the plan, unless applicable laws or regulations prohibit doing so.

The individual plan can be the source for measuring individual outcomes satisfaction.

5.e.(2) The plan is revised to remain meaningful to the person served.

5.B. **6. When it has been determined that there is a need, the following are addressed in the plan:**
   a. **Assistive technology.**
   b. **Reasonable accommodations.**

Intent Statements

In developing an individual service or support plan, these needs are considered, as appropriate, to maximize potential for achievement of goals.

Examples

The organization may provide assistive technology, or it may be provided by referral to other local resources. Reasonable accommodations are addressed when necessary to enable the person served to participate in the organization's activities and fully access services. When appropriate to the person's needs, technology is addressed in the individual service plan. If a person needs services/supports that are not available from the organization, referrals to other services are suggested.

Accommodations and technology may entail the use of communication devices, videos and audiotapes, pictures, and materials in each person's primary language. Many modifications are simple and inexpensive.

Some performance indicators of quality are that the organization provides education to personnel on technology applications and incorporates knowledge and consideration of technology into assessment, evaluation, and training.

See the Glossary for the definitions of *Assistive technology* and *Reasonable accommodations.*

Resources

The Job Accommodation Network (JAN), a service of the President's Committee on Employment of People with Disabilities, provides information about workplace accommodations. JAN's trained consultants have access to a database of more than 200,000 previous accommodations to provide practical options. JAN can be reached at: 1 (800) ADA-WORK or via e-mail: **jan@jan.idci.wvu.edu**.

The website **www.mymdrc.org/assistive-tech/webinars.html** has numerous webinars available to assist providers and persons served with learning about various technology and devices.

A website identifying many Canadian resources available for accessibility is **www.hrsdc.gc.ca/en/lp/lo/lswe/we/related_links/persons_with_disabilities.shtml** and an Assistive Technology link is **www.apt.gc.ca**. The website **www.apt.gc.ca** also provides Assistive Technology links, including an Accessible Procurement Toolkit.

5.B. **7. When applicable to the person and his or her goals and outcomes:**
   a. **The person and/or family served and/or their legal representatives are involved in:**
      (1) **Assessing potential risks to each person's health in the community.**
      (2) **Assessing potential risks to each person's safety in the community.**
      (3) **Deciding whether to accept situations with inherent risks.**
      (4) **Identifying actions to be taken to minimize risks that have been identified.**
      (5) **Identifying individuals responsible for those actions.**
   b. **Risk assessment results are documented in the individual service plan.**

Intent Statements

When there are changes in the environment for the persons served and/or changes in a person's health or functioning, consideration in planning

should include an assessment of risks for the individual. Risks are considered to be exposure to a predictable event or environment that could result in serious physical or psychological injury to the individual. A proactive approach in planning that includes all relevant stakeholders can help to reduce the potential for adverse consequences.

Examples

In recognition of the changing lifestyles and choices of persons served and the wide variety of opportunities for community inclusion and access, this standard encourages the active participation of persons served to explore fully any risks inherent in their choices in terms of health, safety, lifestyle, sexuality, and so forth, in order that persons are better able to make informed choices.

The personal and professional opinions of staff members do not influence the information that is provided beyond what are known to be and what may possibly be expected benefits, risks, and responsibilities.

Examples of potential risks to a person's health might include a person who takes psychotropic medication being employed in a position that requires working in extreme temperatures or a person who takes seizure medications having to wait for public transportation in hot weather.

Examples of potential risks to a person's safety might include a person being placed in a supported apartment who does not know how to contact appropriate emergency personnel if needed, a person being placed in a job that requires him or her to wait for public transportation after dark, or a person who takes psychotropic medication being employed in a position that requires him or her to work with industrial machines.

These may include risk versus choice of different treatment modalities such as aquatherapy or hippotherapy and may take into account where services are provided, such as in a person's home, in the community, or at a center. Other examples of things to consider regarding risk versus choice are specific healthcare needs of the child, such as when a child uses a feeding tube or is susceptible to infections and how often the playground

equipment and toys are cleaned. After discussion of such issues with the parents and child, the parents' choice might be documented in some way, such as on an informed consent form.

When identifying actions to minimize risks, always include consideration of the person's existing support system.

As part of an organization's risk management, any health or safety risks identified during the planning process would be addressed to limit an individual's exposure to adverse consequences.

5.B. 8. The persons served are informed about resources to assist them in securing and retaining related benefits for which they are eligible.

Intent Statements

The staff members are knowledgeable about requirements for obtaining and retaining benefits, due process, and time frames, or are able to refer persons to authorities who are. The organization provides information directly or through referral about benefits and application procedures to the persons and/or families served.

Examples

Providing persons with this information enables them to make more informed decisions about how choices could impact their ability to retain current benefits or acquire different benefits.

Benefits may include, but are not limited to, Supplemental Security Income, Social Security Administration income, Social Security Disability Insurance, Labor and Industry benefits, employer insurance, unemployment insurance, food stamps, bus passes, public health services, energy assistance, child care assistance, housing assistance, and other governmental assistance program benefits.

5.B. 9. If a person served needs services/ supports that are not available through the organization, referrals to other providers or resources are suggested to the person served and/or referral source, as appropriate.

Intent Statements

The organization may not be able to provide all services/supports a person may want or need. If this is the case, the organization refers the person to other services outside the organization.

Examples

The organization maintains listings and demonstrates knowledge of agencies and organizations to which it can refer individuals, if so requested or needed. As a best practice, an organization would have a procedure in place to ensure that individuals are satisfied with the services/supports they receive elsewhere as a result of these referrals and that the agencies and organizations receiving its referrals are quality-driven, person-centered services.

Some organizations also provide persons served with a handbook, which lists other community resources that could be used by a person to enhance his or her quality of life.

5.B. **10. An exit summary report is prepared:**

   a. On a timely basis.
   b. For each person who leaves the organization's services.
   c. That summarizes results of services received.

Intent Statements

The exit summary report serves as a tool to facilitate continuity of services/supports.

NOTE: *An exit summary report is not required for persons who leave services due to death, unless this is relevant to the type of service provided.*

For persons who "drop out" of services or exit without notice, the summary indicates these circumstances and may be very brief.

Examples

The report typically summarizes the results of the services received by the person and makes recommendations for future services to continue the achievement of the person's life goals. The plan could suggest referrals to other services that are not available through the organization, as specified in Standard 5.B.9.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Handbook and information regarding responsibilities in services
- Orientation checklist, information, etc.
- Individual service plans
- Information demonstrating reasonable accommodations and assistive technology used, if applicable
- Documentation of advocacy training or curriculum
- Referral information
- Exit summary report

C. Community Services Principle Standards

5.C. **1. The organization assists persons served to enhance their quality of life:**

　　a. By providing opportunities to develop and/or increase, as desired:

　　　　(1) Social contacts.

　　　　(2) Personal relationships.

　　　　(3) Community networks.

　　　　(4) New supports.

　　b. By facilitating exposure to community experiences.

　　c. By achieving desired or greater participation in community activities.

Intent Statements

Persons served have access to assistance as desired to address issues in community participation. There should be opportunities for growth and development in the personal lives of those persons served.

Examples

Some examples of life skills related to this standard are interpersonal skills, which can include:

- Make new friends.
- Maintain old friendships.
- Act appropriately in response to how others are feeling.
- Express dissatisfaction when mistreated.

1.b. Persons served may have limited knowledge of community activities. By initial exposure to new and varied experiences, persons may identify new interests and activities for continued participation.

5.C. **2. Individualized service plans identify community inclusion activities, as desired by the person served.**

Intent Statements

The plan addresses objectives in accordance with expressed preferences or goals.

Examples

Identifying opportunities for community inclusion is a joint responsibility that is shared by the organization and the persons and/or families served. Overcoming identified barriers may be beyond the organization's service delivery capability, but may be addressed by referrals to other community agencies, organizations, and resources.

5.C. **3. The organization assists persons served to achieve desired participation in community activities by developing:**

　　a. Skills and behaviors that relate to the desired outcome.

　　b. Abilities and skills that empower the persons served.

5.C. **4. The organization:**

　　a. Considers the individual preferences of those served when selecting direct care staff.

　　b. Addresses the input of persons served on an ongoing basis.

Intent Statements

The agency and individual workers have the skills and competencies to support participation effectively in this.

Examples

This standard does *not* necessarily involve the service recipients in the organization's hiring practices, but it does suggest that some selection is possible among available qualified staff. It also relates to standards in Section 5.B. with regard to plans, planning, and enhancing the self-direction of services/supports, as well as to Standard 1.K.4., referencing complaint resolution procedures.

4.b. The person served could be involved in a variety of activities in which they participate in the selection of their direct staff. Examples of these activities include participating in the interviews of new staff members, being introduced to the potential staff member during a tour of the organization and being asked their input about the potential candidate, asking the person served during intake if they prefer a male or female to be

their direct staff member, or giving the opportunity to request a different group home when an opening is available.

Additional Resources

The CARF publication *Using Individual-Centered Planning for Self-Directed Services*, which is available on request from your resource specialist, provides an easy-to-understand guide of essential elements, examples of planning procedures, sample plans, and a list of additional resources for individual-centered planning of services based on the preferences and needs of the persons served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Progress notes
- Individual service plans
- Orientation information
- Self-advocacy training information
- Conflict resolution information
- Assistive technology and reasonable accommodation information, if applicable
- Information regarding community resources utilized
- Procedures manual

D. Employment Services Principle Standards

Description

An organization seeking CARF accreditation in the area of employment services provides individualized services and supports to achieve identified employment outcomes. The array of services and supports may include:

- Identification of employment opportunities and resources in the local job market.
- Development of viable work skills that match workforce needs within the geographic area.
- Development of realistic employment goals.
- Establishment of service plans to achieve employment outcomes.
- Identification of resources and supports to achieve and maintain employment.
- Coordination of and referral to employment-related services and supports.

The organization maintains its strategic positioning in the employment sector of the community by designing and continually improving its services based on input from the persons served and from employers in the local job market, and managing results of the organization's outcomes management system. The provision of quality employment services requires a continuous focus on the persons served and the personnel needs of employers in the organization's local job market.

Some examples of the quality results desired by the different stakeholders of these services and supports include:

- Individualized, appropriate accommodations.
- A flexible, interactive process that involves the person.
- Increased independence.
- Increased employment options.
- Timely services and reports.
- Persons served obtain and maintain employment consistent with their preferences, strengths, and needs.

- Person served obtains a job and maintains appropriate benefits.
- Person served maintains the job.

Services Design for Persons Served

5.D. **1. The following information is considered in developing the individual's service plan for employment:**
  a. **Self-reported interests and skills.**
  b. **Work and volunteer history.**
  c. **Previous training and education.**
  d. **Benefits the person is receiving.**
  e. **Availability to work, including hours.**
  f. **Transportation availability.**
  g. **Support needs.**
  h. **Self-reported barriers to employment.**
  i. **Legal history.**

Intent Statements

The program should become knowledgeable about the person served in order to develop a plan that identifies resources and supports to achieve the person's goals.

5.D. **2. The person served is involved in making informed employment-related decisions, including:**
  a. **The expected outcome for services.**
  b. **His or her role and responsibilities related to achieving desired employment outcomes.**

Intent Statements

Informed choice is reflected in the individual planning process through full disclosure of the capabilities of the organization to meet the person's outcomes expectations and the person's understanding of his/her responsibilities.

Examples

For persons with significant communication barriers, the program may assess the person's interests, preferences, and input through other means, such as observation or interviews with family members, advocates of the person, or staff who work with the person.

Decision making based on informed choice may be reflected in:

- The scope, duration, and expected outcomes of the employment services.
- Employment choices, plans, and options.
- Paid or unpaid work.
- Work settings.
- Career development and/or training activities.
- Career advancement opportunities.

5.D. **3. The person served is informed about opportunities for employment in the local community consistent with his or her desired outcome.**

Intent Statements

Current information on employment opportunities is vital to the individual planning process, as well as to the continuous improvement of the service delivery design.

Examples

Much of the information is available in the federal, state, or provincial Department of Labor occupational guidebooks. This standard does not require an organization to develop this information on its own if it can use readily accessible information from the community or other sources, such as the internet.

A comprehensive understanding of local employment needs can lead to effective provision of services/supports, such as assistive technology; the identification of employment objectives in services planning and coordination; the exploration of options of employment for students transitioning from school to work, such as customized employment, the exploration of interests in evaluation or actual work settings; and the development of individualized services to overcome barriers to achieving maximum employment outcomes.

Sometimes there may be incremental steps toward the desired outcome, when it is not quite in reach at the present time but can become achievable with some intermediate efforts. For example, a person may initially work part-time hours to develop the stamina to handle a full-time position.

Services Design for Employers

An employer may be an integrated business in the community or it may be the organization itself.

5.D. **4. Employment services provided reflect current needs of employers and trends in the local job market.**

Intent Statements

The provision of effective and cost-efficient services requires an organization to maintain up-to-date knowledge of the opportunities in the local job market. This knowledge is a reference point for the setting of goals and the coordination of resources to achieve the individual's desired service outcomes.

By analyzing the employment opportunities in the local region, the organization can design its services to be responsive to the personnel needs of employers and provide informed choices to the persons served.

The organization changes its services as warranted to meet employers' needs and provides supports and services to the persons served to assist them in meeting the changing needs of the local job market.

Examples

Obtaining and using stakeholder input in strategic planning and positioning of the organization helps to achieve optimum employment results.

The design and continuous improvement of employment services to meet the personnel needs of employers are further supported through standards in Section 1 of this manual, including input, outcomes, and leadership.

Some examples of input resources may include:

- Establishing business advisory councils or maintaining membership in business associations.

- Participating in business forums.

- Maintaining relationships with public and private schools.

- Person served or stakeholder feedback.

See also Sections 1.D. Input from Persons Served and Other Stakeholders and 1.M. Performance Measurement and Management.

5.D. **5. As appropriate to the services provided, employers are made aware of the following resources:**

  a. **Customer service/supports available from the organization.**

  b. **Referrals of job applicants closely matched to the employers' requirements.**

  c. **The organization's ability to partner with employers to develop employment opportunities.**

  d. **Tax credits that the employer may secure as a result of hiring an eligible candidate.**

Intent Statements

The success of employment services is based on meeting the needs of employers.

Examples

Not all aspects of this standard have to be provided to every employer, but should be available upon request, either directly from the organization or through referral to and coordination with other community resources.

Successful employment services use input from these stakeholders to manage their performance by measuring the satisfaction of employers and related key stakeholders. Further guidance can be found in Section 1.M. Performance Measurement and Management. The CARF publication *Managing Outcomes*, which is available on request from your resource specialist, may also be helpful.

5.c. Partnering with employers may include providing opportunities such as job carving, job shadowing, and internships, which may help the employer to meet diversity or recruiting goals.

An employment services organization can provide leadership in its community by being a resource for the recruitment, education, and successful development of employment opportunities for persons who are seeking employment.

Some examples may include:

- Assisting employers in the elimination of architectural, procedural, instructional, communication, and attitudinal barriers to

the employment and advancement of persons with employment challenges.

- Educating employers about various disabilities and resulting vocational implications, assistive devices, job accommodations, and current disability-related legislation.

Follow-up and post-employment services may include:

- Contact with the employed person and with the employer, when this is appropriate.

- A documented system to provide organized support contacts at regular intervals with the person served. As appropriate, contact at regular intervals is made with the employer and significant others.

- The availability of appropriate personnel for the person served and/or employer during and, if feasible, after regular working hours to provide support services, if requested.

- The maintenance of contact for a reasonable period of time to promote adequate job adjustment and retention.

- The availability of services, including re-placement, for persons who are unsuccessful in maintaining employment.

Resources

A resource for organizations to use in establishing successful employer partnerships is *Developing Effective Partnerships with Employers as a Service Delivery Mechanism*, which was published by Stout Vocational Rehabilitation Institute in June 1997.

The Organization as Employer

NOTE: *These standards apply only when the organization has an employer-employee relationship with the person served in the service being accredited.*

5.D. **6. In an employer/employee relationship with a person served, the organization complies with:**

★ **a. All applicable United States Internal Revenue Service rules and regulations.**

b. Other applicable laws and regulations.

c. Its own internal policies and procedures.

Intent Statements

Compliance with all applicable laws and regulations is an integral part of the organization's procedures. Changes in applicable laws and regulations are integrated into the organization's system.

🍁 Canadian organizations should be able to demonstrate how they comply with their federal and provincial/territorial labor laws.

Examples

The organization is encouraged to develop its work measurement and payment system with the assistance of regional or local wage and hour representatives.

🍁 In Canada, such information can be obtained from the provincial/territorial ministries of labor.

The organization uses generally accepted techniques such as time studies, Methods Time Measurement, modular arrangement of predetermined time standards (MODAPTS), etc.

🍁 Volunteer placements and unpaid placements are considered acceptable closures in Canada.

This standard is linked to other standards related to the organization's compliance with laws and regulations and adherence to a written code of ethical conduct related to its business and financial practices.

Resources

Further information can be obtained from the U.S. Department of Labor (**www.dol.gov**), 1-866-4-USA-DOL. TTY: 1-877-889-5627. Employment and training questions: 1-877-US-2JOBS. Wage and hour questions: 1-866-4USWAGE. Workplace safety and health questions: 1-800-321-OSHA.

5.D. **7.** **For U.S. organizations, when an individual receives less than the minimum wage, governmental requirements for work measurement and wage payment are followed, including documentation of:**

★

    a. **How the person's disability affects his or her productivity.**

    b. **Performance levels based on work measurements.**

    c. **Commensurate wages paid.**

    d. **Changes made based on annual prevailing wage studies.**

Intent Statements

For individuals receiving less than minimum wage, the organization should document how their disabilities impair their productivity.

Annual prevailing wage studies must be done. Wages are not simply based on minimum wage as the prevailing wage is frequently higher.

Examples

The documentation regarding a person's wage rate is kept in the individual's file.

Governmental requirements include establishing the community wage rate for each type of job by contacting employers that have the work or closely approximate the work on which the wage rate is being based at least annually and documenting that the wages paid to the persons served have been adjusted based on changes in the prevailing wage survey. When the minimum wage increases, organizations should conduct prevailing wage surveys within 60 days and adjust wages accordingly. This information includes:

- The prevailing wage for similar types of work.
- The date obtained.
- The source of information.
- Documentation that an entry-level wage was not used.

Further information may be obtained from the U.S. Department of Labor and/or State Department of Labor.

A good system of work measurement:

- Applies generally accepted work measurement techniques to specifically identified work tasks.
- Determines the level of performance required for qualified, competent workers to accomplish the prescribed task in a given situation.
- Makes allowances for personal, fatigue, and delay factors specific to each job.
- Uses the same equipment, environment, and methods as workers without disabilities.

Good practice would establish individual hourly wage rates within the first 30 calendar days of employment and every time an individual changes jobs. Wage payments are based on a system of individual performance rather than on pooled and/or group wage payments. Wage payments are of a monetary nature and not payments in kind.

Hourly wage rates are based on acceptable time study techniques unless the federal minimum wage is paid.

The productivity of those persons served who are paid at an hourly rate that is less than minimum wage is measured at least every six months, with wages adjusted as indicated.

A regular pay period is established and does not exceed the maximum number of days allowed under state law. Each person receives a written statement for each pay period, which may take a variety of forms (e.g., a check stub, a written statement inside the pay envelope, a notation on the outside of the pay envelope, etc.) but complies with any applicable legal requirements, such as indicating gross pay, hours worked, deductions, and net pay.

The Department of Labor requires full payment of wages for work performed within the pay period. This standard is applicable even if the organization desires to delay the payment of wages based on the expected receipt of payment for work performed by the organization.

There is no charge to the persons served for the privilege of employment.

7.a. Organizations typically use documents such as case notes, performance evaluations, progress notes, and training documents to

capture information on how a particular disability impacts an individual's productivity. For example, an employee with a diagnosis of a developmental disability may require additional prompting to remember tasks during work due to diminished cognitive retention, thus causing him or her to have lower productivity. Issues with quality may also exist that would impact earning capacity. There has to be a relationship between the disability and the decreased productivity/quality, and documentation should exist that outlines the specific areas that make the individual considered to have a disability for the work to be performed.

5.D. 8. **When persons make less than the minimum wage, they are:**

    a. Informed at least semiannually about how their productivity affects their wage.

    b. Assisted to understand:

        (1) Their current rate of pay.

        (2) Ways to improve their earnings.

Intent Statements

The organization should not only ensure fair wages, it should also consider avenues for enhanced productivity and increased wages.

In some promising practices, organizations use job restructuring, assistive technology, and natural supports to increase earning levels.

Examples

The organization evaluates the equipment and techniques used in order to maximize the earning potential of persons served. In production and training activities, it strives to use the tools, equipment, technology, and machinery to replicate methods utilized by competitive industry, which might open local job opportunities to the persons served. This does not, however, preclude individually tailored adaptive devices that may be used by persons to accomplish tasks which otherwise they could not do.

5.D. 9. **When the organization is producing a product or providing a service for businesses, it maintains a standardized system of quality control.**

Intent Statements

The program maintains an organized system of quality control with responsibility vested in specified personnel to ensure that the quality of products and services meets competitive industrial standards.

Examples

Several elements characterize a quality control program in standard commercial practices. The practices include use of a written policy assuring customers of quality commitment and product/performance reliability, good communications, and written quality control procedures specific to individual products and services (including inspection and testing requirements).

When the organization is involved in prime manufacturing and/or subcontract operations, files on work methods, quality control, and production scheduling are maintained and actively used by supervisory personnel. Written specifications are maintained for each article produced. Products are made in conformance to relevant specifications and meet the standards of competitive products in the open market. Work methods might include work station setup, steps in the production process, work flow, and equipment to be used. Production scheduling might include production hours per job, shipping dates, coordination with other jobs, and customer time frames.

5.D. 10. ★ **For U.S. organizations, when the organization bids for contract work or establishes prices for products or services, it:**

    a. Considers:

        (1) All direct costs.

        (2) All indirect costs applicable to each job.

        (3) Profit.

        (4) Fair market value.

    b. Reviews bids/prices at least annually.

    c. Revises bids/prices as necessary.

Intent Statements

The organization seeks business on a fair and competitive basis. It does not engage in unfair competition with other programs or commercial

organizations in selling its services and products. To achieve financial stability, the organization knows its costs and bids competitively in the local job market.

Examples

When production of goods or contracted service delivery is carried out by the organization, sound and acceptable practices are observed in all business and industrial activities, including purchase of materials, sale of products, subcontracting, and pricing. See related standards in Section 1.F. Financial Planning and Management.

The bid price includes all direct and indirect costs applicable to each job, product, or service. An overhead markup supported by a precise written analysis of production costs is charged. The value of any services, equipment, or space provided by the organization for the contract operation is included in the determination of this markup. Indirect costs include staff salaries and benefits, occupancy, depreciation, administrative costs, and all other costs which cannot be directly identified with the job. All retooling, training, and remodeling costs necessary to accomplish the job are also calculated. All donated equipment, materials, and services are included in the contract bid price at fair market value.

Selling prices of the program's products are based upon full cost reimbursement and are in line with the prevailing price range for such products in the competitive market areas.

The activities of analyzing costs may also include reviewing methods for achieving optimal efficiency in the work environment consistent with the needs of the persons served.

This standard relates to the code of ethical conduct of business practices and marketing activities referred to in Standard 1.A.6. and to standards in Section 1.F. Financial Planning and Management.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Individual employment service plans
- Records of the persons served
- Information on local job opportunities and trends
- Information regarding community services and resources used
- U.S. Department of Labor Certificate, if applicable
- Documentation related to U.S. Department of Labor laws, if applicable
- IRS information, if in the U.S.
- Canada Revenue Agency information, if in Canada
- Information related to applicable labor laws and regulations
- Information on referrals made
- Documentation of supports given to employers, if applicable
- Information regarding time studies and wage payment practices
- Information regarding prevailing wage studies
- Information regarding bidding practices
- Information demonstrating annual analysis of products and services pricing

E. Medication Monitoring and Management

Applicable Standards

- If a program provides only medication monitoring, Standards 5.E.1. and 5.E.2. are applicable. (See the Glossary for the definition of *medication monitoring*.)

- If a program provides medication management, all standards in this subsection are applicable. (See the Glossary for the definition of *medication management*.)

To clarify whether your program provides medication monitoring or management as defined by CARF, contact your designated resource specialist in the Services customer service unit.

5.E. **1. An up-to-date individual record of all medications, including prescription and nonprescription medications, used by the person served includes:**
   a. **The name of the medication.**
   b. **The dosage, including strength or concentration.**
   c. **The frequency.**
   d. **Instructions for use, including administration route.**
   e. **Potential side effects.**
   f. **Drug interactions.**
   g. **For prescribed medications:**
      (1) **The prescribing professional and phone number.**
      (2) **Dispensing pharmacy and contact information.**

Intent Statements

The intent of this record is to have accurate information typically provided by the pharmacy or prescribing individual readily available for appropriate personnel.

Examples

Guidance for an organization could come from State Professional Registration Practice Acts and Statutes; licensing requirements; or other regulatory requirements.

1.e.–f. Information on pertinent potential side effects and/or drug interactions are those identified by the prescriber, provided by the dispensing pharmacy, and/or provided by support medical or nursing staff. Program personnel are given access to resource materials.

5.E. **2. The organization has written procedures that address:**
   a. **Storage, including handling of medications requiring refrigeration or protection from light.**
   b. **Safe handling.**
   c. **Packaging and labeling.**
   d. **Safe disposal.**
   e. **Maintenance of an adequate supply of medications for the persons served.**
   f. **Documentation of medication use.**

Intent Statements

Documented procedures related to medications are an important aspect of an organization's management of potential risk.

Examples

Guidance for an organization could come from licensing, contractual, funding, legal, or other regulatory requirements.

2.a.–b. Written procedures for storage and safe handling include addressing limited/secure access and biohazard management.

2.d. Safe disposal of medications includes addressing management of biohazards associated with the use of medications.

2.e. Efforts to ensure adequate supply would relate to the organization's level of responsibility, whether monitoring or management.

5.E. **3. As requested, the persons served or their parents or guardians are provided with or given information about resources for:**

   a. Advocacy and advocacy training to assist them in being actively involved in making decisions related to the use of medications.

   b. Training and education regarding medications.

Intent Statements

The active involvement of the persons served can be demonstrated by evidence of their consent and input regarding changes in medications. The persons served and others, as appropriate, are provided with information about medication management procedures and side effects. Appropriate education and training provided to the persons served and/or family members identified by the persons served enables informed decisions.

In cases involving involuntary hospitalization and the presence of court orders, there are rare situations in which medications are used involuntarily by the persons served.

Examples

3.a. Advocacy training can include guidance given to the persons served/families about questions they might ask, such as "What are potential side effects of particular medications? What are the benefits of taking a particular medication? What are the consequences of not taking the medication?"

3.b. This training and education may be provided by a medical or nursing licensed professional as appropriate, and may include:

- How the medication works.
- The risks associated with each medication.
- The intended benefits.
- Side effects.
- Contraindications.
- Appropriate knowledge of adverse interactions between multiple medications and food.
- The importance of taking medications as prescribed.
- The need for laboratory monitoring.

- The rationale for each medication.
- Alternatives to the use of medications.
- Alternative medications.
- Signs of nonadherence to medication prescriptions.
- Potential drug reactions when combining prescription and nonprescription medications, including alcohol, tobacco, caffeine, illicit drugs, and alternative medications.
- Instructions on self-administration, when applicable.
- The availability of financial supports and resources to assist the persons served with handling the costs associated with medications.

5.E. **4. The organization documents that the use of all medications by the person served is reviewed on at least an annual basis by a single physician or qualified professional licensed to prescribe medications.**

Intent Statements

Organizations realize the importance to the health and safety of the person served that a regular systematic review of all medications being used is conducted by a medical professional to ensure that adverse reactions between multiple medications are avoided and persons are not overly medicated.

Examples

To avoid replication of efforts, a program may obtain documentation from another provider, family member, guardian, etc. that this review of medications occurred.

Medication reviews typically address:

- The appropriateness of each medication, as determined by the needs and preferences of each person served.
- The efficacy of the medication. (See the Glossary for the definition of *efficacy*.)
- The presence of side effects, unusual effects, and contraindications.
- The use of multiple simultaneous medications.
- Medication interactions.

The frequency of the reviews depends on:

- The degree of severity of the person's medical condition.
- Whether multiple medications are provided and other contraindications exist.
- Guidelines related to the medication itself.

5.E. **5. An organization that manages medications for persons served has written procedures that address:**

a. **Purchase, including processes for handling medication shortages on weekends.**

b. **Transportation and delivery.**

c. **Off-site use.**

d. **Administration of medications by personnel, including:**

(1) **Staff credentials and competencies.**

(2) **Documentation of medication administration.**

(3) **Documentation of the use and benefits, or lack thereof, of as needed (prn) doses.**

Intent Statements

Documented procedures related to medications are an important aspect of an organization's management of potential risk and its ability to administer medications on a consistent and safe basis.

Examples

5.c. *Off-site use* refers to administration or self-administration during time away, such as at home, at school, at recreational activities, or at work by persons served who normally receive medications at the organization's facilities and programs, or the organization dispenses the medications for the person to self-administer at home or elsewhere.

5.d.(2) When examining medication management errors as part of risk management, items to address may include:

- Unauthorized drug use.
- Dispensing errors.
- Prescribing errors.

- Administration errors, including:
  - Medication omissions.
  - Incorrect drug.
  - Incorrect rate or dose.
  - Incorrect route.
  - Incorrect timing.
  - Incorrect labeling.
  - Incorrect identification of person served.
- Medication documentation errors.

5.E. **6. An organization that manages medications for persons served has written procedures regarding medications that provide for:**

a. **Compliance with all applicable laws and regulations pertaining to medications and controlled substances.**

b. **Documentation or confirmation of informed consent for each medication administered, when possible.**

c. **Integrating any prescribed medications into a person's overall plan, including, if applicable, special dietary needs and restrictions associated with medication use.**

d. **Identification, documentation, and required reporting, including to the prescribing professional:**

(1) **Of any medication reactions experienced by the person served.**

(2) **Of medication errors, as appropriate.**

e. **Review of medication errors and drug reactions as part of the quality monitoring and improvement system.**

f. **Actions to follow in case of emergencies related to the use of medications, including ready access to the telephone number of a poison control center by:**

(1) **The program personnel.**

(2) **The persons served, as appropriate.**

g. **Availability of medical resources for consultation during hours of program operation.**

h. **Coordination as needed with the physician providing primary care needs.**

Intent Statements

Documented procedures regarding medication management helps to ensure that the use of medications is addressed and integrated with other service strategies for each person served.

Examples

6.b. Evidence of consent for administering of medications may include formal signed consent forms reviewed at least annually, and preferably with each medication change as preferred by the person served and/or guardian; a notation by the prescribing individual in the record of the person served that the medication has been discussed and agreed upon; or medication to be administered listed on an individual plan actively developed with the person served. It may not be possible to obtain informed consent in situations where the person served is not coherent or competent, or is under a court-ordered commitment for the purpose of requiring medications.

6.c. It is important that there be an initial review as soon as the person enters services of all medications currently being taken and their efficacy, potential side effects, and contraindications. Service planning addresses the fact that the person is taking medication and integrates medication use with the planning of services and supports for the person served.

6.f. Identification of actions might also include in addition to the number of a poison control center ready access by program personnel and/or the persons served to the telephone number of the prescriber, physician, and/or support nursing staff or of emergency medical services.

6.g. Consistent with licensure, physician assistants, nurse practitioners, and clinical nurse specialists may substitute for physician availability. Consultation can be obtained through direct employment, contract or consultant agreement, or medical facility agreements. Organizations may also use telemedicine as a method of obtaining consultation.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Policy on whether the organization has any role related to medications in the program seeking accreditation

■ Records of the persons served

■ Individual medication records for persons served

■ Procedures regarding storage, safe handling, packaging/labeling, and safe disposal

■ List of educational and training resources for advocacy

■ Medication procedures regarding purchase, transportation, inventory, off-site use, and administration, if applicable

■ Individual service plans

■ Staff training records

■ Documentation of training regarding medication of persons served, if applicable

■ Records of informed consent, if applicable

■ Procedures related to medication reactions/errors

■ Actions to follow in case of medication emergencies

■ Written procedures regarding compliance with all laws/regulations pertaining to medications

F. Children and Adolescents Specific Population Designation

Applicable Standards

If an organization provides services to children or adolescents, the standards in this section must be applied in addition to the standards identified in the Applicable Standards statements in the individual services in Section 5.

5.F. **1. As relevant to the services provided, information is gathered from families about each child/youth served that includes:**

   a. Developmental history, such as developmental age factors.

   b. Motor development and functioning.

   c. Health history and status, including:

   (1) Medical.

   (2) Physical.

   (3) Mental.

   (4) Social/emotional.

   (5) Immunization record.

   (6) Prenatal exposure to alcohol, tobacco, or other drugs.

   d. Culture/ethnicity, including specific needs and preferences.

   e. School history.

   f. Communication functioning, including:

   (1) Speech.

   (2) Hearing.

   (3) Language.

   g. Visual functioning.

   h. Learning style.

   i. Intellectual functioning.

   j. Family relationships.

   k. Interactions with peers.

   l. Environmental surroundings.

   m. History of use of alcohol, tobacco, or other drugs.

   n. Past exposure to trauma.

   o. Assistive devices or technology, if used.

   p. Coordinated information if dealing with multiple systems or other current service providers for the child/youth.

Intent Statements

Comprehensive, current information concerning the individual's needs, abilities, and health status is gathered and used to develop a personalized service plan, which is appropriate to the intensity of services provided and identified in the program's scope.

Examples

The organization establishes its protocol for gathering, assessing, and synthesizing information for persons served. The information listed may be acquired from referral sources, affiliations, associations, etc.

1.c.(5) Determination of the status of the child's immunization does not require a copy of the immunization record.

5.F. **2. The methods used for gathering information are appropriate with respect to the child's or youth's:**

   a. Age.

   b. Development.

   c. Culture.

   d. Education.

   e. Functional limitations, if applicable.

   f. Language/communication skills and abilities.

Intent Statements

The needs of the person served dictate the methods by which information is gathered.

Examples

Methods and strategies for gathering information are flexible and individualized to be appropriate to the person served. The organization may make use of input from select family members, authorities, and educational resources for the individual's planning process.

5.F. **3.** **Information gathered is shared with families in understandable terms so they can make informed decisions.**

Intent Statements

Families have the authority and are supported to direct and manage their own services/supports to the extent of their wishes. Information and support are available to help families make informed decisions.

Examples

In some instances, families may not have the experience or sophistication necessary to make informed decisions. In all cases, the organization is a supportive partner in helping the families served to choose wisely. Families served are satisfied that the overall service design meets their identified needs. Related areas may include input, accessibility, and performance management.

5.F. **4.** **The program works with family members to identify the following regarding the development of their child or youth:**
   a. **Strengths.**
   b. **Resources.**
   c. **Priorities.**
   d. **Expectations.**
   e. **Activities that might be beneficial.**
   f. **Concerns.**
   g. **Perceived barriers.**

Intent Statements

The organization obtains information from the family regarding resources and services they want or require.

Examples

Families may provide a wealth of information that drives the design and delivery of services/supports. This information will be valuable to the organization in providing services that satisfy the needs and desires of the persons and families served.

5.F. **5.** **Program staff identify with the family:**
   a. **Family values to be considered in services.**
   b. **The amount of involvement that the family desires on an ongoing basis.**

Examples

5.b. Family desires regarding control/input may include identifying a primary decision-maker or a specific contact person, if appropriate.

5.F. **6.** **As relevant to the services provided, these areas are considered in identifying needs of each child/youth served:**
   a. **Healthcare.**
   b. **Nutrition.**
   c. **Physical activity.**
   d. **Safety.**
   e. **Education.**
   f. **Emotional/behavioral.**
   g. **Mobility and functional independence.**
   h. **Child development.**
   i. **Social and leisure.**
   j. **Others, as identified.**

Intent Statements

Methods are established to identify and respond to the individual's needs.

Examples

The organization may not provide services to address all needs, but identified needs may be addressed in planning and by referrals to other organizations. Also refer to Standards 5.B.1.–7. for additional planning guidelines.

5.F. **7.** **Individualized services are provided based on:**
   a. **The identified needs of the child/youth served.**
   b. **The desired outcomes of the family.**
   c. **Information gathered.**
   d. **Results from and responses to previous services and supports, if applicable.**

Intent Statements

Persons served are supported to direct and manage services to achieve their outcomes. Programs are developed based on the needs/desires of the child/youth served and their family.

Examples

The focus of the services is on the families, and the effectiveness of the services will ultimately be measured by how well the families use the resources of the organization and their communities. Their input into the service design is vital. See also the standards in Section 5.B. relating to individual planning.

5.F. 8. Based on the identified needs of the child or youth served, services include the development of:
a. **Skills for independence.**
b. **Social skills.**
c. **Social supports.**

Intent Statements

The organization and its direct support workers possess the skills, competencies, and qualifications to support the persons served. The persons served have access to an array of services/supports.

Examples

Services support development of mobility and functional skills, communication skills, adaptive/self-care, and community living skills. Based on age and individual preferences and needs, services to support skill development may be identified in areas such as early childhood development, family activities, physical activities, social and recreational activities, school activities, vocational or work-related activities, and independent living.

Utilizing the data and demographics from an organization's performance management system, the services are designed and delivered to achieve results and personal outcomes satisfaction.

The organization regularly looks at the needs of the child/youth served and provides services based on those needs. Services may change from time to time based on trends of those served and their needs.

5.F. 9. Educational opportunities are available for the family to learn about:
a. **Child development.**
b. **Aspects of disability, as appropriate.**
c. **Futures planning.**
d. **Community resources, including availability of support groups.**
e. **Parenting skills.**

Intent Statements

Educational opportunities may be provided by the organization or made available to the family through appropriate referrals.

5.F. 10. Personnel receive training that covers, as appropriate to the services:
a. **Child growth and development.**
b. **Behavior support skills.**
c. **Learning styles.**
d. **Social and emotional needs.**
e. **The effects of separation and placement on children.**
f. **Health and nutrition.**
g. **Applicable legal issues.**
h. **Methods of communication.**
i. **Crisis situations.**
j. **Family support practices.**
k. **Family systems theory.**
l. **Other specific needs.**

Intent Statements

Training is provided jointly involving program personnel and service providers.

Examples

10.a. Includes readiness to learn, brain development, and cognitive development.

10.b. Includes dealing with aggressive or violent behaviors.

10.d. Includes identifying and reporting child maltreatment.

10.h. May include sign language and assistive communication technology.

10.l. Additional needs could include issues around attachment theory or specific issues

to the child served such as medical or physical needs or the use of assistive technology.

5.F. 11. **If providing early intervention services, the program provides guidance and/or information to families to support their child's acquisition of:**
   a. **Motor skills development.**
   b. **Physical health and development.**
   c. **Physical fitness.**
   d. **Social development.**
   e. **Intellectual/cognitive development.**
   f. **Speech and language development.**
   g. **Creativity.**
   h. **Emotional development.**
   i. **Safety.**
   j. **Self care.**
   k. **Identity development.**
   l. **Proper nutrition and growth.**
   m. **Independence and self-determination.**

Intent Statements

When the organization is providing early intervention services, it is important that it provide as much training as possible to parents as early as possible. This training should help parents to further support development of their child.

5.F. 12. **When the services disrupt the child's or youth's day-to-day educational environment, the service provides or makes arrangements for the continuity of his or her education.**

Intent Statements

Education services are provided without undue disruption.

Examples

Such arrangements could include:
- Use of a site-based school.
- Use of a private school at the organization.
- Use of on-site educators from a local school system.
- Coordination with home school services.

- Coordination and monitoring of assignments.
- Coordination with the community school to facilitate reintegration.

5.F. 13. **Based on the needs and age of each child/youth served, or as required by law, an educational professional or transition specialist is a member of the planning team.**

Intent Statements

There are competent staff and resources available to support the persons served.

Examples

The educational specialist or transition specialist can be available when needed and is not required to attend all planning team meetings.

5.F. 14. **If educational services are provided, they:**
   a. **Are appropriate to the child/youth served.**
   b. **Meet applicable legal requirements.**

Intent Statements

Educational services should be individualized and appropriate to the needs of each child and youth served.

Examples

Educational services may include provisions for evaluation, group instruction, and/or individual instruction, as appropriate.

There are a number of related standard areas that can provide direction in meeting this standard. They include individualized planning, legal requirements, and analysis of data from an organization's outcomes system. By knowing the needs of its customers and stakeholders, services can be redesigned and the organization strategically positioned to meet their needs.

5.F. 15. **If services are provided outside the home, the service environment is configured appropriately to meet the needs of the child/youth served, including:**
   a. **The physical site.**
   b. **The furniture.**

c. Any equipment used in services.

d. Environmental factors.

e. Assistive technology, if utilized.

Intent Statements

The environment or setting is configured in a manner that is consistent with identified needs and capabilities of the persons served.

Examples

Considerations include the provision of:

- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and videos.

5.F. **16.** **The organization does not exclude children or youths from services solely on the basis of their juvenile justice status.**

Intent Statements

Individuals who need services but are not eligible are linked to other resources.

Examples

Children and youths cannot be excluded from services solely because they are involved in the juvenile justice system, however, some of the rights standards in Section 1.K. Rights of Persons Served may not be applicable.

5.F. **17.** **When a child/youth served moves to a school or other community service, transition planning/information is provided in a timely manner:**

a. **To the family.**

b. **To the new service provider, with consent of the child/family.**

Intent Statements

Information and support are available to help a person served and his or her family to make informed decisions and smooth transitions.

Examples

With a continued focus on the family and its role in the child's life, information about new services, alternative settings and strategies, etc., is provided for the family's use to assist in such transitions and to help give service continuity.

5.F. **18.** **The organization conducts nationwide criminal background checks on all personnel providing direct services to children or youths.**

Intent Statements

Direct support workers are appropriately screened before being allowed to provide services.

🍁 In Canada, depending on provincial/territorial/tribal requirements, a criminal record check and a child welfare information system check would be required to meet this standard.

Examples

Background checks may include fingerprinting, FBI criminal history checks, child abuse and neglect registry, sex offender registries, or other appropriate methods available.

Resources

The Dru Sjodin National Sex Offender Public Website (NSOPW), coordinated by the U.S. Department of Justice, is a cooperative effort between jurisdictions hosting public sex offender registries ("Jurisdictions") and the federal government and is offered free of charge to the public. These Jurisdictions include the 50 states, U.S. Territories, the District of Columbia, and participating tribes. The web site provides an advanced search tool that allows a user to submit a single national query to obtain information about sex offenders; a listing of public registry web sites by state, territory, and tribe; and information on sexual abuse education and prevention. The criteria for searching are limited to what each individual Jurisdiction may provide. Also, because information is hosted by each Jurisdiction and not by the federal government, search results should be verified by the user in the Jurisdiction where the information is posted. Users are advised to visit the corresponding Jurisdiction web sites for further information and/or guidance, as appropriate.

5.F. **19.** The program assists family members to optimize resources and opportunities as desired through:
   a. Community linkages.
   b. Enhanced social support networks.
   c. Outreach to encourage involvement.

Intent Statements

The organization is knowledgeable of the community and provides resource materials to parents.

Examples

19.b. Social support networks may include parent mentoring or support groups.

Applicable Standards

Standards 20.–22. apply only if the service provided is Community Housing, Supported Living, Foster Family Services, or Host Family/Shared Living Services.

5.F. **20.** If residential services are provided, there are separate areas for beds for children/youths served according to their:
   a. Ages.
   b. Genders.
   c. Needs.

Intent Statements

Because of the unique needs of children in residential settings, the program provides sleeping quarters apart from adults and members of the opposite sex. When family services are provided, the same sleeping areas may be appropriate. The program considers social, emotional, developmental, and cultural needs and actively addresses the need to designate space for privacy.

Examples

20.c. Other considerations may include a child who sleep walks or has night terrors.

5.F. **21.** If residential services are provided, the in-home safety needs of the child/youth served are addressed with respect to:
   a. Environmental risks.
   b. Abuse and/or neglect inflicted by self or others.
   c. Self-protection skills.
   d. Medication management.

5.F. **22.** If residential services are provided, the organization provides opportunities for visits, when appropriate and in compliance with applicable laws and court orders, with:
   a. Family members and significant others.
   b. Peers.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the children and youths served
- Individual service plans
- Progress notes
- Information provided to the families about new services
- Procedures manual

G. Child and Youth Services (CYS)

Description

Child and youth services provide one or more services, such as prenatal counseling, service coordination, early intervention, prevention, preschool programs, and after-school programs. These services/supports may be provided in any of a variety of settings, such as a family's private home, the organization's facility, and community settings such as parks, recreation areas, pre-schools, or child day care programs not operated by the organization.

In all cases, the physical settings, equipment, and environments meet the identified needs of the children and youth served and their families. Families are the primary decision makers in the process of identifying needs and services and play a critical role, along with team members, in the process.

Some examples of the quality results desired by the different stakeholders of these services include:

- Services individualized to needs and desired outcomes.
- Collection and use of information regarding development and function as relevant to services.
- Children/youths developing new skills.
- Collaborative approach involves family members in services.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.C.
- Standards in Section 5.E. as applicable

5.G. **1. As relevant to the services provided, information is gathered from families about each child/youth served that includes:**

   a. **Developmental history, such as developmental age factors.**

   b. **Motor development and functioning.**

   c. **Health history and status, including:**

      (1) **Medical.**

      (2) **Physical.**

      (3) **Mental.**

      (4) **Social/emotional.**

      (5) **Immunization record.**

      (6) **Prenatal exposure to alcohol, tobacco, or other drugs.**

   d. **Culture/ethnicity, including specific needs and preferences.**

   e. **School history.**

   f. **Communication functioning, including:**

      (1) **Speech.**

      (2) **Hearing.**

      (3) **Language.**

   g. **Visual functioning.**

   h. **Learning style.**

   i. **Intellectual functioning.**

   j. **Family relationships.**

   k. **Interactions with peers.**

   l. **Environmental surroundings.**

   m. **History of use of alcohol, tobacco, or other drugs.**

   n. **Past exposure to trauma.**

   o. **Assistive devices or technology, if used.**

   p. **Coordinated information if dealing with multiple systems or other current service providers for the child/youth.**

Intent Statements

Comprehensive, current information concerning the individual's needs, abilities, and health status is gathered and used to develop a personalized service plan.

Examples

The organization establishes its protocol for gathering, assessing, and synthesizing information for persons served. The information listed may be acquired from referral sources, affiliations, associations, etc.

1.c.(5) Determination of the status of the child's immunization does not require a copy of the immunization record.

5.G. **2. The methods used for gathering information are appropriate with respect to the child's or youth's:**
  a. **Age.**
  b. **Development.**
  c. **Culture.**
  d. **Education.**
  e. **Functional limitations, if applicable.**
  f. **Language/communication skills and abilities.**

Intent Statements

The needs of the person served dictate the methods by which information is gathered.

Examples

Methods and strategies for gathering information are flexible and individualized to be appropriate to the person served. The organization may make use of input from select family members, authorities, and educational resources for the individual's planning process.

5.G. **3. Information gathered is shared with families in understandable terms so they can make informed decisions.**

Intent Statements

Families have the authority and are supported to direct and manage their own services/supports to the extent of their wishes. Information and support are available to help families make informed decisions.

Examples

In some instances, families may not have the experience or sophistication necessary to make informed decisions. In all cases, the organization is a supportive partner in helping the families

served to choose wisely. Families served are satisfied that the overall service design meets their identified needs. Related areas may include input, accessibility, and performance management.

5.G. **4. The program works with family members to identify the following regarding the development of their child or youth:**
  a. **Strengths.**
  b. **Resources.**
  c. **Priorities.**
  d. **Expectations.**
  e. **Activities that might be beneficial.**
  f. **Concerns.**
  g. **Perceived barriers.**

Intent Statements

The organization obtains information from the family regarding resources and services they want or require.

Examples

Families may provide a wealth of information that drives the design and delivery of services/supports. This information will be valuable to the organization in providing services that satisfy the needs and desires of the persons and families served.

5.G. **5. Program staff identify with the family:**
  a. **Family values to be considered in services.**
  b. **The amount of involvement that the family desires on an ongoing basis.**

Examples

5.b. Family desires regarding control/input may include identifying a primary decision-maker or a specific contact person, if appropriate.

5.G. **6. As relevant to the services provided, these areas are considered in identifying needs of each child/youth served:**
  a. **Healthcare.**
  b. **Nutrition.**
  c. **Physical activity.**
  d. **Safety.**

e. Education.

f. Emotional/behavioral.

g. Mobility and functional independence.

h. Child development.

i. Social and leisure.

j. Others, as identified.

Intent Statements

Methods are established to identify and respond to the individual's needs.

Examples

The organization may not provide services to address all needs, but identified needs may be addressed in planning and by referrals to other organizations. Also refer to Standards 5.B.1.–7. for additional planning guidelines.

5.G. **7. Individualized services are provided based on:**

a. **The identified needs of the child/ youth served.**

b. **The desired outcomes of the family.**

c. **Information gathered.**

d. **Results from and responses to previous services and supports, if applicable.**

Intent Statements

Persons served are supported to direct and manage services to achieve their outcomes. Programs are developed based on the needs/ desires of the child/youth served and their family.

Examples

The focus of the services is on the families, and the effectiveness of the services will ultimately be measured by how well the families use the resources of the organization and their communities. Their input into the service design is vital. See also the standards in Section 5.B. relating to individual planning.

5.G. **8. Based on the identified needs of the child or youth served, services include the development of:**

a. **Skills for independence.**

b. **Social skills.**

c. **Social supports.**

Intent Statements

The organization and its direct support workers possess the skills, competencies, and qualifications to support the persons served. The persons served have access to an array of services/supports.

Examples

Services support development of mobility and functional skills, communication skills, adaptive/ self-care, and community living skills. Based on age and individual preferences and needs, services to support skill development may be identified in areas such as early childhood development, family activities, physical activities, social and recreational activities, school activities, vocational or work-related activities, and independent living.

Utilizing the data and demographics from an organization's performance management system, the services are designed and delivered to achieve results and personal outcomes satisfaction.

The organization regularly looks at the needs of the child/youth served and provides services based on those needs. Services may change from time to time based on trends of those served and their needs.

5.G. **9. Educational opportunities are available for the family to learn about:**

a. **Child development.**

b. **Aspects of disability, as appropriate.**

c. **Futures planning.**

d. **Community resources, including availability of support groups.**

e. **Parenting skills.**

Intent Statements

Educational opportunities may be provided by the organization or made available to the family through appropriate referrals.

5.G. 10. Personnel receive training that covers, as appropriate to the services:
a. **Child growth and development.**
b. **Behavior support skills.**
c. **Learning styles.**
d. **Social and emotional needs.**
e. **The effects of separation and placement on children.**
f. **Health and nutrition.**
g. **Applicable legal issues.**
h. **Methods of communication.**
i. **Crisis situations.**
j. **Family support practices.**
k. **Family systems theory.**
l. **Other specific needs.**

Intent Statements

Training is provided jointly involving program personnel and service providers.

Examples

10.a. Includes readiness to learn, brain development, and cognitive development.

10.b. Includes dealing with aggressive or violent behaviors.

10.d. Includes identifying and reporting child maltreatment.

10.h. May include sign language and assistive communication technology.

10.l. Additional needs could include issues around attachment theory or specific issues to the child served such as medical or physical needs or the use of assistive technology.

5.G. 11. If providing early intervention services, the program provides guidance and/or information to families to support their child's acquisition of:
a. **Motor skills development.**
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c. **Physical fitness.**
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e. **Intellectual/cognitive development.**
f. **Speech and language development.**
g. **Creativity.**

h. **Emotional development.**
i. **Safety.**
j. **Self care.**
k. **Identity development.**
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m. **Independence and self-determination.**

Intent Statements

When the organization is providing early intervention services, it is important that it provide as much training as possible to parents as early as possible. This training should help parents to further support development of their child.

5.G. 12. When the services disrupt the child's or youth's day-to-day educational environment, the service provides or makes arrangements for the continuity of his or her education.

Intent Statements

Education services are provided without undue disruption.

Examples

Such arrangements could include:
■ Use of a site-based school.
■ Use of a private school at the organization.
■ Use of on-site educators from a local school system.
■ Coordination with home school services.
■ Coordination and monitoring of assignments.
■ Coordination with the community school to facilitate reintegration.

5.G. 13. Based on the needs and age of each child/youth served, or as required by law, an educational professional or transition specialist is a member of the planning team.

Intent Statements

There are competent staff and resources available to support the persons served.

Examples

The educational specialist or transition specialist can be available when needed and is not required to attend all planning team meetings.

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   a. **Are appropriate to the child/youth served.**

   b. **Meet applicable legal requirements.**

Intent Statements

Educational services should be individualized and appropriate to the needs of each child and youth served.

Examples

Educational services may include provisions for evaluation, group instruction, and/or individual instruction, as appropriate.

There are a number of related standard areas that can provide direction in meeting this standard. They include individualized planning, legal requirements, and analysis of data from an organization's outcomes system. By knowing the needs of its customers and stakeholders, services can be redesigned and the organization strategically positioned to meet their needs.

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   a. **The physical site.**

   b. **The furniture.**

   c. **Any equipment used in services.**

   d. **Environmental factors.**

   e. **Assistive technology, if utilized.**

Intent Statements

The environment or setting is configured in a manner that is consistent with identified needs and capabilities of the persons served.

Examples

Considerations include the provision of:

- Appropriately sized furniture.
- Recreational equipment.
- Age-appropriate reading materials and videos.

5.G. 16. **The organization does not exclude children or youths from services solely on the basis of their juvenile justice status.**

Intent Statements

Individuals who need services but are not eligible are linked to other resources.

Examples

Children and youths cannot be excluded from services solely because they are involved in the juvenile justice system, however, some of the rights standards in Section 1.K. Rights of Persons Served may not be applicable.

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   a. **To the family.**

   b. **To the new service provider, with consent of the child/family.**

Intent Statements

Information and support are available to help a person served and his or her family to make informed decisions and smooth transitions.

Examples

With a continued focus on the family and its role in the child's life, information about new services, alternative settings and strategies, etc., is provided for the family's use to assist in such transitions and to help give service continuity.

5.G. 18. **The organization conducts nationwide criminal background checks on all personnel providing direct services to children or youths.**

Intent Statements

Direct support workers are appropriately screened before being allowed to provide services.

❦ In Canada, depending on provincial/territorial/tribal requirements, a criminal record check and a child welfare information system check would be required to meet this standard.

Examples

Background checks may include fingerprinting, FBI criminal history checks, child abuse and neglect registry, sex offender registries, or other appropriate methods available.

Resources

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5.G. **19. The program assists family members to optimize resources and opportunities as desired through:**

a. Community linkages.

b. Enhanced social support networks.

c. Outreach to encourage involvement.

Intent Statements

The organization is knowledgeable of the community and provides resource materials to parents.

Examples

19.b. Social support networks may include parent mentoring or support groups.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the children and youths served
- Individual service plans
- Progress notes
- Information provided to the families about new services
- Procedures manual

H. Community Housing (CH)

Description

Community housing addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the persons served, regardless of the home in which they live and/or the scope, duration, and intensity of the services they receive. The residences in which services/supports are provided are typically owned, rented, leased, or operated directly by the organization, or may be owned, rented, or leased by a third party, such as a governmental entity. Providers exercise control over these sites in terms of having direct or indirect responsibility for the physical conditions of the facility.

Community housing is provided in partnership with individuals. These services/supports are designed to assist the persons served to achieve success in and satisfaction with community living. They may be temporary or long-term in nature. The services/supports are focused on home and community integration and engagement in productive activities. Community housing enhances the independence, dignity, personal choice, and privacy of the persons served. For persons in alcohol and other drug programs, these services/supports are focused on providing sober living environments to increase the likelihood of sobriety and abstinence and to decrease the potential for relapse.

Community housing programs may be referred to as group homes, halfway houses, three-quarter way houses, recovery residences, sober housing, domestic violence or homeless shelters, and safe houses. These programs may be located in rural or urban settings and in houses, apartments, townhouses, or other residential settings owned, rented, leased, or operated by the organization. They may include congregate living facilities and clustered homes/apartments in multiple-unit settings. These residences are often physically integrated into the community, and every effort is made to ensure that they approximate other homes in their neighborhoods in terms of size and number of individuals.

Community housing may include either or both of the following:

- Transitional living that provides interim supports and services for persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless. Transitional living is typically provided for six to twelve months and can be offered in congregate settings that may be larger than residences typically found in the community.

- Long-term housing that provides stable, supported community living or assists the persons served to obtain and maintain safe, affordable, accessible, and stable housing.

The residences in which Community Housing services are provided must be identified in the Intent to Survey. These sites will be visited during the survey process and identified in the survey report and accreditation outcome as a site at which the organization provides a Community Housing program.

NOTE: *The term* home *is used in the following standards to refer to the dwelling of the person served, however CARF accreditation is awarded based on the services/supports provided. This is not intended to be certification, licensing, or inspection of a site.*

Some examples of the quality results desired by the different stakeholders of these services/supports include:

- Safe housing.
- Persons choosing where they live.
- Persons having privacy in their homes.
- Persons increasing independent living skills.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional.
- All standards in Sections 5.A., 5.B., and 5.C.
- Standards in Sections 5.E. and 5.F. as applicable.

NOTE:

- Standards 1.H.11.–1.H.12 (Section 1.H. Health and Safety) are applied to the community housing residence only when the organization owns the home.

- Standard 1.H.13. is not applied to community housing residences.

  If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.

5.H. **1. Each person served is in a residential setting with his or her own personal space that:**

   a. **Respects privacy.**
   b. **Promotes personal security.**
   c. **Promotes safety.**

Intent Statements

Persons served have a right to personal, private space.

Examples

1.a. This standard does not require a separate room for each resident, but it does suggest the provision of a safe, secure, private location that can be thought of by the person served as his or her own.

1.c. Safety needs are determined on the basis of the individuals' strengths and needs. See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

5.H. **2. The organization provides the following community living components:**

   a. **Regular meetings between the persons served and staff.**
   b. **Opportunities to participate in typical home activities.**
   c. **Appropriate linkage when health-care needs of the persons served are identified.**
   d. **A personalized setting.**
   e. **Daily access to nutritious meals and snacks.**

   f. **The opportunity for expression of choice by the persons served in regard to rooms and housemates.**
   g. **Based on the choice of the persons served, opportunities to access:**
      (1) **Community activities.**
      (2) **Cultural activities.**
      (3) **Social activities.**
      (4) **Recreational activities.**
      (5) **Spiritual activities.**
      (6) **Employment/income generation activities.**
      (7) **Necessary transportation.**
      (8) **Self-help groups.**
      (9) **Other activities as identified in the person's plan.**
   h. **Guidelines related to:**
      (1) **Visitors or guests.**
      (2) **Pets.**

Intent Statements

Persons served have choice in services/supports.

Examples

2.a. These meetings could be community meetings or meetings for the purpose of collaboratively discussing issues such as:

- Program operations.
- Problems.
- Plans.
- The use of program resources.

2.b. The program encourages all persons served to take increasing responsibility for cooperative operation of the household. Activities may include the preparation of food and the performance of daily household duties.

2.f. Depending on the program structure and the needs of the persons served, there may be procedures for maintaining separate sleeping areas in accordance with the genders, ages, and developmental level of the persons served. Whenever possible, each person served has the choice of a private room or the opportunity to participate in the selection of roommates.

2.g.(8) Activities could include meetings of 12-step and other self-help groups.

5.H. 3. In-home safety needs of persons served are addressed with respect to:

a. **Environmental risks.**

b. **Abuse and/or neglect inflicted by self or others.**

c. **Self-protection skills.**

d. **Medication management.**

Intent Statements

Safety needs are determined on the basis of the individuals' strengths and needs.

Examples

See also standards in Section 1.H. Health and Safety for all sites owned, leased, or operated by the organization.

5.H. 4. When possible, persons served have options to make changes in their living arrangements:

a. **At their request.**

b. **At the request of their families, when applicable.**

c. **In transitional living, on a periodic basis when initiated by the organization.**

d. **Based on informed choice.**

Intent Statements

Residential services and supports are flexible and fluid, as the needs and desires of the persons served change.

Examples

The preference for a different living situation is typically addressed at the person's annual planning meeting.

Knowledge of existing and planned services is important for the persons served so that they can make informed choices about alternative living arrangements. Alternative living arrangements may be provided by the organization or other providers. The term living arrangements refers to the service model and not the residence or home itself.

5.H. 5. Based on the needs of persons transitioning to other housing, there are procedures in place to assist them in securing housing that is:

a. **Safe.**

b. **Affordable.**

c. **Accessible.**

d. **Acceptable.**

Intent Statements

The safety and security of the living arrangements of the persons served are assessed, risk factors and accessibility issues are identified, and modifications are made to make the housing choices acceptable.

Examples

Successful transition of a person served to safe and affordable housing requires the organization to establish organizational procedures based on input from a variety of customers and stakeholders. Planning considerations should include the strengths and needs of the persons served, as well as areas of organizational consideration and resources that will need to be addressed. Those areas include accessibility plans and resources budgeted to remove barriers, appropriate review of health and safety factors as defined by local authorities, and the various aspects of risk management, and are all part of the individual services and organizational planning necessary to secure transitional housing.

5.H. 6. Each person served receives:

a. **Skill development necessary to live as independently as possible.**

b. **Ongoing support/services as they explore changes in their living arrangements.**

Intent Statements

The person served has continuous access to services and support. The person's plan is continuously monitored, and modifications are made in the plan as the needs and circumstance of the person served change.

6.b. The person served may need confidence and courage to try alternative living arrangements. It is the responsibility of the provider organization

to attempt to minimize risks of trying alternative living arrangements.

Examples

Often, the development of a professional team and a circle of support and friends can be helpful in encouraging persons served to try alternative living arrangements.

Resources

A number of resources can be helpful to the planning of delivery of services/supports. These include the CARF publication *Using Individual-Centered Planning for Self-Directed Services*, which is available on request from your resource specialist, as well as related standards regarding accessibility, health and safety, and fiscal management in Section 1 of this manual. Additional guidance may also be found in Section 5.M. Supported Living (SL).

5.H. 7. Personnel are on site based on the needs of the persons served, as identified in their individual plans.

Intent Statements

Personnel have the experience/training needed to effectively deal with the needs of the persons served.

Examples

If the program serves persons with autism, personnel have experience and training in this area.

5.H. 8. There is a system for the on-call availability of designated personnel 24 hours a day, 7 days a week.

5.H. 9. In congregate housing, provisions are made to address the need for:
   a. **Smoking or nonsmoking areas.**
   b. **Quiet areas.**
   c. **Areas for visits.**
   d. **Other issues, as identified by the residents.**

Intent Statements

When housing is shared by two or more individuals, the program actively addresses the need to designate space for privacy and individual interests.

5.H. 10. The organization assists the person served to identify and utilize available modes of transportation.

Intent Statements

When transportation cannot be accessed independently by the persons served, the organization coordinates transportation to other relevant services and activities.

5.H. 11. The organization demonstrates efforts to maintain a person's residence as long as possible during temporary medical, legal, or personal absences.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Individual service plans
- Progress notes
- Health and safety information
- Procedures manual

I. Community Integration (COI)

Description

Community integration is designed to help persons to optimize their personal, social, and vocational competency to live successfully in the community. Persons served are active partners in determining the activities they desire to participate in. Therefore, the settings can be informal to reduce barriers between staff members and persons served. An activity center, a day program, a clubhouse, and a drop-in center are examples of community integration services. Consumer-run programs are also included.

Community integration provides opportunities for the community participation of the persons served. The organization defines the scope of these services and supports based on the identified needs and desires of the persons served. This may include services for persons who without this option are at risk of receiving services full-time in more restrictive environments with intensive levels of supports such as hospitalization or nursing home care. A person may participate in a variety of community life experiences or interactions that may include, but are not limited to:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Pre-vocational experiences.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism in the community.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.

- Interacting with volunteers from the community in program activities.
- Community collaborations and social connections developed by the program (partnerships with community entities such as senior centers, arts councils, etc.).

Note: *The use of the term* persons served *in Community Integration may include members, attendees, or participants, as appropriate.*

Some examples of the quality results desired by the different stakeholders of these services include:

- Increased community participation, including by reverse integration.
- Increased independence.
- Increased interdependence.
- Greater quality of life.
- Skill development.
- Slowing of decline associated with aging.
- Volunteer placement.
- Movement to employment.
- Center-based socialization activities during the day that enable persons to remain in their community residence.
- Activity alternatives to avoid or reduce time spent in more restrictive environments, such as hospitalization or nursing home care.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.C.
- Standards in Sections 5.E. and 5.F. as applicable

5.I. **1. The persons participating in services/ activities move toward:**
- **a. Optimal use of:**
  - **(1) Natural supports.**
  - **(2) Self-help.**
- **b. Greater self-sufficiency or a slowing of the declines associated with aging.**
- **c. Greater choice.**

d. Greater control of their lives.

e. Increased participation in the community.

Intent Statements

Services and supports lead to positive outcomes for persons served. The organization considers the demographics of the population it serves, including such things as medical risk factors, travel concerns, family aspirations, and age of persons served. Outcomes prevent fallback to government institutions and maintain the individual's participation level in defined community settings.

Examples

These services are designed and delivered in such a manner as to enhance the interdependence of the persons served, their self-concept, and their social adaptations. These services are flexible in satisfying the needs and desires of the persons served.

Community integration of the medically fragile can include activities at a center or across campus from their typical home environment. If the person served is medically fragile and unable to attend activities in the community, the organization may consider different methods of reverse integration such as a religious group providing church services at the organization one day a week, or the person served being adopted by a foster grandparent or a college student for one-on-one activities. Another example of reverse integration would be pet therapy where an individual with a certified pet therapy animal visits the organization to allow the persons served to interact with the pet.

5.I. **2.** Services and activities are organized around:

a. The stated goals of the persons served.

b. The identified preferences of the persons served.

c. The identified needs of the persons served.

d. Improving the ability of the persons served to understand their needs.

e. Assisting the persons served to achieve their goals of choice in the following areas:

(1) Community living skills development.

(2) Interpersonal relations.

(3) Recreation/use of leisure time opportunities.

(4) Vocational development or employment.

(5) Educational development.

(6) Self-advocacy.

(7) Access to non-disability related social resources.

Intent Statements

Persons served have an active role in program design and redesigning the program.

Examples

The organization demonstrates that a range of basic services/supports is provided. These services/supports could be arranged within a psychosocial clubhouse, an activity center, or a day program, but the common services consist of providing assistance with independent living skills and the other activities as desired by the persons served and described in this standard.

2.e.(1) The program assists the person served to develop the skills needed to live as independently as possible in the community.

2.e.(4) Paid or volunteer work may be a component of these services.

Some quality of life indicators would be:

■ Social Well-Being

– I have friends who care about me

– I have an active social life

– I feel comfortable in social situations

– My recreational activities often involve interacting with others

- Occupational/Career Development Well-Being
  - I am satisfied with my job options
  - I am satisfied with my job skills
  - I am satisfied with my employment situation
- Material Well-Being
  - I can afford decent housing
  - I can afford decent clothing
  - I feel good about my financial future

5.I. 3. Services are provided at times and locations that meet the needs of the persons served.

Intent Statements

The program demonstrates the ability to provide services in an effective and efficient manner and takes the needs of persons served into consideration.

Examples

The program's services and hours of operation, including evenings, weekends, and holidays, are evaluated periodically to ensure that the services are available and accessible to meet the needs and interests of the persons served.

5.I. 4. Personnel are available to meet with persons served to discuss matters of mutual interest or concern.

Intent Statements

Personnel are accessible to persons served.

Examples

Individual or group meetings can include regularly scheduled meetings or meetings for the purpose of discussing issues such as:

- Program operations and activities.
- Hours of operation.
- Problems.
- Plans.
- The use of program resources.

5.I. 5. The organization provides information or referral to assist the persons served in securing assistance to meet their basic needs.

Intent Statements

Agency and direct support personnel possess the skills, competencies, and qualifications to support the persons served.

Examples

Overcoming identified barriers or meeting specific needs may be beyond the organization's service delivery capability but may be addressed by referrals to other community agencies, organizations, and resources.

This may include any of the following based on the needs of the person served:

- Income maintenance.
- Benefits.
- Food, clothing, and household goods.
- Short-term or emergency shelter.
- Housing subsidies, including long-term housing.
- Medical and healthcare.
- Information on the impact of employment on securing and accessing future benefits.
- Transportation.
- Other community supports.

The organization provides information about public assistance and application procedures to the persons and/or families served. The staff members are knowledgeable about requirements to obtain and retain public assistance, due process, and time frames or are able to refer persons to authorities who are. Sources of public assistance may include, but are not limited to, Supplemental Security Income, Social Security Disability Insurance, food stamps, bus passes, public health services, and local, county, and state or provincial assistance.

5.l. **6.** **The program's outreach to and follow-up procedures for the persons served are directed to:**

    a. **Those who drop out of services.**

    b. **Those who have been admitted to a treatment, institutional, or other setting.**

Intent Statements

The intent of this standard is that the program adopt procedures that describe how the program will coordinate services and referrals to reduce disruption to the services for the persons served.

Examples

Each program is encouraged to work cooperatively with other agencies in the community to develop a seamless continuum of services and to reduce all barriers to access.

Note: *If your community integration program includes a work component, the following two standards are applied.*

5.l. **7.** **When an organization has an employer/ employee relationship with a person served, the organization complies with:**

★   **a.** **All applicable United States Internal Revenue Service rules and regulations.**

    b. **Other applicable laws and regulations.**

    c. **Its own internal policies and procedures.**

Intent Statements

Compliance with applicable laws and regulations is an integral part of the organization's procedures. Changes in applicable laws and regulations are integrated into the organization's system.

An organization in the U.S. demonstrates conformance with Section 14 of the Fair Labor Standards Act and other relevant legislation when persons served are paid less than the minimum wage.

🍁 Canadian organizations should be able to demonstrate how they comply with their federal and provincial labor laws.

Examples

Some organizations have established a policy of paying at least minimum wage to persons who are engaged in any paid work experience.

The organization is encouraged to develop its work measurement and payment system with the assistance of regional or local wage and hour representatives.

The organization uses generally accepted techniques such as time studies, Methods Time Measurement, modular arrangement of predetermined time standards (MODAPTS), etc.

🍁 Volunteer placements and unpaid placements are considered acceptable closures in Canada.

This standard is linked to other standards related to the organization's compliance with laws and regulations and adherence to a written code of ethical conduct related to its business and financial practices.

Resources

★ Further information can be obtained from the U.S. Department of Labor (**www.dol.gov**), 1-866-4-USA-DOL. TTY: 1-877-889-5627. Employment and training questions: 1-877-US-2JOBS. Wage and hour questions: 1-866-4USWAGE. Workplace safety and health questions: 1-800-321-OSHA.

5.l. **8.** **When an individual receives less than**
★   **the minimum wage, governmental requirements for work measurement and wage payment are followed, including documentation of:**

    a. **How the person's disability affects his or her productivity.**

    b. **Performance levels based on work measurements.**

    c. **Commensurate wages paid.**

    d. **Changes made based on annual prevailing wage studies.**

    e. **Sharing of this information with the person served.**

Intent Statements

For individuals receiving less than minimum wage, the organization should document how their disabilities impair their productivity.

Annual prevailing wage studies must be done. Wages are not simply based on minimum wage as the prevailing wage is frequently higher.

Examples

The documentation regarding a person's wage rate is kept in the individual's file.

Governmental requirements include establishing the community wage rate for each type of job by contacting employers that have the work or closely approximate the work on which the wage rate is being based at least annually and documenting that the wages paid to the persons served have been adjusted based on changes in the prevailing wage survey. When the minimum wage increases, organizations should conduct prevailing wage surveys within 60 days and adjust wages accordingly. This information includes:

- The prevailing wage for similar types of work.

- The date obtained.

- The source of information.

- Documentation that an entry-level wage was not used.

Further information may be obtained from the U.S. Department of Labor and/or State Department of Labor.

A good system of work measurement:

- Applies generally accepted work measurement techniques to specifically identified work tasks.

- Determines the level of performance required for qualified, competent workers to accomplish the prescribed task in a given situation.

- Makes allowances for personal, fatigue, and delay factors specific to each job.

- Uses the same equipment, environment, and methods as workers without disabilities.

Good practice would establish individual hourly wage rates within the first 30 calendar days of employment and every time an individual changes jobs. Wage payments are based on a system of individual performance rather than on pooled and/or group wage payments. Wage payments are of a monetary nature and not payments in kind.

Hourly wage rates are based on acceptable time study techniques unless the federal minimum wage is paid.

The productivity of those persons served who are paid at an hourly rate that is less than minimum wage is measured at least every six months, with wages adjusted as indicated.

A regular pay period is established and does not exceed the maximum number of days allowed under state law. Each person receives a written statement for each pay period, which may take a variety of forms (e.g., a check stub, a written statement inside the pay envelope, a notation on the outside of the pay envelope, etc.) but complies with any applicable legal requirements, such as indicating gross pay, hours worked, deductions, and net pay.

The Department of Labor requires full payment of wages for work performed within the pay period. This standard is applicable even if the organization desires to delay the payment of wages based on the expected receipt of payment for work performed by the organization.

There is no charge to the persons served for the privilege of employment.

8.a. Organizations typically use documents such as case notes, performance evaluations, progress notes, and training documents to capture information on how a particular disability impacts an individual's productivity. For example, an employee with a diagnosis of a developmental disability may require additional prompting to remember tasks during work due to diminished cognitive retention, thus causing him or her to have lower productivity. Issues with quality may also exist that would impact earning capacity. There has to be a relationship between the disability and the decreased productivity/quality, and documentation should exist that outlines the specific areas that make the individual considered to have a disability for the work to be performed.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Records of the persons served

■ Individual service plans

■ Progress notes

■ Wage payment information, if applicable

■ Procedures manual

J. Personal Supports Services (PSS)

Description

Personal supports services are designed to provide instrumental assistance to persons and/or families served. They may also support or facilitate the provision of services or the participation of the person in other services/programs, such as employment or community integration services. The services are primarily delivered in the home or community and typically do not require individualized or in-depth service planning.

Services can include direct personal care supports such as personal care attendants and housekeeping and meal preparation services; services that do not involve direct personal care supports such as transporting persons served, information and referral services, translation services, programs offering advocacy and assistance by professional volunteers (such as legal or financial services), specialized or targeted training/educational services (such as English language services), mobile meal services; or other support services, such as supervising visitation between family members and parent aides.

A variety of persons may provide these services/supports other than a program's staff, such as volunteers and subcontractors.

Applicable Standards

■ All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional

■ All standards in Section 5.A.

■ Section 5.B. Standards 1. and 2.

■ Section 5.C. Standard 4.

■ Standards in Sections 5.E. and 5.F. as applicable

5.J. **1. The program clearly identifies the supports and services provided.**

5.J. **2.** Personnel receive training that includes:

    a. Promoting consumer-directed supports.

    b. Advocating for the needs of persons served.

    c. Guidelines for participating in the service planning for persons served, when applicable.

    d. Where appropriate, supportive therapeutic techniques.

    e. As appropriate to the service provided, safety training that includes:

        (1) First aid/CPR.

        (2) Biohazards.

        (3) Physical hazards.

        (4) Body mechanics.

    f. If transportation is provided:

        (1) Proper seat restraints or car seat installation when children are served.

        (2) Wheelchair tie-downs, when applicable.

        (3) Safe driving techniques.

5.J. **3.** When direct personal care supports are provided, the program implements a plan and written procedures for:

    a. The supervision of personnel, including provision of timely feedback to enhance skills.

    b. Addressing unplanned absences to ensure continuity of supports.

Intent Statements

The intent of this standard is to ensure that all personnel used by an organization to provide personal care supports receive appropriate supervision or direction. In addition to staff members and contractees, personnel may include volunteers, trainees, and interns.

Examples

Supervision may occur through the supervisor's participation in service planning meetings, organizational staff meetings, side-by-side sessions with the person served, or one-to-one meetings between the supervisor and personnel.

3.a. May include information on best practices or identify areas for improvement.

5.J. **4.** When applicable, training in the use of adaptive devices and equipment is provided to:

    a. Personnel.

    b. The person served.

    c. The family.

    d. Caregivers.

Examples

Adaptive devices and equipment use would be dependent on the type of service supports provided and the population served. Some examples are wheelchairs, lifts, breathing devices, and feeding devices.

5.J. **5.** When needed, assistive technology is used and reasonable accommodations are made in:

    a. The development of services and supports.

    b. The ongoing provision of services.

Examples

When assistive technology/reasonable accommodations are identified as needed, the organization may directly provide the assistive technology, or it may be provided by referral to other local resources. Reasonable accommodations may be necessary to fully access services and enable the person served to participate in the organization's activities. If a person needs services that are not available from the organization, referrals to other services are suggested.

The organization considers reasonable accommodations and uses assistive technology to convey information about services when needed. Accommodations and technology may entail the use of communication devices, video and audio recordings, pictures, and materials in each person's and/or family's primary language. Many modifications are simple and inexpensive. When necessary, the program also provides education on technology applications.

5.J. **6.** **If training/education is provided, the program follows a written comprehensive curriculum for each course offered that includes:**

   a. **Focus on the needs of the trainees.**

   b. **The course philosophy.**

   c. **The course outline.**

   d. **Competency-based objectives.**

   e. **Instructional methods and materials.**

   f. **The sequence and hours of instruction.**

   g. **Requirements for course completion.**

   h. **Regular review and revision/updates as needed.**

5.J. **7.** **If information and referral services are provided, the program demonstrates:**

   a. **Knowledge of available services/ resources.**

   b. **Knowledge of support systems that are relevant to the persons served.**

   c. **Facilitation of access to available services/resources.**

   d. **Availability at times and locations convenient to the persons served.**

Short-Term Immigration Support Services (ISS)

Description

Immigration Support Services (ISS) encompass a range of services that promote integration, independence, and active participation for persons in their new land. ISS assist persons to feel at home in their new community and integrate into society, while being respectful of the culture from which they came. Preferably services are offered when the organization is able in the first language of the person served by multilingual and culturally diverse staff. Services include provision of information and orientation to the new culture of the person, community referrals, and support. Workshops may be offered on a variety of topics such as general advocacy, legal advocacy, com-

munity supports, and cultural awareness. Other services may include employment supports provided at drop-in resource sites, outreach services, and English acquisition services. Interpretation and translation services may be offered to help limit language and communication barriers.

Services provided under this subcategory are generally short term. Persons with more extensive needs are given appropriate referrals to other programs, which may be within the organization or another service in the community.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Section 5.A.
- Section 5.B. Standard 1.
- Standards in Sections 5.E. and 5.F. as applicable

5.J. **8.** **The persons participating in services/ activities move toward:**

   a. **Optimal use of:**

      (1) **Natural supports.**

      (2) **Self-help.**

   b. **Greater self-sufficiency.**

   c. **Increased participation in the community.**

Intent Statements

Services and supports lead to positive outcomes for persons served. Outcomes prevent fallback to government institutions and maintain the individual's participation level in the community.

Outcomes for immigration support services could relate to persons served securing employment, housing, and developing personal/social support networks.

Examples

These services are designed and delivered in such a manner as to enhance the interdependence of the persons served, their self-sufficiency, and their successful integration into their community. Services are flexible in satisfying the needs and desires of the persons served.

5.J. **9.** **Program design and services/activities are developed based on information gathered from the persons served and considers:**

a. **The desired outcomes from services.**

b. **The identified preferences of the persons served.**

c. **The identified needs of the persons served.**

d. **Improving the ability of the persons served to understand their needs.**

e. **Assisting the persons served to achieve desired outcomes, as appropriate to the individual, in the following areas:**

(1) **Integration into the community.**

(2) **Interpersonal relations.**

(3) **Recreation/use of leisure time opportunities.**

(4) **Vocational development or employment.**

(5) **Educational development.**

(6) **Self-advocacy.**

(7) **Access to nondisability related social resources.**

Intent Statements

Persons served have an active role in program design and redesigning the program to remain relevant to their needs and desires.

Examples

The organization demonstrates that a range of basic services/supports is provided. These service/supports could be arranged within a one-stop resource office or other setting, but the common services consist of providing assistance or basic supports to enable individuals to function fully within their communities, and the other activities as desired by the persons served and described in this standard.

9.e.(1) The program assists the person served to develop skills and connections to their community and integrate into society.

5.J. **10.** **Services are provided at times and locations that meet the needs of the persons served.**

Intent Statements

The program demonstrates the ability to provide services in an effective and efficient manner and takes the needs of persons served into consideration.

Examples

The program's services and hours of operation, including evenings, weekends, and holidays, are evaluated periodically to ensure that the services are available and accessible to meet the needs and interests of the persons served.

5.J. **11.** **Personnel are available to meet with persons served to discuss matters of mutual interest or concern.**

Intent Statements

Personnel are accessible to persons served.

Examples

Individual or group meetings can include regularly scheduled meetings or meetings for the purpose of collaboratively discussing issues such as:

■ Program operations and activities.

■ Hours of operation.

■ Problems.

■ Plans.

■ The use of program resources.

5.J. **12.** **The organization provides information or referral to assist the persons served in securing assistance to meet their basic needs.**

Intent Statements

Agency and direct support personnel possess the skills, competencies, and qualifications to support the persons served.

Examples

Overcoming identified barriers or meeting specific needs may be beyond the organization's service delivery capability but may be addressed

by referrals to other community agencies, organizations, and resources.

This may include any of the following based on the needs of the person served:

■ Income maintenance.

■ Benefits.

■ Food, clothing, and household goods.

■ Short-term or emergency shelter.

■ Housing subsidies, including long-term housing.

■ Medical and healthcare.

■ Information on the impact of employment on securing and accessing future benefits.

■ Transportation.

■ Other community supports.

The organization provides information about public assistance and application procedures to the persons and/or families served. The staff members are knowledgeable about requirements to obtain and retain public assistance, due process, and time frames or are able to refer persons to authorities who are. Sources of public assistance may include, but are not limited to, Supplemental Security Income, Social Security Disability Insurance, food stamps, bus passes, public health services, and local, county, and state or provincial assistance.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

■ Identification of supports and services provided

■ Records of persons served, if applicable to the service provided

■ Individual service plans, if applicable to the service provided

■ Progress notes

■ Procedures manual

■ Documented staff training

■ Curriculum for training/education courses provided

■ Forms authorizing release of confidential information

■ Plan and written procedures for supervision of direct service personnel

K. Respite Services (RS)

Description

Respite services facilitate access to time-limited, temporary relief from the ongoing responsibility of service delivery for the persons served, families, and/or organizations. Respite services may be provided in the home, in the community, or at other sites, as appropriate. An organization providing respite services actively works to ensure the availability of an adequate number of direct service personnel.

Some examples of the quality results desired by the different stakeholders of these services/supports include:

- Services/supports are responsive to the family's needs.
- Services/supports are safe for persons.
- Services/supports accommodate medical needs.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Section 5.A.
- Section 5.C. Standard 4.
- Section 5.E. (when services are provided in an organization site and exceed seven consecutive days duration for an individual, Standards 1.–2. and 5.– 6.)
- Standards in Section 5.F as applicable

5.K. **1. Before services begin, the persons served and their families communicate their:**
   a. **Preferences.**
   b. **Needs.**
   c. **Expectations.**

Intent Statements

The services/supports reflect the needs of each person and family served.

Examples

Continuing two-way communication with the service provider is essential to achieve outcomes that are successful in terms of stakeholder satisfaction.

5.K. **2. Respite services accommodate:**
   a. **The needs of the person served.**
   b. **The needs of each family.**

Intent Statements

This standard amplifies and defines the partnership between the person served and his or her family and the service provider.

5.K. **3. The preferences and needs of each family determine the specific respite services received by the family.**

Intent Statements

Family preferences make these services/supports unique to the families receiving them.

Examples

Ongoing communication between the organization and providers helps to identify the specific respite needs of each family.

5.K. **4. Family members assist with respite training, as appropriate.**

Intent Statements

Persons served are supported to direct and manage their own services.

Examples

Generally families know best what the person served needs and can be helpful in training others.

5.K. **5. The individual respite site is matched to the identified needs of each person and family served.**

Intent Statements

The location of service delivery is an important part of the family's service needs and plan.

Examples

The organization attempts to provide services/
supports when and where the person served
chooses.

Individuals' satisfaction with services, cost
effectiveness, accessibility, and reasonable
accommodations are considered in determining
the locations used to provide respite services/
supports.

5.K. **6. When other needs of the person served
are observed during provision of respite,
communication to the family includes:**

   **a. Information about resources that are
   available and how to access these.**

   **b. Recommendations for additional
   services.**

Intent Statements

Persons served have access to an array of
services/supports.

Examples

As a basis of the partnership between the organi-
zation and the family, the organization has an
equal responsibility to convey its observations
regarding the services/supports needed to the
family and the person served for their
consideration.

5.K. **7. When applicable, the following accom-
pany the person served or are available
at the service site:**

   a. Necessary medications.

   **b. Needed medical and/or adaptive/
   assistive technology equipment.**

   c. Instructions for:

      (1) Medical care.

      (2) Special needs.

      (3) Emergencies.

Intent Statements

The health and safety of persons served are
supported in the service environment.

Documentation Examples

The following are examples of the types of infor-
mation you should have available to demonstrate
your conformance to the standards in this sub-
section. See Appendix A for more information
on required documentation.

- Records of the persons served
- Progress notes
- Procedures manual
- Intake information

L. Services Coordination (SC)

Description

Services coordination programs provide goal-oriented and individualized supports focusing on improved self-sufficiency for the persons served through assessment, planning, linkage, advocacy, coordination, and monitoring activities. Successful services coordination results in community opportunities and increased independence for the persons served. Programs may provide occasional supportive counseling and crisis intervention services, when allowed by regulatory or funding authorities.

Services coordination may be provided by an organization as part of its individual service planning and delivery, by a department or division within the organization that works with individuals who are internal and/or external to the organization, or by an organization with the sole purpose of providing community services coordination. Such programs are typically provided by qualified services coordinators or by case management teams.

Organizations performing services coordination as a routine function of other services or programs are not required to apply these standards unless they are specifically seeking accreditation for this program.

Some examples of the quality results desired by the different stakeholders of these services include:

- Access to a variety of services/supports.
- Access to choices of services.
- Individualized services to meet needs.
- Persons achieving goals.
- Persons achieving independence.
- Access to vocational training.
- Persons achieving employment.
- Access to career development.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.C.
- Standards in Section 5.E. as applicable

5.L. **1. The persons served are linked to services and resources as identified in their individual plans.**

Intent Statements

Persons are provided with the necessary level of assistance to afford them equal access to community services and resources.

Examples

For optimal results and satisfaction of the persons served with their services, the organization assesses the availability, costs, and effectiveness of such services; establishes an efficient referral mechanism; and facilitates the process.

Quality service coordinators maintain contacts and arrangements with community resources to enable the development of the individual plans as noted in the standards in Section 5.B., in which the preferences, needs, and desired outcomes of the persons served are addressed.

Ties to standards in Section 1.M. Performance Measurement and Management and Section 1.N. Performance Improvement are apparent. The CARF publication *Managing Outcomes*, which is available on request from your resource specialist, includes practical examples of customer-driven outcomes systems.

5.L. **2. Services coordination personnel maintain a working knowledge of:**
   a. Services/resources that are appropriate for the needs of the persons served.
   b. Support systems that are relevant to the lives of the persons served.
   c. Funding issues pertinent to the referral process.

Intent Statements

The organization demonstrates the ability to provide services and supports in an effective and efficient manner.

Examples

The service coordinator need not know all the answers, but knows where and how to find the resources and services desired to support the persons served.

In order to provide the linkages, coordination, and support needed by the persons served, the services coordinators are able to demonstrate knowledge of healthcare, social services, employment, housing, recreational opportunities, and other services and systems available in the community.

Service coordinators would identify community services and community resources, establish relationships with these community resources/services, maintain current contact information, and partner to coordinate services for a person as needed.

The internet, local United Way guides, etc. can be used to address individualized needs.

Many organizations keep other agency brochures and referral forms available to facilitate smooth linkages to services.

5.L. **3.** **Based on the needs of the persons served, services coordination includes:**

    a. **Activities carried out in collaboration with the persons served and/or their families, as appropriate.**

    b. **Outreach/facilitation to encourage participation of the persons served.**

    c. **Coordination of, or assistance with, crisis intervention and stabilization services, as appropriate.**

    d. **Assisting the persons served to achieve goals for independence as defined by the persons served.**

    e. **Optimizing resources and opportunities through:**

       (1) **Community linkages.**

       (2) **Enhanced social support networks.**

    f. **Assistance with:**

       (1) **Accessing transportation.**

       (2) **Securing safe housing that is reflective of the:**

          (a) **Abilities of the persons served.**

          (b) **Preferences of the persons served.**

          (c) **Needs of the persons served.**

       (3) **Exploring employment or other meaningful activities.**

       (4) **Accessing employment training.**

       (5) **Job seeking.**

       (6) **Career development and advancement.**

    g. **Provision of, or linkages to, skill development services needed to enable the person served to perform daily living activities, including, but not limited to:**

       (1) **Budgeting.**

       (2) **Meal planning.**

       (3) **Personal care.**

       (4) **Housekeeping and home maintenance.**

       (5) **Other identified needs.**

    h. **Evidence of linkages with necessary and appropriate:**

       (1) **Financial services.**

       (2) **Medical or other healthcare.**

       (3) **Other community services.**

       (4) **Assistive technology assessment.**

Intent Statements

Services coordination meets the needs of the person served in their communities directly or through linkages to qualified providers.

Examples

These services coordination activities are carried out in partnership and collaboration with the persons served. All the elements listed in this standard should be available directly or through referral.

Not all services available are provided to every person served. However, the program has the capability to offer these services.

The services identified for any individual relate to the input and outcomes expectations as identified in the plan of the person served. See related standards in Sections 1.D., 1.M., 1.N., and 5.B.

Services/supports that may be provided include:

- Coordinating crisis assistance and supports.
- Facilitating linkages to community resources.
- Coordinating and documenting of overall service delivery plans.
- Obtaining services necessary to meet basic human needs (e.g., food and shelter).
- Assisting the person served to connect to employment services leading to a job.
- Assisting the persons served in increasing social support networks in the community.
- Assisting the persons served in accessing their financial rights and benefits.
- Assessing the needs for personal advocacy and making recommendations where appropriate.
- Facilitating certain activities of medical or behavioral health services coordination.

3.h.(2) Medical or other healthcare includes the coordination of the healthcare of the persons served. Often individuals are seeing a variety of healthcare professionals and using a variety of medications that need to be monitored and coordinated. When working with infants or children, healthcare includes immunizations.

5.L. **4. The organization provides services coordination activities at times and in locations that meet the needs of the persons served.**

Intent Statements

Persons served have access to assistance as needed in any setting that provides the best access.

Examples

Services such as assessment, planning, coordination, and monitoring can be provided in any setting that provides the best access to the persons served and is preferred by the persons served.

Such locations may include residences, correctional settings, shelters, community resource sites, hospitals, schools, medical, or other service sites.

5.L. **5. The intensity of services coordination is based on the needs of the person as identified in his or her individual person-centered plan.**

Intent Statements

Persons served have authority and are supported to direct and manage their services to the extent they wish.

Examples

The intensity of services coordination and the frequency of contact are individualized and clearly defined.

There is wide variability among types of case management. Many programs provide intensive services coordination to a small, select group of individuals, and other programs provide services only periodically. However, there is a clear relationship between how often persons are served and their specific needs.

5.L. **6. When multiple services coordinators exist:**
   a. A primary service coordinator is identified.
   b. There is coordination to:
      (1) Facilitate continuity of care.
      (2) Reduce duplication of services.

Intent Statements

The person served has access to assistance as needed to obtain services promptly.

Examples

By referencing the individual's service plan and utilizing the personal outcomes satisfaction measurements, services coordination results in effective and efficient service delivery.

5.L.

7. With the permission of the persons served, personnel provide advocacy by sharing feedback regarding the services received with the agencies and organizations providing the services.

Intent Statements

Persons served have an active role in program design, performance appraisal and quality improvement activities. The sharing of performance analysis reports and satisfaction surveys with stakeholders focuses the community on meeting the expectations of the persons served.

Examples

Networks, partnerships, and referral arrangements are maintained when the services meet the expectations of the persons served with regard to quality. Persons are referred to different community services when those expectations are not met.

No information specific to an individual is disclosed unless the person has authorized it.

Additional details for establishing and managing quality outcomes can be located in Section 1.M. Performance Measurement and Management and Section 1.N. Performance Improvement, as well as in the *Managing Outcomes* publication, which is available on request from your CARF resource specialist.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Individual service plans
- Progress notes
- Information regarding the types of services and resources provided
- Consumer satisfaction information
- Signed forms authorizing release of information on service satisfaction
- Procedures manual
- Procedures for coordination of services
- Authorization of persons served to share satisfaction information

M. Supported Living (SL)

Description

Supported living addresses the desires, goals, strengths, abilities, needs, health, safety, and life span issues of persons usually living in their own homes (apartments, townhouses, or other residential settings). Supported living services are generally long-term in nature but may change in scope, duration, intensity, or location as the needs and preferences of individuals change over time.

Supported living refers to the support services provided to the person served, not the residence in which these services are provided. A sampling of people receiving services/supports in these sites will be visited as part of the interview process. Although the residence will generally be owned, rented, or leased by the person who lives there, the organization may occasionally rent or lease an apartment when the person served is unable to do so. Typically, in this situation the organization would co-sign or in other ways guarantee the lease or rental agreement; however, the person served would be identified as the tenant.

Supported living programs may be referred to as supported living services, independent living, supportive living, semi-independent living, and apartment living; and services/supports may include home health aide and personal care attendant services. Typically there would not be more than two or three persons served living in a residence, no house rules or structure would be applied to the living situation by the organization, and persons served can come and go as they please. Service planning often identifies the number of hours and types of support services provided.

The home or individual apartment of the person served, even when the organization holds the lease or rental agreement on behalf of the person served, is not included in the intent to survey or identified as a site on the accreditation outcome.

Some examples of the quality results desired by the different stakeholders of these services/supports include:

- Persons served achieving choice of housing, either rent or ownership.
- Persons served choosing whom they will live with, if anyone.
- Minimizing individual risks.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.C.
- Standards in Sections 5.E. and 5.F. as applicable

NOTE:

- Standard 1.H.6. (Section 1.H. Health and Safety) is not applied to supported living residences.
- Standards 1.H.12.–1.H.13. are applied to the supported living residence only when the organization owns the home.

  If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.

5.M. **1. Based on the needs of the persons served, assistance is offered in securing or maintaining housing that is:**
   a. Safe.
   b. Affordable.
   c. Accessible.
   d. Chosen by the individual.

Intent Statements

Information and support is available to help persons served make informed choices. Although these services/supports are provided to persons in their own home or apartment, it may at some time be necessary for the provider to offer assistance to the individual in locating a different, more appropriate living situation.

Examples

Outcomes and quality indicators for these services/supports may include:

- Persons are safe in their home and neighborhood.
- Persons have the information and opportunity to look at different living arrangements in order to make a choice that makes sense for them.
- Agencies assist persons in finding and securing their own home as needed or requested.

5.M. **2. In-home safety needs of persons served are addressed with respect to:**
  a. **Environmental risks.**
  b. **Abuse and/or neglect inflicted by self or others.**
  c. **Self-protection skills.**
  d. **Medication management.**

Intent Statements

Risk and safety considerations are assessed and potential intervention identified to promote health, independence, and safety.

Examples

Health and safety risks may be greater in this type of residential support service. This standard amplifies those in Section 1.H., and should be considered in their context. Although Standard 1.H.6. (tests of emergency procedures) is not applied to supported living residences, safety authorities advise regular practice of testing emergency procedures in all homes. This may be an area an organization would want to include in its training for persons receiving supported living services.

Outcomes and quality indicators for these services/supports may include the service provider having a procedure for assessing potential risks involved in making choices. Staff, persons served, and others as appropriate are trained in this process.

5.M. **3. Persons served have input into:**
  a. **Where they live.**
  b. **With whom they live.**

Intent Statements

Persons served are supported to direct and manage their own services/supports.

Examples

These elements of interdependence and self-determination are fundamental to the concepts of Supported Living, and will enhance consumer satisfaction results demonstrated as conformance to the standards in Section 1.M. Performance Measurement and Management.

Outcomes and quality indicators for these services/supports may include:

- Persons choosing where to live and with whom and they control what happens in their homes.
- Persons having a key to their own homes and deciding who else has a key and who may enter into their homes.
- The agency mission, strategic plan, policies and procedures all reflecting consistent values about choice.
- Persons making their own everyday choices as well as planning for the future.

5.M. **4. Persons served determine the décor in their homes.**

Intent Statements

Persons self-direct and provide input regarding decor in the home.

Examples

Persons served are given opportunities to access the community to purchase decorative items for their home. Staff provide assistance and counsel regarding budgeting for long-range planning.

5.M. **5. Support personnel are available, based on the needs of the person served, as identified in the individual plan.**

Intent Statements

Direct service personnel possess the skills, competencies, and qualifications to support the persons served.

Examples

Supported Living services may be up to 24/7/365 support, depending on local regulatory requirements and definitions. This is individualized to each person's specific needs.

Outcomes and quality indicators for these services/supports may include:

- Services/supports are provided in the person's home and in the community at times that make sense for the individual and when preferred.

- Persons direct the services/supports they receive and have a choice of agencies and staff.

5.M. 6. Support personnel collaborate with the person's support network, as directed by the person served.

Intent Statements

This standard defines the amount of control the person served has over the living supports.

Examples

Outcomes and quality indicators for these services/supports may include:

- Persons are supported to communicate their preferences, choices, and needs.

- Staff are trained in assisting persons to use their support system in making choices.

- Persons have family, friends, or neighbors who support them in typical ways or as paid help.

- The individual and his or her circle of support work together as a team with the supported living agency and others to share the responsibility for his or her well-being.

5.M. 7. A system is in place to provide access to needed services/supports 24 hours a day, 7 days a week.

Intent Statements

Refer to Standard 5. The extent of service support is determined by the needs of the individuals, based on their program plans, local definitions, and regulations.

5.M. 8. Based on the needs and desires of the persons served, support is offered in the following areas:
  a. **Healthy lifestyles.**
  b. **Personal care.**
  c. **Home maintenance.**
  d. **Their role as a tenant, when applicable.**
  e. **Effective self-advocacy and decision making.**
  f. **Family contact, if desired.**
  g. **Social life and friendships/ relationships.**
  h. **Community membership and social networks.**
  i. **Financial stability.**
  j. **Other identified needs.**

Intent Statements

Supported living services may be more inclusive of life needs than traditional residential support for basic food and shelter requirements.

Examples

Outcomes and quality indicators for these services/supports may include:

- Persons are secure in their home and do not have to move if their needs change.

- Support of self-advocacy for the persons served is not only empowering the persons to advocate on behalf of themselves, but also at times to take a direct role as an advocate on behalf of the person served.

- Organizations have a method for changing individual services as service/support needs change.

- Persons have opportunities and support for building and maintaining relationships with family, friends, and community members.

- Persons have opportunities to learn about relationships, including how to protect themselves against abuse and exploitation and developing and maintaining friendships and relationships.

- Persons have access to generic community services and supports.

- The organization maintains a directory of local community and generic services.
- Persons are supported in locating and accessing mental and physical resources.
- Individual support plans show adequate planning for health and safety needs and include plans for possible emergencies and disasters.

5.M. **9. Persons served are provided opportunities to choose and access:**
   a. **Community activities.**
   b. **Cultural activities.**
   c. **Social activities.**
   d. **Recreational activities.**
   e. **Spiritual activities.**
   f. **Employment/income generation activities.**
   g. **Transportation, when necessary.**
   h. **Other.**

Examples

Outcomes and quality indicators for these services may include:

- The person fully participates in the mainstream of community life according to personal choice and preference.
- He or she has opportunities to join clubs, groups, organizations, and religious groups and to use local community resources.
- Support staff are knowledgeable about local community and generic services.
- Staff are trained in building community connections and ways to help individuals in locating and accessing mental and physical health resources.

Additional Resources

The CARF publication *Using Individual-Centered Planning for Self-Directed Services*, which is available on request from your resource specialist, provides an easy-to-understand guide of essential elements, examples of planning procedures, sample plans, and a list of additional resources for individual-centered planning of services based on the preferences and needs of the persons served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Individual service plans
- Progress notes
- Health and safety information
- Procedures manual

N. Community Employment Services

Description

Community employment services assist persons to obtain successful community employment opportunities that are responsive to their choices and preferences. Through a strengths-based approach the program provides person-directed services/supports to individuals to choose, achieve, and maintain employment in integrated community employment settings.

Work is a fundamental part of adult life. Individually tailored job development, training, and support recognize each person's employability and potential contribution to the labor market. Persons are supported as needed through an individualized person-centered model of services to choose and obtain a successful employment opportunity consistent with their preferences, keep the employment, and find new employment if necessary or for purposes of career advancement.

Such services may be described as individual placements, contracted temporary personnel services, competitive employment, supported employment, transitional employment, mobile work crews, contracted work groups, enclaves, community-based NISH contracts, and other business-based work groups in community-integrated designs. In Canada employment in the form of bona fide volunteer placements is possible.

Individuals may be paid by community employers or by the organization. Employment is in the community.

The following service categories are available under Community Employment Services (please refer to the indicated page for program descriptions and applicable standards):

- Job Development (CES:JD)—page 320
- Employment Supports (CES:ES)—page 325
- Personnel Services to Employers (CES:PSE)—page 330

NOTE: *If an organization provides only Job Development or Employment Supports, then it may be accredited for only that service. If it is providing both Job Development and Employment Supports, then it must seek accreditation for both. Personnel Services to Employers is a distinct program that may be included or accredited separately.*

In making the determination of what an organization is actually providing in comparison to these service descriptions, these factors are considered: the mission of the services, the program descriptions, brochures and marketing image for these services, and the outcomes of the services.

If any clarification is needed, please contact your CARF resource specialist. There is no charge for consultation.

Job Development (CES:JD)

Description

Successful job development concurrently uses assessment information about the strengths and interests of the person seeking employment to target the types of jobs available from potential employers in the local labor market. Typical job development activities include reviewing local employment opportunities and developing potential employers/customers through direct and indirect promotional strategies. Job development may include facilitating a hiring agreement between an employer and a person seeking employment. Some persons seeking employment may want assistance at only a basic, informational level such as self-directed job search.

Some examples of the quality outcomes desired by the different stakeholders of these services include:

■ Persons obtain community employment.

■ Employment matches interests and desires of persons.

■ Wages, benefits, and hours of employment achieved as desired.

■ Average number of hours worked per week increases.

■ Average number of hours worked per week meets the desires of the person served.

■ Job retention/length of employment.

■ Potential for upward mobility.

■ Integration.

■ Responsive services.

■ Safe working conditions.

■ Cost-effective for placement achieved.

■ Reasonable length of time from referral to placement.

■ Employers satisfied with the services.

Applicable Standards

■ All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional

■ All standards in Sections 5.A., 5.B., and 5.D.

■ Standards in Section 5.E. as applicable

NOTE: *Standards 1.H.6., 1.H.12., and 1.H.13. (Section 1.H. Health and Safety) are not applied to community sites where persons served are working. These sites are not considered to be facilities of the program being used for service delivery, but rather are employment sites of the person served. If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.*

5.N. **1. Job development planning uses a strengths-based approach that considers, as appropriate to the person served:**

   a. The person's preferences.

   b. Successful aspects of work history.

   c. Noted strengths and abilities from volunteer experience or hobbies.

   d. Successful aspects of previous training, education, and life experiences.

   e. The management and planning of benefits the person is receiving.

   f. Resources for career planning and advancement.

   g. Transportation availability.

   h. Availability of mentors and natural supports.

   i. Legal history, if applicable.

Intent Statements

Job placement services use an individualized, person-centered process to assist persons to identify, obtain, and/or advance in employment.

Examples

Employment preparation services/supports should include:

■ Assessing the appropriateness of the referral for job placement services.

■ Analyzing pertinent findings from medical, psychological, or prior vocational services and/or work adjustment services and any special considerations determined by living arrangements in order to maximize the person's employment opportunities, job performance, job satisfaction, and job retention.

■ Counseling and/or teaching of individuals and/or groups techniques for obtaining and maintaining employment.

- Assisting the persons served to become knowledgeable about job duties, personnel benefits, rates of pay, employment policies and practices, and the job location prior to job acceptance.

- Eliciting information about job preference, salary expectations and needs, insurance needs, transportation needs, and hours and days that the person is available to work.

- Assisting the person served to become knowledgeable regarding the impact of employment on disability and other benefits as well as providing information on the means available to access such benefits. It is important that this information be provided by qualified personnel or external authorities.

Career counselors, job developers, and individual job seekers can use formal and informal assessments for a variety of purposes:

- To clarify a job seeker's likes and dislikes.

- To uncover individual strengths and talents.

- To connect skills to interesting occupations.

- To identify which, if any, work accommodations are needed.

- To pinpoint the settings where target jobs occur and, more importantly, where the job seeker will be happiest.

Assessment activities provide the job developer with invaluable material for matching a job seeker's interests, skills, and abilities to the right job. Some examples of informal assessment activities that can help guide the job search are:

- A "career autobiography"—a narrative description of the hobbies, interests, education, training, and volunteer and paid work experiences that make them who they are today. The skillful job developer will use the autobiography to identify themes recurring throughout the person's personal history that indicate the kinds of activities he or she gravitates toward, enjoys, and excels at.

- Quick "paper and pencil" checklists, available from a variety of sources, are useful for interacting with and getting to know job seekers. Look for ones covering a wide range of skills and abilities and that include a rating scale which job seekers can use to indicate the

degree to which they have mastered each skill. If possible, complete skills inventories with candidates and use the opportunity to explain what is being asked and to prompt recall of all relevant experiences.

- "Testimonials" about strengths, accomplishments, and abilities gathered from peers, teachers, parents, and past employers provide external validation and help round out the picture.

The job developer then synthesizes all of the information collected through formal and informal assessment activities and reflects back the important highlights and themes to job seekers in an organized way.

Refer to related standards in Section 1.L. Accessibility; and in Section 5.B. Individual-Centered Service Planning, Design, and Delivery.

5.N. **2. Individual service plans for job development are individualized to the person seeking employment and:**
 a. Involve his or her:
  (1) Input.
  (2) Approval.
 b. Are tracked in a systematic manner to ensure ongoing monitoring until employment is achieved.
 c. Are revised periodically, as necessary.

Intent Statements

Individual plans are based on informed choices and input from the person served and are kept relevant. The person served is involved in planning and makes the decision about whether to disclose his or her disability.

Examples

Job development and placement services would include:

- Contacting employers to develop and/or identify job opportunities for persons seeking employment.

- Maintaining communication and coordination with other community agencies and resources.

■ Maintaining an organized system of recording job openings including the names of employers, persons referred, and actions taken.

■ Providing feedback of information to other personnel regarding community employment opportunities and labor market trends.

An individual service plan for a person served may:

■ Integrate the results and/or recommendations from other services.

■ Contain the job objective(s) and the roles and responsibilities of the individual providing placement and the person served.

■ Consider career planning, including job advancement and job changes.

■ Identify criteria for wage increases, including productivity, longevity, and skill level.

■ Specify short- and long-term goals and objectives related to employment.

■ Identify opportunities for integration and independence.

■ Utilize generic integrated community resources to meet nonwork needs.

■ Identify short- and long-term support needed, including such supports as financial resources, natural supports, and assistive technology.

■ Consider ancillary support services, if needed.

■ Specify the length of time for which follow-up contact will be maintained, primarily based on the person's needs.

It is a good practice to review the plans of persons referred for job placement services who have not been placed at least every 30 days. Consultation occurs with the person, other appropriate professional personnel, and/or the referral source to determine if the placement plan should be amended.

Individual job development plans for persons seeking employment in crews, enclaves, etc. consider the specific tasks to be performed and match the persons' talents, interests, and strengths to the opportunities available. Also consider providing information on available job opportunities to persons who may currently be working in crews, enclaves, etc.

5.N. **3. Job development activities include, depending on the needs of the individual served:**

   a. Contacting employers and building networks to develop and/or identify job opportunities.

   b. Providing access to information about current job openings.

   c. Work-site analysis, as needed.

   d. Supports that assist the person served in an individual site, including:

     (1) Job-site consultation to identify or modify barriers to employment.

     (2) Negotiating:

       (a) Job carving.

       (b) Job accommodations.

       (c) Job sharing.

     (3) Natural supports in the workplace.

   e. Assisting the job applicants in finding jobs and employers well matched to their employment goals.

   f. Education and support in:

     (1) Self-directed job search, when appropriate.

★   **(2) ADA rights and EEOC.**

   g. Disability awareness education to the employer, when indicated.

Intent Statements

Job developers maintain active relationships with employers to promote employment opportunities for persons.

Examples

The organization enhances relationships with the community employers by:

■ Providing for close cooperation between the organization and community employers through such mechanisms as a business advisory council, membership in community employer associations, business forums, and/or formal relationships with public and private schools.

- Providing on-site job analysis, consultation, and recommendations for work-site and job modification and customized employment, when appropriate.

- Assisting employers to identify, modify, and/or eliminate architectural, procedural, instructional, communication, and/or attitudinal barriers to employment.

- Educating employers about various disabilities and resulting vocational implications, assistive technology devices, job accommodations, services provided by the organization, incentives to the employer, and current disability-related legislation affecting the employer.

During job-site consultation, recommendations may be made for customized employment. This may include work-site and job modification and assisting employers to identify, modify, and eliminate barriers to the employment and advancement of the persons served.

Best practices for contracted work groups and other personnel designs for employers often include clear guidelines in a written format outlining the roles and responsibilities of the community-based employer and the accredited organization.

Related areas include Section 1.L. Accessibility, Section 1.A. Leadership, and Section 1.C. Strategic Planning, specifically standards concerning public information and strategic planning. The CARF publication *Strategic Positioning and Planning in the 21st Century*, which is available on request from your resource specialist, may also be helpful.

3.a. Job developers in rural areas often are more successful through building face-to-face relationships with employers so that when the employer does have an opening, they are first to be contacted. Job developers in large urban areas may also have success with random lead generation by cold calling and asking if the employer is hiring and has the opening been posted yet.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration

(RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to state vocational rehabilitation (VR) agencies and their partners.

The State Employment Leadership Network (SELN) (**www.seln.org**) is a multi-state technical assistance collaborative established to improve employment outcomes for adults receiving developmental disabilities services in the U.S. Working in partnership with the National Association of State Directors of Developmental Disabilities Services and the Institute for Community Inclusion at the University of Massachusetts Boston as a community of practice, SELN assists states in developing effective employment systems by maximizing available state and federal resources through improved rate and payment systems, using data to guide daily program management and system performance, sharing resources of both time and knowledge, and providing ongoing technical assistance and training. Currently, seventeen member states participate in SELN.

Another resource for establishing successful employer partnerships is *Developing Effective Partnerships with Employers as a Service Delivery Mechanism*, which was published by Stout Vocational Rehabilitation Institute in June 1997.

5.N. **4. The services ensure that the new employee is provided information:**
   a. **Needed to be appropriately oriented to the:**
      (1) **Job.**
      (2) **Work culture.**
   b. **As is available to all employees.**

Intent Statements

Complete orientation of new employees helps ensure success.

Examples

Information provided directly by the developer or the employer includes:

- The conditions of maintaining employment.
- Job description.
- Responsibilities of the employee.
- Wage payment practices.
- Rate of pay.
- Benefits provided by the business.
- Work rules and customs.
- Nondiscrimination practices.
- Conflict resolution procedures.
- Policies for transfer.
- Employee classifications in the business.
- Health and safety practices.
- Union membership policies, if applicable.
- Potential for career growth.
- Job advancement.
- Conditions for advancement.
- Employment options available in the business.
- Career opportunities and requirements.
- Job retention.
- Improved benefits.

Information is given to the person served in a manner that is understandable to that person. These informational items may be given in a variety of ways—classroom instruction, advocacy groups, website listings, handbooks, etc.

Best practices include keeping records of persons who have been placed in outside employment that contain, at a minimum:

- Place of employment.
- Job title.
- Rate of pay and fringe benefits.
- Date on which employment commenced.
- Employment status following commencement.
- Name of the immediate supervisor, if available, at the work site.

See Section 5.B. Individual-Centered Service Planning, Design, and Delivery, and Section 1.D. Input from Persons Served and Other

Stakeholders, for additional guidance and related standards.

5.N. **5. If the person served has authorized disclosure, the organization provides the employer with information about or access to resources as needed regarding:**

    a. **Job modifications and/or reasonable accommodations.**

    b. **Federal, state, provincial, or employer tax credits, if applicable.**

    c. **Supports available from the organization, including a staff contact person.**

Intent Statements

If authorized by the person, potential employers are made aware of the resources the organization can provide to support a continued successful employment outcome.

Examples

Employers are provided with complete information about supports and assistance that can be provided by the organization and the mechanisms to obtain the assistance, such as the availability of job coach services.

The organization's job development staff may offer guidance on communication, simple redirection, and positive reinforcement suggestions for motivation.

The organization might inform or provide a resource to the employer about tax credits and disability-related legislation that may affect the employer.

To develop a successful business relationship and reputation with local employers, the organization must maintain an employer-responsive, customer-designed service and partnership. This creates a win-win situation for both the employer and the organization, thus opening the door for future placements.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Employment information or a handbook
- Individual service plans
- Progress notes
- Job development activity records
- Records of the persons served
- Systems for recording job openings and contacts
- Assessment information
- Local job market information
- Assessment of work sites

Employment Supports (CES:ES)

Description

Employment support services are activities that are employment-related to promote successful training of a person to a new job, job adjustment, retention, and advancement. These services are based on the individual employee with a focus on achieving long-term retention of the person in the job.

The level of employment support services is individualized to each employee and the complexity of the job.

Often supports are intensive for the initial orientation and training of an employee with the intent of leading to natural supports and/or reduced external job coaching. However, some persons may not require any employment supports at the job site; others may require intensive initial training with a quick decrease in supports, while some will be most successful when long-term supports are provided.

Supports can include assisting the employee with understanding the job culture, industry practices, and work behaviors expected by the employer. It may also include helping the employer and coworkers to understand the support strategies and accommodations needed by the worker.

Supports are a critical element of the long-term effectiveness of community employment. Support services address issues such as assistance in training a person to complete new tasks, changes in work schedule or work promotion, a decrease in productivity of the person served, adjusting to new supervisors, and managing changes in non-work environments or other critical life activities that may affect work performance. Routine follow-up with the employer and the employee is crucial to continued job success.

Some examples of the quality outcomes desired by the different stakeholders of these services include:

- Performance level achieved meets requirements of job or position.
- Increase in skills.
- Increase in hours worked independently.
- Increase in productivity.

- Increase in hours worked.
- Increase in pay.
- Employment retention.
- Increase in natural supports from co-workers.
- Persons served treated with respect.
- Increase in participation in the community.
- Minimize length of time for supports.
- Type and amount of staff interaction meets needs.
- Job/career advancement.
- Employer satisfaction.
- Satisfaction outcomes that reflect needs and expectations of the employee are met.
- Responsiveness to customers.
- Job club to provide a forum for sharing experiences.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.D.
- Standards in Section 5.E. as applicable

NOTE: *Standards 1.H.6., 1.H.12., and 1.H.13. (Section 1.H. Health and Safety) are not applied to community sites where persons served are working. These sites are not considered to be facilities of the program being used for service delivery, but rather are employment sites of the person served. If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.*

5.N. **6. Training strategies include, as needed:**
   a. **On-site or off-site consultations.**
   b. **Decreasing the trainer's presence on the job site.**
   c. **Transferring training and support to natural supports, when available.**
   d. **Mentoring.**
   e. **Referral to support groups or employee assistance programs, if appropriate and available.**

Intent Statements

Training strategies are individualized to the person and placement.

Examples

6.c. The design and implementation of the training plan to transfer:

- Facilitates integration at the work site through social interaction, physical proximity, participation in social activities available to all employees, and opportunities for supervision by nonprogram personnel.
- Promotes the presence and participation of the person served in natural proportions in both work and nonwork activities.
- Promotes opportunities for work site integration during the organization's marketing and job development activities within the industry.

When appropriate, a plan to transfer supervision and/or support from the organization to the employer is developed. Based on the strengths, abilities, needs, and preferences of the person served, the organization facilitates the development of natural supports.

6.d. Mentoring is an on-the-job educational process that provides opportunities for professional development, growth, and support for the person being mentored. Individuals receive information, encouragement, and advice from their mentors, who are experienced in the career field of the person being mentored.

Individuals with disabilities continue to face attitudinal barriers in employment. The mentoring process can help break down employment barriers by encouraging individuals with disabilities to take a more active role in planning and pursuing their careers. Conducting mentoring programs provides employers with access to new talent and an often underutilized workforce. It also promotes greater awareness and understanding of disabilities in the workplace.

The length of participation in job-site training is determined by the strengths, abilities, needs, and preferences of the person served and often may be of unlimited duration.

5.N. **7. When the organization provides supervision at the community employment site:**

   a. **The support staff has sufficient knowledge of the industrial and programmatic aspects of the assignment.**

   b. **Backup contingency plans exist in the event of the support staff's absence or tardiness.**

   c. **The support staff follows industry and workplace practices.**

   d. **The support staff is able to communicate effectively with staff at all levels within the employment site.**

Intent Statements

The organization trains personnel to manage field-based services.

Examples

Some staff training topics may include:

- Documentation and record keeping.
- Facilitation of use of natural supports.
- Personal counseling.
- Functional skills training.
- Medication management.
- Incident reporting.
- Legal requirements and hiring practices (e.g., Americans with Disabilities Act and Department of Labor).
- Legal requirements and hiring practices set out by provincial/territorial ministries of labor.
- Positive training and support.
- Prevention/reporting of neglect and abuse.
- Public relations and marketing for the organization.
- Reasonable accommodation including assistive technology.
- Social skills training.
- Work environments including negotiating skills, interacting with supervisors, understanding of employer needs and expectations, and organized labor.

Workplace practices include such areas as dress, grooming, appropriate identification, access to common areas, etc.

See Sections 1.H. Health and Safety and 1.I. Human Resources and Standards 1.G.1. and 5.B.7. regarding risk management and assessment.

5.N. **8. Any nonwork needs of the person served that may impact employment are:**

   a. **Identified.**

   b. **Addressed through one of the following:**

      (1) **Referral to supportive services.**

      (2) **The individual planning process.**

   c. **Monitored.**

Intent Statements

The organization understands that nonwork needs that affect employment potential must be addressed.

Examples

Based on the choices and needs of persons served, the organization provides, arranges, or refers the person for support and training in:

- Daily living tasks.
- Communication skills.
- Consumer affairs and rights (e.g., familiarity with warranties and policies and procedures of governmental and community service agencies).
- Contingency planning, problem solving, decision making.
- Developing socially and age-appropriate behaviors.
- Financial management including techniques of purchasing, banking, handling taxes, budgeting, and repaying debts.
- Functional academic skills.
- Health maintenance (e.g., personal hygiene, exercise and fitness, nutrition and diet management, infection control, and use of medical services and medicine).
- Housekeeping and home maintenance skills.
- Human sexuality.

- Interpersonal relationships including those with the person's spouse, family, and friends.
- Life issues and transitions (e.g., leaving home, substance abuse, parenting, divorce, retirement, and death).
- Management of personal and legal affairs.
- Menu planning and meal preparation.
- Mobility and community transportation skills.
- Recreational activities.
- Safety practices including dealing with injuries and life-threatening situations.
- Self-advocacy and assertiveness training.
- Use of the telephone.
- Utilization of community services and resources (e.g., laundromats, the library, post office, and consumer affairs office).

See Section 5.B. Individual-Centered Service Planning, Design, and Delivery.

5.N. **9. Individualized support services to maintain employment address, as needed:**

   a. **Knowledge of attendance and punctuality expectations.**

   b. **Demonstration of grooming skills, appropriate hygiene, and appropriate work attire.**

   c. **Job-site safety practices.**

   d. **On-the-job performance skills related to quality and quantity of work.**

   e. **Work-related community skills such as time management, mobility, and money management skills.**

   f. **Work-related communication skills.**

   g. **Work ethics and job expectations.**

   h. **Health maintenance and medication management.**

   i. **Corporate or work culture, including things such as chain of command, work relationships, and grievance procedures.**

   j. **Knowledge of governmental and community service agencies to support work success.**

   k. **Information related to how to access these services.**

   l. **Functional job-related literacy skills.**

   m. **Work-related academic skills.**

   n. **Knowledge of work practices.**

   o. **Work-related technology.**

   p. **Self-advocacy and assertiveness skills.**

Intent Statements

The services and supports provided by the organization cover a sufficient array of work-related skills and knowledge necessary to assist persons to understand the meaning, value, and demands of work, as well as how to access services and supports when necessary. The individual support services related to maintaining employment should assist individuals served to develop personal characteristics, attitudes, and work behaviors, and enhance functional capacities to continue success in employment.

Examples

Ongoing individual input and preferences, coupled with the person's strengths/skills, are essential to achieving employment goals and reaching maximum employment potential. To ensure success, the person served is oriented to the expectations of the employer and what is required to maintain the job. Items covered in this standard can be addressed in real paid work activities where the person served gets hands-on experience with the demands of the world of work, in a classroom-type setting, or an individual guidance session from staff. Literature and contacts for other community services may be of assistance to persons served.

Specific education supports and services regarding work-related skills are available based on the person's needs and preferences. Supports and services should be flexible enough to meet the need of the person at his/her functioning level and preferences and not require the person to receive training in skills that are already achieved.

Work-related community skills may include supports and services for such matters as how the individual will plan for his/her lunches, how to deal with transportation problems, and how to cash checks.

5.N. 10. Individual support activities address, as needed, integration into the employment setting.

5.N. 11. Ongoing job support services to retain employment are provided at times and locations suited to meet the needs and desires of the:
   a. Person served.
   b. Employer.

Intent Statements

Supports are convenient to all stakeholders.

Examples

The services/supports may be provided at the employment site itself or at another location off-site if this better meets the person's needs.

Supports to help those served to retain employment may be time limited or ongoing, and may be provided by the organization or through affiliation, association, or other agreements that enhance the success of the person served. Support may be given to the employer's personnel as a strategy for transferring supervision from the organization to the employer and reducing the need for paid support services. Postemployment and follow-up services are designed to promote adequate job adjustment and retention.

When the organization provides supervision and training at the work site, the supervisor or trainer is knowledgeable of:

■ The type of work performed in the assignment.

■ The rehabilitation techniques appropriate to the persons served to support them and promote adequate performance.

5.N. 12. For persons who are receiving long-term services, there is review at least semi-annually of the level of ongoing supports needed with the:
   a. Person served.
   b. Employer, as appropriate.

Intent Statements

The level of support is individualized and changes as needs change.

Examples

A documented system is in place to provide organized support contacts at regular intervals with the persons served. As appropriate, contact at regular intervals is made with the employer.

Follow-along supports would be documented.

With the permission of the person served, personnel maintain communication with family members and others who are likely to influence the probability of successful outcomes.

5.N. 13. Based on the aspirations of the person served, the program provides or refers the person to resources for career planning and advancement.

Intent Statements

The organization ensures that it has the availability of or linkages to other resources to improve the employment situation of persons served by supporting them in additional training, education, and advocacy, according to the employment service plan.

Examples

When an individual decides that an alternative job or location is desirable, the organization supports the person in the transfer process.

The staff is aware of persons' progress and their potential desire to advance or consider an alternative career path. The organization is able to assist persons in developing a plan to achieve alternative career goals and assist them in such pursuits if they desire. If the training that is required to reach new goals is outside the organization's level of expertise, it may refer the person served to another resource. Documentation supporting these activities may be found in the case record.

5.N. 14. If applicable to the persons served, the program has a policy that indicates its role in providing or arranging for employment crisis intervention services.

Intent Statements

Individuals may have a need for crisis intervention services. The organization should ensure that these services can be accessed as necessary.

Examples

Critical incidents may arise that require an organization to assist the person served to resolve a crisis that could disrupt the continuity of employment.

Based on the person's preferences, strengths, and needs, the employment service plan identifies the type of crisis services that may be needed as well as the action that may be necessary to resolve the crisis. The work plan would include, but not be limited to, emergency contacts, individual preference for psychiatric/medical care, and what works best for the individual during a crisis. Although each crisis is different, it helps to have a general idea of what level of intervention may be comfortable and required for the individual.

If the person has an advance health care directive, it is available and used by the organization.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Individual service plans
- Information regarding community services and resources
- Documentation of services provided
- Progress reports
- Staff training records
- Training plans
- Task analysis
- Local job market information
- Job development activity records
- Assessments of work sites
- Policy regarding crisis intervention services, if applicable

Personnel Services to Employers (CES:PSE)

Description

When an organization identifies itself as a personnel service, it pays wages at or above minimum wage and provides a benefit package for all employees when they are on the organization's payroll. Employment is provided in regular business settings in the community, and career advancement resources are provided. The service may use customized employment, which focuses on creating negotiated employment relationships that meet both employer and job seeker needs. (*Customized employment* is individualizing the employment relationships between employees and employers in ways that meet the needs of both.)

A business plan is used to design and strategically position the service to be responsive to the changing needs of employers and desires of job seekers.

Some examples of the quality results desired by the different stakeholders of these services include:

- Employment.
- Earnings and benefits.
- Increased skills.
- Building a résumé with varied experience.
- Career development.
- Employment in an integrated environment.
- Meaningful work.
- Opportunities to feel valued.
- Employers satisfied with the services.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- Section 5.A. Standards 1.–11.
- Standards in Section 5.E. as applicable

NOTE: *Standards 1.H.6., 1.H.12., and 1.H.13. (Section 1.H. Health and Safety) are not applied to community sites where persons served are working. These sites are not considered to be facilities of the program being used for service delivery, but rather are*

employment sites of the person served. If any clarification is needed, please contact a resource specialist in the Behavioral Health customer service unit.

5.N. **15.** **The personnel service develops a business plan that addresses:**
   a. **The defined geographical market service area.**
   b. **Analysis of job seekers' preferences.**
   c. **Analysis of employer needs.**
   d. **Linkages between community agencies.**
   e. **The proposed services.**
   f. **Establishment of a distinct business identity and operating budget.**
   g. **Identified requirements of doing business.**
   h. **Business objectives.**

Intent Statements

The personnel service is designed and strategically positioned to meet the needs of local employers and job seekers.

Examples

A successful personnel service manages its services in a dynamic fashion. Although the standard encourages the development of a business plan, a successful organization with visionary leadership will realize that its business plan will be constantly evolving and changing to meet the needs of its local market place.

Some related standards in business practices include Sections 1.D. Input from Persons Served and Other Stakeholders, 1.M. Performance Measurement and Management, and 1.N. Performance Improvement.

Resources

Additional guidance for establishing and positioning a successful personnel service may be found in the CARF publication *Strategic Positioning and Planning in the 21st Century*, which is available on request from your resource specialist.

5.N. **16.** **The personnel service develops a marketing plan that includes:**
   a. **Market demographics/size.**
   b. **Competitive analysis.**
   c. **Target markets.**
   d. **Services differentiation between it and its competitors.**
   e. **Marketing budget.**
   f. **Marketing strategy to promote the business.**

Intent Statements

The personnel service is designed to fulfill a unique niche in employer services and create a match that is unique to the job seeker's needs and abilities.

Examples

An accredited personnel service establishes and maintains its niche in the market of employer services by managing and planning its design based on data on employment needs and satisfaction of employers. By the organization examining its own strengths, business needs, business opportunities, and threats to its business, it is able to target the market and create a service design that fits within its service capabilities and results in successful "the customer is satisfied" service.

5.N. **17.** **The personnel services are continuously improved based on:**
   a. **Local employer input and information.**
   b. **Review of labor and employer trends.**
   c. **Service satisfaction of job seekers.**
   d. **Satisfaction of employers.**

Intent Statements

A successful personnel service is managed from the data and information of its business and service results.

Examples

A business plan for personnel services should be considered a dynamic and ever-changing guide—not a one-time event. The continuous improvement of an organization's personnel service reflects the perspectives of its job seekers and employers. Supportive standards and guidance

can be found in Section 1.A. Leadership, Standard 3. and in Section 1.N. Performance Improvement.

5.N. **18.** **The job seeker/employee is given information about:**

a. **The training of staff to provide the services.**

b. **Availability of jobs in the local job market.**

c. **Potential career advancement.**

d. **Rates of pay.**

e. **Availability of benefits.**

Intent Statements

The job seeker is provided with information to make informed choices.

Examples

The job seeker is able to get accurate and current information about the organization's potential to deliver services relevant to their needs and desires. Information may be provided through various means including promotional materials, videos, audio recordings, written information, handbooks, website postings, or annual reports.

5.N. **19.** **As needed, the job seeker receives educational resources on:**

a. **Safety precautions and the prevention of injuries and occupational diseases.**

b. **Appropriate medical or behavioral health resources/options.**

c. **Medications and their potential effects on employment performance.**

d. **Job analysis, restructuring, modification, and work conditioning.**

e. **Employment applications.**

f. **Résumé development.**

g. **Interviewing skills.**

h. **Salary and benefits negotiations.**

i. **The role of organized labor in business.**

j. **Employee assistance services and resources.**

k. **Career development.**

l. **Self-advocacy.**

m. **Managing the impact of earned income on government or insurance benefits.**

n. **Other issues identified for the individual, as desired.**

Intent Statements

Current and individualized information on employment and employment-related issues is vital to the individual job seeker's successful adjustment to employment and eventual career development.

Examples

This standard does not require that an organization develop this information on its own nor does all this information have to be provided to each individual. Many of these services may be arranged, contracted for, or identified through many different means and resources, including online websites or up-to-date printed materials, audio and video recordings, or alliance with local community resources.

5.N. **20.** **The employer is provided with:**

a. **Educational resources.**

b. **Referrals of qualified job applicants.**

c. **Technical assistance.**

Intent Statements

The value of this standard is that the success of personnel services is based on meeting the needs of employers.

Examples

Qualified job applicants are matched to the unique and often customized employment support expectations of the employer. This "customer designed" personnel service is provided in such a way that the employer sees the personnel service as a human resource partner. Although not all employers will need educational resources or technical assistance, the accredited personnel service is capable of locating or arranging for them on an individualized and "as needed" basis.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration (RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to state vocational rehabilitation (VR) agencies and their partners.

5.N. **21. When the personnel service has an employment relationship with the job seeker/employee, the organization complies with:**

★ **a. All applicable United States Internal Revenue Service rules and regulations.**

b. Other applicable laws and regulations.

c. Its own internal policies and procedures.

Intent Statements

An organization in the U.S. demonstrates compliance with the Fair Labor Standards Act and other relevant legislation. Canadian organizations should be able to demonstrate how they comply with their federal and provincial labor laws. Compliance with applicable laws and regulations is an integral part of the organization's procedures. Changes in applicable laws and regulations are integrated into the organization's system.

Resources

Further information can be obtained from the U.S. Department of Labor **www.dol.gov**, 1-866-4-USA-DOL, TTY 1-877-889-5627. Employment and training questions: 1-877-US-2JOBS. Wage and hour questions: 1-866-4USWAGE. Workplace safety and health questions: 1-800-321-OSHA.

5.N. **22. The job developer ensures that the new employee is provided with:**

a. A strategy for making informed choices.

b. Information as is available to all employees to be appropriately oriented to the job.

Intent Statements

Complete orientation of new employees helps ensure success.

Examples

Information provided directly by the developer or the employer includes:

- The conditions of maintaining employment.
- Job description.
- Responsibilities of the employee.
- Wage payment practices.
- Rate of pay.
- Benefits provided by the business.
- Work rules and customs.
- Nondiscrimination practices.
- Conflict resolution procedures.
- Policies for transfer.
- Employee classifications in the business.
- Health and safety practices.
- Union membership policies, if applicable.
- Potential for career growth.
- Job advancement.
- Conditions for advancement.
- Employment options available in the business.
- Career opportunities and requirements.
- Job retention.
- Improved benefits.

Information is given to the person served in a manner that is understandable to that person. These informational items may be given in a variety of ways—classroom instruction, advocacy groups, website listings, handbooks, etc.

Best practices include keeping records of persons who have been placed in outside employment that contain, at a minimum:

■ Place of employment.

■ Job title.

■ Rate of pay and fringe benefits.

■ Date on which employment commenced.

■ Employment status following commencement.

■ Name of the immediate supervisor, if available, at the work site.

See Section 5.B. Individual-Centered Service Planning, Design, and Delivery and Section 1.D. Input from Persons Served and Other Stakeholders for additional guidance.

5.N. **23. When the organization bids for contracted personnel services, it includes:**

   a. All direct costs.

   b. All indirect costs applicable to each contract.

   c. Profit.

   d. Consideration of fair market value.

   e. An annual review of all contracts.

Intent Statements

The organization seeks business on a fair and competitive basis. To achieve financial stability, the organization knows its costs and bids competitively in the local job market.

Examples

When the organization provides personnel services, sound and acceptable practices are observed in all business activities, including pricing. See related standards in Section 1.F. Financial Planning and Management.

The bid price includes all direct and indirect costs applicable to each job. An overhead markup supported by a precise written analysis of costs is charged. The value of any administrative or operational services, equipment, or space provided by the organization for the personnel service is included in the determination of this markup. Indirect costs include staff salaries and benefits, occupancy, depreciation, administrative costs, and all other costs which can be directly

identified with the job. All donated equipment, materials, and services are included in the contract bid price at fair market value.

Rates charged businesses for its temp services are based upon full cost reimbursement and are in line with the prevailing price range in the competitive market.

This standard relates to the code of ethical conduct of business practices and marketing activities referred to in Standard 1.A.6.a.

5.N. **24. Job development planning considers these factors:**

   a. Referral and assessment information.

   b. Desires of the job seeker.

   c. Job-seeking skills assessment of the person.

   d. Opportunities available for employment in the employment market.

Intent Statements

Job placement services are provided or made available to assist persons to identify, obtain, maintain, and/or advance in employment. Provided on an organized, planned basis, these services should include, but not be limited to, preparation of the person for employment, job development and placement, follow-up, and post-employment services.

Examples

The most successful employment preparation services include:

■ Assessing the appropriateness of the referral for job placement services.

■ Analyzing pertinent findings from medical, psychological, or prior vocational services and/or work adjustment services in order to maximize the person's employment opportunities, job performance, job satisfaction, job retention, and special considerations determined by living arrangements.

■ Counseling and/or training of individuals and/or groups regarding the techniques for obtaining and maintaining employment.

■ Assisting the persons served to become knowledgeable about job duties, personnel benefits, rates of pay, employment policies

and practices, and the job location prior to job acceptance.

■ Eliciting information about job preference, salary expectations and needs, insurance needs, transportation needs, and hours and days that the person is available to work.

■ Assisting the person served to become knowledgeable regarding the impact of employment on disability and other benefits as well as providing information on the means available to access such benefits.

Career counselors, job developers, and individual job seekers can use formal and informal assessments for a variety of purposes:

■ To clarify a job seeker's likes and dislikes.

■ To uncover individual strengths and talents.

■ To connect skills to interesting occupations.

■ To identify which, if any, work accommodations are needed.

■ To pinpoint the settings where target jobs occur and, more importantly, where the job seeker will be happiest.

Assessment activities provide the job counselor with invaluable material for matching a job seeker's interests, skills, and abilities to the right job. Some examples of informal assessment activities that can help guide the job search are:

■ A "career autobiography"—a narrative description of the hobbies, interests, education, training, and volunteer and paid work experiences that make them who they are today. The skillful job counselor will use the autobiography to identify themes recurring throughout the person's personal history that indicates the kinds of activities he or she gravitates toward, enjoys, and excels at.

■ Quick "paper and pencil" checklists, available from a variety of sources, are useful for interacting with and getting to know job seekers. Look for ones covering a wide range of skills and abilities and that include a rating scale which job seekers can use to indicate the degree to which they have mastered each skill. If possible, complete skills inventories with candidates and use the opportunity to explain

what is being asked and to prompt recall of all relevant experiences.

■ "Testimonials" about strengths, accomplishments, and abilities gathered from peers, teachers, parents, and past employers provide external validation and help round out the picture.

The job counselor then synthesizes all of the information collected through formal and informal assessment activities and reflects back the important highlights and themes to job seekers in an organized way.

Refer to related standards in Section 1.L. Accessibility and Section 5.B. Individual-Centered Service Planning, Design, and Delivery.

5.N. 25. Job development activities include:

a. Contacting employers and building networks to develop and/or identify job opportunities.

b. Work-site analysis, as needed.

c. When appropriate, providing job-site consultation to identify or modify barriers to employment.

d. Providing consultation in job carving or other job accommodations.

e. Maintaining an organized system of current job openings.

f. Assisting the job applicants in finding jobs and employers well matched to their employment goals.

g. Methods to create the job seekers' employment profile.

h. Guidance on how to create and use an employment portfolio.

Intent Statements

Job developers promote active relationships with employers.

Examples

The organization enhances relationships with the community employers by:

■ Providing for close cooperation between the organization and community employers through such mechanisms as a business advisory council, membership in community employer associations, business forums,

and/or formal relationships with public and private schools.

- Providing on-site job analysis, consultation, and recommendations for work-site and job modification and customized employment, when appropriate.

- Assisting employers to identify, modify, and/or eliminate architectural, procedural, instructional, communication, and/or attitudinal barriers to employment.

- Educating employers about various disabilities and resulting vocational implications, assistive technology devices, job accommodations, services provided by the organization, incentives to the employer, and current disability-related legislation affecting the employer.

During job-site consultation, recommendations may be made for customized employment. This may include work-site and job modification and assisting employers to identify, modify, and eliminate barriers to the employment and advancement of the persons served.

Best practices for contracted work groups and other personnel designs for employers often include clear guidelines in a written format outlining the roles and responsibilities of the community-based employer and the accredited organization.

Related areas include Section 1.L. Accessibility and 1.A. Leadership, specifically standards concerning public information and strategic planning.

5.N. **26. Training activities address, as needed:**

   a. **Orientation to the work-site environment.**

   b. **Orientation to the work-site culture.**

   c. **Orientation to work duties.**

   d. **Job performance and progress.**

   e. **Increasing individual performance to company standards.**

   f. **Work-site job modifications, if needed.**

   g. **Integration into the employment setting.**

   h. **Strategies for resolving job-related issues.**

   i. **Use of transportation.**

Examples

Some important results from the Employment Intervention Demonstration Program (EIDP) showed that:

- Persons who receive a relatively balanced amount of well-integrated and coordinated vocational and clinical services have much better employment outcomes than those who receive non-integrated services.

- Persons' employment success increases over time, making it important that programs be prepared to offer ongoing support and services that build on career achievements.

- Integrated employment services result in positive employment outcomes regardless of personal characteristics, health problems, diagnoses, symptom levels, work histories, and functioning level of the persons served.

- Persons need to receive more vocational services to complement the levels of clinical services they are offered.

- Some persons may need extra assistance or tailoring of programs to meet special needs (e.g., help with medical problems, support for dealing with troublesome symptoms, and extra training for those with little prior work experience).

5.N. **27. Based on the needs and choices of the job seeker, the organization provides or refers the job seeker to resources for addressing, as relevant to employment and career advancement:**

   a. **Basic academic skills.**

   b. **Basic self-care skills.**

   c. **Communication skills.**

   d. **Work attitudes.**

   e. **Tools and equipment related to the person's job.**

   f. **Mobility and travel training.**

   g. **Interpersonal relationships with coworkers.**

   h. **Job-site safety practices.**

i. **Self-advocacy and assertiveness skills.**

j. **Career planning.**

k. **Problem solving and decision-making skills.**

l. **Health maintenance and medication management.**

m. **Knowledge of governmental and community service agencies.**

n. **Management of legal affairs.**

o. **Management of benefits and financial resources.**

p. **Use of technology.**

q. **Use of community services and resources.**

r. **Benefits management and planning.**

Intent Statements

Job support services are provided according to the individual needs.

Examples

27.q. Community services and resources include laundromats, the library, post office, etc.

It is not required that every person served receive all services/supports available. Each person receives only those services/supports that will help the person meet his or her employment goals. However, the organization has the capability in place to address each area listed in this standard.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Business plan
- Operating budget
- Marketing budget
- Marketing plan
- Business records
- Employee handbook
- Employee personnel files
- Employee evaluations
- Employee training records
- Personnel policies
- Contract bids
- Skills assessments
- Training activities

O. Employment Skills Training Services (EST)

Description

Employment skills training services are organized formal training services that assist a person seeking employment to acquire the skills necessary for specific jobs or families of jobs. Such services can be provided at job sites in the form of apprenticeships, on-the-job training, and/or volunteer situations; within formal and organized training and educational settings (such as community colleges and trade and technical schools); or within the organization.

Some examples of the quality outcomes desired by the different stakeholders of these services include:

- Persons show improvement in skill level.
- Specific marketable skills are developed.
- Persons served achieve employment in the area of training.
- Persons secure employment with benefits.
- Persons retain employment.
- Training is completed in a timely manner.
- Training is cost-effective for the results produced.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional.
- All standards in Section 5.A.
- All standards in Section 5.B.
- All standards in Section 5.D. Employment Services Principle Standards
- Standards in Section 5.E. as applicable.

5.O. **1.** **An employment skills training course is designed to meet the workforce needs identified by employers within regional industry sectors.**

Examples

The skills training course is based on the community's personnel needs. In the United States, these potential jobs are usually categorized by the Department of Labor into specific families of jobs or categories of occupations. In Canada, job classifications are set out by provincial/territorial ministries of labor.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration (RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to state vocational rehabilitation (VR) agencies and their partners.

5.O. **2.** **Each course description/curriculum includes:**
- a. **The planned length of the course and the course schedule.**
- b. **The sequence of topics or areas to be covered.**
- c. **The materials, equipment, and tools relevant to the job that will be used.**
- d. **Methods of instruction.**
- e. **Education or certification requirements for course instructors, if applicable.**
- f. **Minimum requirements necessary to participate in the course.**
- g. **Training objectives relative to:**
  - (1) **Skills.**
  - (2) **Work place competencies.**
  - (3) **Knowledge.**
- h. **Requirements for course completion.**
- i. **Jobs or job titles held by a person completing the course.**
- j. **Credentials or certifications recognized by employer that are received upon completion, if applicable.**

Intent Statements

A written course description or curriculum identifies everything to know about the course.

Examples

2.a. Course schedules indicate whether the training offers open enrollment or has a set schedule.

The list of topics covered is maintained and refined using the organization's outcomes management system to guide and improve services.

5.O. **3.** Realistic information is provided about:

    a. **Availability of similar jobs in the local industry sector.**

    b. **Potential career pathways and advancement opportunities.**

    c. **Typical pay ranges.**

    d. **Benefits typically available.**

Intent Statements

The organization provides accurate information that relates courses to jobs in the local area.

Examples

In order to be informed, make choices, and be involved, the persons served should be able to get accurate and current information about the organization's results of services and its potential to deliver services/supports relevant to their needs and desires. Information is provided about the variety of service options available, or support approaches to a service need.

5.O. **4.** In addition to technical skills, courses address, as needed:

    a. **Attendance and punctuality.**

    b. **Grooming skills, hygiene, and appropriate work attire.**

    c. **Job-seeking skills.**

    d. **On-the-job performance skills related to quality and quantity of work.**

    e. **Functional literacy skills.**

    f. **Knowledge of work practices.**

    g. **Work-related academic skills.**

    h. **Work-related communications skills.**

    i. **Work-related interpersonal skills.**

    j. **Work ethics.**

    k. **Corporate or work culture.**

    l. **Customer service.**

Intent Statements

The skills training program is designed and continually enhanced with input from an employer association, educational entity, or specific employer. Soft skill requirements as listed in this standard may vary from employer to employer. The purpose of this standard is to ensure provision of resources or linkages to encourage successful employee behaviors in persons served.

Examples

4.c. Job-seeking skills include skills such as interviewing, completing applications, and developing and using job-finding networks and resources.

4.e. Functional literacy skills include skills such as time management, mobility, and money management skills.

4.f. Knowledge of work practices includes items such as payroll deductions, insurance, benefits, safety, unions, and retirement.

4.i. Work-related interpersonal skills include conflict resolution and anger management.

4.k. Corporate or work culture includes areas such as chain of command, work relationships, and grievance procedures.

5.O. **5.** When the skills training program is an industry-based apprenticeship:

    a. **The design and implementation of the program is based on input from relevant stakeholders, including:**

        (1) **Employers.**

        (2) **Unions, if applicable.**

    b. **Staff members are knowledgeable in the requirements of the industry.**

    c. **There is a clear description of the role and function of program staff members assigned to the apprenticeship site.**

    d. **Lines of communication between staff members and appropriate individuals at the apprenticeship site are clearly defined.**

e. If program staff provide work site supervision:

  (1) The supervisor is qualified in the industrial and programmatic aspects of the assignment.

  (2) Contingency plans for supervision when the supervisor is late or absent are:

      (a) In place.

      (b) Communicated to all appropriate parties.

f. Written procedures and techniques specific to the services provided and the location where they occur are shared with all appropriate parties.

g. Provisions are in place to cover:

  (1) Workers' compensation.

  (2) Other potential liability issues specific to the industry, if applicable.

h. Employers are informed about confidentiality requirements regarding persons served in the program.

i. Ensuring periodic feedback to and assessment of the trainee is part of the program's responsibilities.

Intent Statements

The program is designed to meet the personnel needs of employers and achieve employment outcomes success for persons served.

Examples

5.b. Industry knowledge includes regulations, practices, procedures, conduct, and any other requirements specific to the industry.

5.O. **6.** The services are expanded, modified, or discontinued based on:

  a. Local industry sector information.

  b. Labor market trends/forecasts and industry expectations.

  c. Satisfaction of and input from the person served.

  d. Satisfaction of and input from employers.

  e. Satisfaction of other stakeholders, if applicable.

  f. Performance outcomes analysis.

Intent Statements

The training is continually designed to meet industrial and business needs and overall stakeholder satisfaction.

Examples

A review of the course examines the currency and relevance of the curriculum content, materials, and equipment. Information on the satisfaction of the persons served and employers can also be used to guide curriculum revisions.

A promising practice for planning and continuously improving a skills training program is to consider changing population characteristics and demographics such as new immigrant populations, relocation data, aging, etc.

Conformance to this standard may be determined by comparing the results of job development/job placement to the curriculum and the local job market.

The organization's outcomes management system can provide valuable information on planning and continuously improving the design and delivery of employment training services.

Resources

The CARF publication *Strategic Positioning and Planning in the 21st Century*, which is available on request from your resource specialist, provides assistance in designing services to meet customer needs and responding to environmental considerations.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- A course description
- A formal training curriculum
- Individual service plans
- Progress notes
- Records of the persons served

P. Employee Development Services (EDS)

Description

Employee development services are individualized services/supports that assist persons seeking employment to develop or reestablish skills, attitudes, personal characteristics, interpersonal skills, work behaviors, functional capacities, etc., to achieve positive employment outcomes.

Such services/supports are time limited and can be provided directly to persons seeking employment or indirectly through corporate employer/employee support programs. These services/supports can be provided at job sites, within formal and organized training and educational settings, through coaching, by tutorial services, or within the organization. These services may be offered in a free-standing unit or as a functional piece of other services.

Some examples of the quality outcomes desired by the different stakeholders of these services include:

- Person served obtains employment.
- Person served moves to a training program or better employment.
- Person served retains his or her job.
- Person served obtains improved benefits.
- Increased wages.
- Increased skills.
- Increased work hours.
- Movement to competitive employment.
- Employment in an integrated environment.
- Job advancement potential increases.
- Job-seeking skills are developed.
- Job-keeping skills are developed.
- Career growth and development.
- Level of support needed is reduced.
- Exposure to and availability of a variety of jobs.
- Program is kept at capacity.

- Services are cost-effective for the results achieved.
- Responsiveness (days from referral to starting services).

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.D.
- Standards in Section 5.E. as applicable

5.P. **1. Individualized employee development services:**
   a. **Identify the employment objective of each person seeking employment, if this has not been completed prior to entering the service.**
   b. **Identify the supports/services needed by the person to progress toward the desired employment outcome.**
   c. **Reflect the progress of the person over time toward achieving the identified employment outcomes.**

Intent Statements

The design of services is specific to the employment objective of the person seeking employment.

Examples

Services will vary and be influenced by cultural diversity, customs of the local job market, and the specific employer/work-site culture.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration (RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to

state vocational rehabilitation (VR) agencies and their partners.

5.P. 2. When indicated as needed in a person's individual plan, services/supports are provided to address:

a. **Attendance and punctuality.**

b. **Grooming skills, hygiene, and appropriate work attire.**

c. **Job-seeking skills such as interviewing, completing applications, and developing and using job-finding networks and resources.**

d. **On-the-job performance skills related to quality and quantity of work.**

e. **Work-related skills such as time management, mobility, and money management skills.**

f. **Functional literacy skills.**

g. **Knowledge of work practices such as payroll deductions, insurance, benefits, safety, unions, and retirement.**

h. **Work-related academic skills.**

i. **Work-related communication skills.**

j. **Work-related interpersonal skills, including conflict resolution and anger management.**

k. **Work ethics.**

l. **Corporate or work culture, including things such as chain of command, work relationships, and grievance procedures.**

m. **Customer service.**

Intent Statements

Services/supports are individualized to the person's needs. Corporate and community cultures should also be considered in services design.

Examples

The organization may provide or arrange for these services/supports. It is not required that all of these services/supports be provided for every person; each person is provided with only the services/supports that will help him or her to achieve the desired employment outcomes.

Referrals or contracted services are provided, as appropriate, that address barriers to the person's employment goals. Some resources may include:

■ Access to governmental and community services agencies.

■ Resources for legal affairs/tax matters.

■ Resources for transportation needs.

■ Resources for nonwork-related needs, including housing and child care.

Use of assistive technology and/or reasonable accommodations may reduce or eliminate barriers to successful employment outcomes.

Related standards in Section 5.B. Individual-Centered Service Planning, Design, and Delivery may provide additional guidance.

5.P. 3. When an employee development training course is provided:

a. **The course description specifies the:**

(1) **Job-related work competencies/skills that are addressed in the course.**

(2) **Methods of instruction.**

(3) **Course objectives in measurable terms.**

b. **Course content is:**

(1) **Reviewed at least annually.**

(2) **Updated as needed to ensure continuing relevance to the potential labor market.**

Intent Statements

A written course description or curriculum identifies everything to know about the course.

Examples

The list of topics covered is maintained and refined using the organization's outcomes management system to guide and improve services.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Individual service plans
- Progress notes
- Results of service—placements, additional training, and movement

Q. Employment Planning Services (EPS)

Description

Employment planning services are designed to assist a person seeking employment to learn about employment opportunities within the community and to make informed decisions. Employment planning services are individualized to assist a person to choose employment outcomes and/or career development opportunities based on his or her preferences, strengths, abilities, and needs. Services begin from a presumption of employability for all persons and seek to provide meaningful information related to planning effective programs for persons with intervention strategies needed to achieve the goal of employment.

Employment planning uses some type of employment exploration model. This may involve one or more of the following:

- Situational assessments.
- Paid work trials.
- Job tryouts (may be individual, crew, enclave, cluster, etc.).
- Job shadowing.
- Community-based assessments.
- Simulated job sites.
- Staffing agencies/temporary employment agencies.
- Volunteer opportunities.
- Transitional employment.

Some examples of quality outcomes desired by the different stakeholders of these services include:

- Work interests are explored and identified.
- Recommendations for employment options are appropriate.
- Employment planning reports lead to job goals.
- Transferable work skills and employment barriers are identified.
- Benefits planning is included.
- Services are timely in their delivery.

- Services are cost-effective.
- Individuals served understand recommendations that are made.
- Individuals served identify desired employment outcomes.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- Section 5.A. Standards 1.–11.
- Section 5.B. Standard 1.
- All standards in Section 5.D.
- Standards in Section 5.E. as applicable

5.Q. **1. Employment exploration sites utilized for the person seeking employment are appropriate to obtain desired information.**

Intent Statements

The assessment of employment sites in relation to the individual's interests, needs, and functional abilities is critical to the individual making informed choices about his or her future employment goals.

Examples

Information about a person served to be considered in identifying suitable sites might include:

- Self-reported interests and experiences.
- Needs regarding safety and supervision.
- Needs regarding assistive technology and/or job accommodations.
- Other considerations identified, as appropriate to the individual.

In conjunction with risk management strategies, an organization would want to consider the safety of any site before using it. Factors that might be considered about individual sites include:

- Adequacy of supervision.
- Safety or individual risk management concerns.
- Specific work-site requirements.
- Potential job accommodations.

- Accessibility.
- Expectations for quality and quantity of work.
- Job/task analysis.
- Potential employment opportunities in the local job market.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration (RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to state vocational rehabilitation (VR) agencies and their partners.

5.Q. **2. Employment exploration assesses the person's performance related to:**
   a. Job skills.
   b. Interest in a particular job.
   c. Work-related behaviors.
   d. Need for potential job accommodations.
   e. Other pertinent information related to the job seeker.

Examples

Assessments might include information about the person's:

- Learning style, which might include demonstration, written, verbal, or modeling.
- Aptitudes, which might include mechanical or clerical.
- Modes of communication.
- Endurance/stamina.

2.d. Job accommodations may include the use of assistive technology.

5.Q. **3.** **A person seeking employment is informed of job opportunities and requirements in the employment market consistent with his or her interests and abilities.**

Intent Statements

Employment planning calls for a determination of realistic employment opportunities in the local job market.

Examples

This planning is done within the context of the local job market and the geographic area accessible to the persons served. The organization may define in its promotional materials or orientation sessions with the persons which geographical and labor market areas it serves.

Current information on local job opportunities is maintained. This information addresses not only labor trends and employer needs, but also relevant community supports, services, and transportation. The organization may make use of local employment studies, employment offices, internet connections, and other data-based methods for determining the nature of the local labor market. Job carving or customized employment may be an important strategy to the development of job opportunities. Self-employment may consist of several micro-enterprises that the person operates.

The standard may also form the basis for questions used on stakeholder satisfaction surveys in the organization's outcomes system. See related standards in Section 1.M.

Related standards may be found in Section 5.B. Individual-Centered Service Planning, Design, and Delivery.

5.Q. **4.** **A written employment planning report:**
   a. **Is completed for each person served.**
   b. **Addresses:**
      (1) **Employment exploration results.**
      (2) **The planned employment outcome and/or plan to achieve the desired employment outcome, including:**
         (a) **Relevant jobs available in the employment market.**
         (b) **Strengths of the person evidenced during explorations.**
         (c) **Barriers to the achievement and maintenance of employment.**
         (d) **Transportation and other support needs.**
   c. **Includes:**
      (1) **Self-evaluation by the person of the employment exploration experience, if possible.**
      (2) **Individualized environmental, assistive technology, or job-task accommodations used.**
      (3) **Recommendations for community resources and/or services, as needed, to assist in addressing employment barriers.**

Intent Statements

This provides a blueprint guiding to desired employment outcomes.

Examples

The employment planning report clearly identifies the next steps for a person to take to achieve successful employment.

For people with significant disabilities, the need for long-term supports and the likelihood of developing natural supports is addressed.

4.b.(1) The exploration results capture a comprehensive summary of all information from the assessment.

5. The person's employment planning report is:

   a. Shared in an understandable manner with the person seeking employment.

   b. Disseminated in a timely manner to the referring agency individual responsible for implementing recommendations in the report.

Examples

5.a. The report is shared in an understandable manner with the person seeking employment. This may mean some additional explanations and supports are necessary for comprehension and retention (e.g., the person might desire to have a personal advocate in attendance).

5.b. "Disseminated in a timely manner" implies that the persons served and significant stakeholders were satisfied in the time it took to receive the written report. Sharing the report with entities beyond the referring entity individual and the person served would require written permission of the person served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Individual service plans
- Progress notes
- Employment planning reports
- Referral information
- Guidelines/procedures for methods used
- Information related to assessment of career exploration sites
- Information regarding local job opportunities

R. Evaluation Services

Introduction

In this section two distinct programs are available for accreditation. Although both programs offer services to assist persons to identify viable vocational options, there are differences in scope. An organization may seek accreditation in only one or in both, based on the services it provides and its desires for accreditation.

- Comprehensive Vocational Evaluation Services (CVE)—page 346
- Targeted Employment Screening (TES)—page 352

Comprehensive Vocational Evaluation Services (CVE)

Description

Comprehensive vocational evaluation services provide an individualized, timely, and systematic process by which a person seeking employment, in partnership with an evaluator, learns to identify viable vocational options and develop employment goals and objectives. A vocational evaluator or vocational specialist provides or supervises the services.

An accredited comprehensive vocational evaluation service is capable of examining a wide range of employment alternatives. The following techniques are used, as is appropriate to the person being assessed, to provide comprehensive vocational evaluation services:

- Pre-evaluation assessment of assistive technology needs.
- Assessment of functional/occupational performance in real or simulated environments.
- Work samples.
- Employment exploration model.
- Psychometric testing.
- Preference and interest inventories.
- Personality testing.
- Extensive personal interviews.

- Other appropriate evaluation tests, depending on the individual.

- Analysis of prior work and/or volunteer experience and transferable skills.

Some examples of the quality results desired by the different stakeholders of these services include:

- Realistic job opportunities are explored and identified for individuals.

- Employment barriers are identified and ways to overcome these are suggested.

- Identification of assistive technology or other accommodations.

- The evaluation is completed within the authorization period.

- The person served understands the results.

- The cost per evaluation is acceptable.

- Interests of the persons served are thoroughly explored.

- Evaluation reports lead to job goals.

- Transferable skills are identified.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional

- Section 5.A. Standards 1.–11.

- Section 5.D. Standards 1.–3.

5.R. **1.** **An individual evaluation plan is developed in a timely manner with each person served and is based on:**

   a. **Referral information.**

   b. **Referral questions to be answered.**

   c. **Questions from the person served.**

   d. **The initial interview.**

   e. **The stated overall purpose of the evaluation.**

   f. **Pre-evaluation assessment of potential modifications required to meet a person's specific needs.**

Intent Statements

Timeliness (the development of the plan in a timely manner) is determined by the organization based on each person's satisfaction with his or

her services, stakeholder input, funder or referral source rules and regulations, practical considerations, or established professional protocols.

The organization is not required to have more than one plan for each person. This standard and plan, rather than Section 5.B. Individual-Centered Service Planning, Design, and Delivery, apply to CVE.

Examples

The information in the plan is often summarized in the final vocational evaluation report. These items often form the basis for the evaluation and strategies used to learn about the individual's employment strengths and abilities.

1.f. The pre-evaluation assessment may include reviewing referral information to determine if technology needs are indicated and whether there are functional limitations that may require accommodations during the assessment. This can help to ensure that all test and instructional materials that are likely to be used are available in appropriate formats and that the evaluation area is completely accessible for individuals with disabilities. It might be helpful to consult with technology specialists for cases where significant assistive technology needs have already been noted.

In conducting the initial interview some helpful points to consider are:

- Determine if the individual uses or has used any assistive devices.

- Determine if there are any apparent functional limitations that would suggest the need for involving a technology specialist.

- Determine what the person's attitude is toward using assistive technology or workplace accommodations. If any reluctance is noted, explore this before considering using assistive technology.

Resources

Visit the Technical Assistance Network (TA Network) website (**http://rsatac.ed.gov**), provided by the Rehabilitation Services Administration (RSA) and the National Vocational Rehabilitation Technical Assistance Center (NTAC), for current information relevant to vocational rehabilitation with the aim of improving employment of people

with disabilities. The TA Network combines the resources of multiple entities to provide current research, practical experience, grass-roots networks, and the input of recognized experts to state vocational rehabilitation (VR) agencies and their partners.

5.R. **2. The plan is prepared:**

    a. By the person seeking employment and the evaluator.

    b. With input of the referral source or other stakeholder, as appropriate.

Intent Statements

The active participation of the person served is vital to a successful evaluation.

Examples

Participation may be demonstrated by interviews, records, checklists, accommodations, etc. The organization might indicate this mutual participation by having the plan signed by both the person served and the evaluator.

The organization may address the quality of service planning with questions in its outcomes measurement system about the satisfaction of the persons served and other stakeholders. Informed choices and active participation exist in all phases of vocational evaluation.

5.R. **3. The plan identifies:**

    a. How questions in the plan will be answered through the evaluation.

    b. Strategies to use assistive technology when a need is identified.

Intent Statements

The plan identifies the questions to be answered during the evaluation and the methods to be used.

Examples

Methods might include which evaluation techniques, assessment tools, and procedures will be used to answer the questions documented in the evaluation plan.

The plan is modified as necessary by the person seeking employment and the evaluator.

Considered in plan modification are the individual's interests, preferences, and choices; barriers; supports needed; etc.

Strategies to use assistive technology might include:

- Arrange for any consultation or other involvement of technology specialists if assistive technology needs have been identified.
- If immediate need for assistive technology aids/devices was noted, arrange to obtain the necessary equipment.
- If formats of tests and assessment activities may not be appropriate for the individual, consider what other assessment instruments or alternate formats may be needed.

5.R. **4. When administering assessment tasks and activities, if an individual is experiencing difficulties performing assessment tasks/activities, the evaluator modifies the task or activity to obtain the optimal performance possible.**

Intent Statements

The focus is on the person's ability to perform essential functions rather than on norms.

Examples

The evaluator may permit the individual to use any device necessary to complete the assessment.

5.R. **5. Comprehensive vocational evaluation services including psychological testing are conducted:**

    a. By an evaluator who meets the qualifications defined by state or provincial law, as applicable.

    b. Under the supervision requirements of state or provincial law, as applicable.

Intent Statements

Qualified personnel conduct the evaluation services in accordance with any applicable state or provincial laws and have the required credentials as established by the organization.

Examples

Evaluators have the qualifications and supervision identified as necessary to conduct evaluations using work samples, employment career exploration, psychological/psychometric testing, functional capacities assessments, or other methods.

A psychological test is a systematic procedure for observing behavior; i.e., interests, academic achievement, intelligence, aptitudes, and personality characteristics, with the aid of numerical scales or fixed categories.

Psychological tests are categorized for administrative qualification purposes into three levels: A, B, and C. Levels A and B are objective tests and require the administrator/interpreter to have a minimum of one course in tests and measurements. Level C tests are subjective tests and require that the interpretation of results be done by a professional who is certified by individual state or provincial requirements. The administration, scoring, and reporting may be done under the supervision/signature of a certified professional. Please refer to the *Standards for Educational and Psychological Testing* published by the American Psychological Association (APA).

5.R. 6. Evaluators using work samples to provide assessments:

a. **Have knowledge and experience with the work sample method/ assessment.**

b. **Follow written instructions that specify:**
   (1) **The materials used.**
   (2) **The equipment used.**
   (3) **The layout.**
   (4) **Methods for administration.**
   (5) **Interpretation of scoring.**

Intent Statements

Work sample methodology is documented to ensure consistency in use.

Examples

Best practices would use work samples that are representative of realistic local job market

opportunities. When there are some existing jobs that the work samples do not replicate, attempts are made to access the related transferable skills. Guidance can be found through the Department of Labor's Dictionary of Occupational Titles and related literature. In Canada, guidance can be found through job classifications set out by provincial/territorial ministries of labor. Career titles can be found at **www23.hrdc-drhc.gc.ca/ch/e/ docs/ch_classification_structure.asp**. To justify the development and use of particular work samples, the organization may make use of local employment resources, employment offices, and other methods of determining the nature of the local job market.

Some work samples may require, depending on the person served, the use of assistive technology or reasonable accommodations in the materials and equipment used, methods for giving instructions, or safety precautions.

5.R. 7. If career exploration activities are used:

a. **The focus is on interests and knowledge of the person.**

b. **Job analysis techniques identify essential functions and explore ways to adapt the job and/or utilize devices to compensate for loss of function.**

c. **Persons have opportunities to try out and perform work tasks before vocational options are eliminated from consideration.**

Intent Statements

Options and opportunities are not limited. Often vocational options that had been considered not feasible, or perhaps not considered at all, may become feasible through the use of assistive technology.

5.R. 8. Employment exploration sites that are used for evaluations are assessed as to their appropriateness for the person seeking employment with regard to:

a. **Adequacy of supervision.**

b. **Safety.**

c. **Specific work-site requirements.**

d. **Potential job accommodations.**

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e. Accessibility.

f. Expectations for quality and quantity of work.

g. Job/task analysis.

h. Potential employment opportunity.

i. Other considerations identified as appropriate to the individual.

Intent Statements

Employment exploration sites are assessed before placing a person there as part of a program's risk management.

Examples

Situational assessments can be accomplished using simulated job stations or on-the-job evaluations. Simulated job sites are located within the organization. On-the-job evaluations are located outside the organization. Both do not have to be used unless the needs of a person served are unmet with only one.

At on-the-job locations the person is given the opportunity to experience the requirements of the actual job, and the evaluation is often conducted by the job-site supervisor. The organization should ensure that Department of Labor guidelines for paid work are followed.

Related standards and supports may be found in Section 1.H. Health and Safety.

5.R. **9.** The evaluation report from a functional capacities assessment identifies:

a. The person's functional strengths and needs.

b. Accommodations/assistive technology needed to enhance the person's capacities.

c. Supports and resources available for inclusion in the community.

Intent Statements

Functional assessments are comprehensive.

Examples

To facilitate integration into the community, the report stresses abilities as well as strategies to overcome limitations in order to enhance the person's interdependence.

These types of data elements are often collected in an organization's demographic/characteristics database. Analysis of these data may provide information to modify or create services.

If a need for job accommodations seems apparent, information about the specific need is identified.

5.R. **10.** Comprehensive vocational evaluation services have the capability to assess or obtain the following information:

a. Ability to learn about oneself as a result of the information obtained and furnished through the evaluation experience.

b. Assistive technology and reasonable accommodations needed.

c. Employment and community supports needed.

d. Environmental conditions needed.

e. Work and nonwork needs.

f. Intellectual capacities.

g. Learning style, including ability to understand, recall, and respond to various types of instruction.

h. Interests, aptitudes, and career aspirations.

i. Personal, social, and work-related behaviors.

j. Modes of communication.

k. Physical and psychomotor capacities.

l. Work skills and tolerances.

m. Job-seeking and job-keeping skills.

n. Knowledge of occupational information.

o. Possible employment objectives, including self-employment.

p. Customer service skills.

q. Attitude toward work.

r. Understanding of work culture.

s. Identified health risks.

t. Identified safety risks.

Intent Statements

The needs of each person served will dictate the areas in which assessment is done.

Examples

Services do not have to assess every person's functioning in each of these areas.

Referral information may provide valuable insights to the evaluation process and results.

Contracted services may be used to meet the intent of the standard.

5.R. **11. The information in each evaluation report:**

a. **Answers the referral questions.**

b. **Includes recommendations, as appropriate, for training, employment, community resources, and job accommodations.**

c. **Is shared in an understandable manner with the person seeking employment.**

d. **Is disseminated in a timely manner to the referring agency individual responsible for implementing the report recommendations.**

e. **Is relevant to the desired employment outcome.**

Intent Statements

The evaluation report identifies viable vocational options.

Examples

The evaluation report may include independent living considerations; behavior observations; proposed reasonable accommodations; recommendations for assistive technology; assessed interests, aptitudes, and abilities; and specific vocational recommendations or career options based on the local job market. When a specific job has been identified, if necessary consult with an appropriate technology specialist to identify specific worksite accommodation strategies.

11.c. The report is shared in an understandable manner with the person seeking employment. This may mean some additional explanations and supports are necessary for comprehension and retention (e.g., the person might desire to have a personal advocate in attendance). When recommendations are made for assistive technology resources or services, exit interviews specifically

discuss use, maintenance/repair, and replacement of assistive technology equipment. The responsibilities of the employer, funders, and the person to replace equipment over time are clarified.

An organization may consider asking in its outcomes measurement system questions regarding satisfaction with the outcomes of the items in this standard. Follow-up may also provide insight into the eventual result achieved by the person seeking employment in comparison to the recommendations that were made.

11.d. "Disseminated in a timely manner" implies that the persons served and significant stakeholders were satisfied in the time it took to receive the written report. Sharing the report with entities beyond the referring entity individual and the person served would require written permission of the person served.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Evaluation plans and reports
- Testing results
- Work sample written instructions
- Evidence of qualifications of the persons administering evaluation tests
- Guidelines/procedures for techniques used
- Policies and procedures for the evaluation process

Targeted Employment Screening Services (TES)

Description

The service model includes targeted personnel tests or samples of jobs designed to assess aptitudes/skills in a very specific, limited area as identified by the employer/funder. Many organizations have contracts with funding sources and/or businesses that are quite specific to the questions to be answered which will occur in a time-limited assessment situation. The screening situation may be a simulated business/work environment or specific psychometrics per the employment opportunity.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional.
- Section 5.A. Standards 1.–9. and 11.
- Section 5.D. Standard 5. only.

5.R. 12. Targeted employment screening is based on the referral questions, including the specific aptitudes/skills to be evaluated.

Intent Statements

The needs of the referral source will dictate the specific tests or work samples that would be used to assess the person's ability to perform the identified job.

Examples

The screening service would inform the persons seeking employment about the jobs for which it is conducting screening to ascertain the person's interest in screening for particular jobs and then would proceed accordingly.

5.R. 13. If an individual experiences difficulties performing the tasks/activities, the evaluator:

    a. Discusses the situation with the person served.

    b. Identifies potential modifications required to meet a person's specific needs.

    c. Implements strategies to use assistive technology or accommodation, if possible, when a need is identified.

    d. Documents any modification/adaptation and its effectiveness.

Intent Statements

The focus is on the person's ability to perform essential functions rather than on norms.

Examples

The evaluator may permit the individual to use any device necessary to complete the assessment. If technology needs or accommodations are indicated due to functional limitations, it might be helpful to consult with technology specialists.

Resources

The CARF publication *CARF Guide to Accessibility*, which is available on request from your CARF resource specialist, may provide additional resources.

The Job Accommodation Network (JAN), a service of the President's Committee on Employment of People with Disabilities, provides information about workplace accommodations. JAN's trained consultants have access to a database of more than 200,000 previous accommodations to provide practical options. JAN can be reached at: 1 (800) ADA-WORK or via email: **jan@jan.idci.wvu.edu**.

5.R. 14. Personnel conducting psychometric assessments meet the qualifications defined by state or provincial law, as applicable.

Intent Statements

Qualified personnel conduct the evaluation services in accordance with any applicable state or provincial laws and have the required credentials as established by the organization.

Examples

Evaluators have the qualifications and supervision identified as necessary to conduct evaluations using work samples, employment career exploration, psychological/psychometric testing, functional capacities assessments, or other methods. Legal or regulatory requirements generally indicate that a vocational evaluator or

vocational specialist provides or supervises these assessments.

A psychological test is a systematic procedure for observing behavior; i.e., interests, academic achievement, intelligence, aptitudes, and personality characteristics, with the aid of numerical scales or fixed categories.

Psychological tests are categorized for administrative qualification purposes into three levels: A, B, and C. Levels A and B are objective tests and require the administrator/interpreter to have a minimum of one course in tests and measurements. Level C tests are subjective tests and require that the interpretation of results be done by a professional who is certified by individual state or provincial requirements. The administration, scoring, and reporting may be done under the supervision/signature of a certified professional. Please refer to the *Standards for Educational and Psychological Testing* published by the American Psychological Association (APA).

5.R. **15.** **Personnel administering work samples:**
   a. **Have knowledge and experience with the work sample assessment.**
   b. **Follow written instructions that specify:**
      (1) **The materials used.**
      (2) **The equipment used.**
      (3) **The layout.**
      (4) **Methods for administration.**
      (5) **Interpretation of scoring.**

Intent Statements

Work sample methodology is documented to ensure consistency in use.

Examples

Best practices would use work samples that are representative of realistic local job market opportunities. When there are some existing jobs that the work samples do not replicate, attempts are made to access the related transferable skills. Guidance can be found through the Department of Labor's Dictionary of Occupational Titles and related literature. To justify the development and use of particular work samples, the organization

may make use of local employment resources, employment offices, and other methods of determining the nature of the local job market.

Some work samples may require, depending on the person served, the use of assistive technology or reasonable accommodations in the materials and equipment used, methods for giving instructions, or safety precautions.

5.R. **16.** **Based on the evaluation objective, targeted employment screening services can assess or obtain the following information about a person:**
   a. **Learning styles, including ability to understand, recall, and respond to various types of instruction.**
   b. **Interests, aptitudes, and career aspirations.**
   c. **Modes of communication.**
   d. **Physical and psychomotor capacities.**
   e. **Work skills and tolerances.**
   f. **Customer service skills, attitude toward work, and understanding of work culture.**
   g. **Interpersonal and emotional aspects as observed in the assessment process.**

Intent Statements

The time-limited screening is designed and positioned to answer specific referral questions.

Examples

Service design is based on input from the referral source. Often these referral sources might be from special education departments or employment personnel departments.

5.R. **17.** **The information gained from the targeted employment screening:**
   a. **Answers the referral questions.**
   b. **Is shared in an understandable manner with the person served.**
   c. **Is relevant to the evaluation objective.**
   d. **Is shared with the funding source or employer, as requested in the referral.**

Intent Statements

The employment screening identifies viable vocational options.

Examples

The screening may include independent living considerations; behavior observations; proposed reasonable accommodations; recommendations for assistive technology; assessed interests, aptitudes, and abilities; and specific vocational recommendations or career options based on the local job market. When a specific job has been identified, if necessary consult with an appropriate technology specialist to identify specific worksite accommodation strategies.

17.b. The information is shared in an understandable manner with the person seeking employment. This may mean some additional explanations and supports are necessary for comprehension and retention (e.g., the person might desire to have a personal advocate in attendance). When recommendations are made for assistive technology resources or services, exit interviews specifically discuss use, maintenance/repair, and replacement of assistive technology equipment. The responsibilities of the employer, funders, and the person to replace equipment over time are clarified.

17.c. An organization may consider asking in its outcomes measurement system questions regarding satisfaction with the outcomes of the items in this standard. Follow-up may also provide insight into the result achieved by the person seeking employment in comparison to the recommendations that were made.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of persons served
- Personnel records
- Written instructions for work samples
- Documentation related to results of screenings

S. Organizational Employment Services (OES)

Description

Organizational employment services are designed to provide paid work to the persons served in locations owned, leased, rented, or managed by the service provider. A critical component and value of organizational employment services is to use the capacity of the organization's employment and training service design to create opportunities for persons to achieve desired employment outcomes in their community of choice.

Service models are flexible and may include a variety of enterprises and business designs, including organization-owned businesses such as retail stores, restaurants, shops, franchises, etc.

Some examples of the quality outcomes desired by the different stakeholders of these services include:

- Movement to competitive employment.
- Movement to an integrated environment.
- Increased wages.
- Increased skills.
- Increased work hours.
- Minimized downtime.
- Exposure to and availability of a variety of jobs.
- Increased ability to interact with others as part of a professional team and to resolve interpersonal issues appropriately.

Applicable Standards

- All standards in Sections 1.A. and 1.C.–1.N.; 1.B. is optional
- All standards in Sections 5.A., 5.B., and 5.D.
- Standards in Section 5.E. as applicable

5.S. 1. The following information is provided to the person served:

a. **The conditions of maintaining employment.**

b. **Benefits provided by the organization.**

c. **Responsibilities of the organization.**

d. **Responsibilities of the person served.**

e. **Wage payment practices.**

f. **Rate of pay, including:**

(1) **Methods of performance measurement.**

(2) **Methods to increase earnings.**

g. **Work rules and customs.**

h. **Nondiscrimination practices.**

i. **Civil rights practices.**

j. **Policies for transfer.**

k. **Employee classifications in the organization.**

l. **Health and safety practices.**

m. **Potential for advancement opportunities.**

n. **Conditions for advancement.**

o. **Employment options available in the organization.**

p. **Opportunities for training on other jobs.**

q. **How the individual can move to community integrated employment.**

Intent Statements

Persons served are given complete information related to their employment, as would be available to all employees.

Examples

Strategies include posting information from entities such as the Equal Employment Opportunity Commission; Occupational Health and Safety Administration; Department of Labor; and other governmental and regulatory agencies on bulletin boards, and providing it in electronic formats, in handbooks, and at regular informational discussions at employee-management meetings.

1.e.–f. When appropriate, a parent, guardian, or advocate should be informed of the organization's pay practices when the person is paid less than the minimum wage.

1.i. The organization provides information to persons served about voting rights and opportunities.

5.S. 2. Training activities address, as needed:

a. **Job performance and progress.**

b. **Increasing individual performance.**

c. **Work-site job modifications, if needed.**

d. **Strategies for resolving job-related issues.**

e. **Safe workplace practices.**

Intent Statements

A systematic plan of instruction and/or support in work skills and behaviors to be acquired is developed.

Examples

A plan to develop appropriate social and interpersonal skills necessary to retain employment may also need to be considered.

Support in the use of available transportation is provided as needed.

See Section 5.B. Individual-Centered Service Planning, Design, and Delivery.

5.S. 3. Based on the needs and choices of the person served, the organization provides or refers the person to resources for addressing, as relevant to job support:

a. **Basic academic skills.**

b. **Basic self-care skills.**

c. **Communication skills.**

d. **Work attitudes.**

e. **Tools and equipment related to the person's job.**

f. **Mobility and travel training.**

g. **Interpersonal relationships with coworkers.**

h. **Job-site safety practices.**

i. **Career planning.**

j. **Problem-solving and decision-making skills.**

k. **Health maintenance and medication management.**

l. **Knowledge of governmental and community service agencies.**

m. **Management of legal affairs.**

n. **Management of benefits and financial resources.**

o. **Recreational and leisure time activities.**

p. **Use of phone and computer resources.**

q. **Use of community services and resources.**

r. **Accommodations or assistive technology needs, if identified.**

s. **Other issues or barriers to success, as identified.**

Intent Statements

Development of a person's competencies in related areas can impact the person's job success and opportunity for career advancement.

Examples

It is not required that every person served receive all the services/supports available. Each person receives only those services that will help the person meet his or her employment goals. However, the organization has the capability in place to address each area listed in this standard, as is appropriate to the needs and desires of the person served.

3.q. Community services and resources may include laundromats, libraries, post offices, consumer affairs offices, etc.

3.s. If left unaddressed, nonwork needs may negatively affect employment potential. Based on the choices and needs of persons served, the organization may provide, arrange, or refer the person for support and training in:

- Daily living tasks.
- Communication skills.
- Consumer affairs and rights (e.g., familiarity with warranties, policies, and procedures of governmental and community service agencies).
- Contingency planning, problem solving, and decision making.
- Developing socially appropriate and age-appropriate behaviors.
- Financial management including purchasing, banking, handling taxes, budgeting, and repaying debts.
- Functional academic skills.
- Health maintenance (e.g., personal hygiene, exercise and fitness, nutrition and diet management, infection control, and use of medical services and medicine).
- Housekeeping and home maintenance skills.
- Human sexuality.
- Interpersonal relationships including those with the person's spouse, family, and friends.
- Life issues and transitions (e.g., leaving home, substance abuse, parenting, divorce, retirement, and death).
- Management of personal and legal affairs.
- Menu planning and meal preparation.
- Mobility and community transportation skills.
- Recreational activities.
- Safety practices including dealing with injuries and life-threatening situations.
- Self-advocacy and assertiveness training.
- Use of the telephone.
- Utilization of community services and resources (e.g., laundromats, the library, post office, and consumer affairs office).
- Work attitudes and skill exploration.

5.S. **4. At the request of the person served and at least annually, persons are provided informed choices for exploration of other work opportunities, as desired:**

a. **Within the organization.**

b. **In the community.**

Intent Statements

Informed choice is vital in conforming to this standard. Persons served frequently lack knowledge about existing community employment opportunities.

Examples

Many people with developmental disabilities may not be able to exercise informed choice until and unless they have been provided with opportunities to experience something different. All persons served should be given experiential opportunities to explore community employment options to ensure that choice is truly informed.

The persons served and appropriate staff members or partnership agencies are involved in the assessment of opportunities for community employment. If indicated, a person served is referred for other services either within the organization or to external services. Clear reasons are documented in the assessment explaining why a person was not referred to other services.

Related standards to consider are in Section 1.D. Input from Persons Served and Other Stakeholders; 1.L. Accessibility; 1.M. Performance Measurement and Management; 1.N. Performance Improvement; and 5.B. Individual-Centered Service Planning, Design, and Delivery.

Documentation Examples

The following are examples of the types of information you should have available to demonstrate your conformance to the standards in this subsection. See Appendix A for more information on required documentation.

- Records of the persons served
- Employment information or a handbook
- Individual service plans
- Progress notes

5.S. **5. Relevant training activities are available during periods of reduced work activity.**

Intent Statements

The persons served are engaged in meaningful, age-appropriate activities that are supportive of their goals, even when work is low.

Examples

Training opportunities might include computer lab activities, job exploration, simulated work activities to improve or develop new skills, and volunteer experiences in the community. Training activities might also include areas identified in Standard 3., as relevant to a person's individual plans.

APPENDIX A

Required Written Documentation

The following tables list standards that explicitly require some form of written evidence in order to achieve full conformance.

When interpreting CARF standards, the following terms *always* indicate the need for written evidence: *policy*, *plan*, *documented*, *documentation*, and *written*. Other terms may also indicate the need for specific written information.

This list of standards is not inclusive of all the documentation that will be reviewed during the survey of your organization.

Section 1. ASPIRE to Excellence®

Assess the Environment

Standard(s)	Requirements
A. Leadership	
1.A.5.a.	Cultural competency plan
1.A.6.a., b.	Ethical codes of conduct and written procedures to deal with allegations of violations of ethical codes
1.A.7.	For US organizations receiving federal funds, policy on corporate compliance, including an authorizing document, and designation of a primary contact
B. Governance (Optional)	
1.B.1.	Governance policies that facilitate ethical practices, assure accountability, and meet legal requirements
1.B.2.	Governance policies regarding organization and development of the board, and signed ethical declarations
1.B.5.	Policies addressing executive leadership development and evaluation, including a written performance review and succession plan
1.B.6.	Policies, written statements, and documented processes addressing executive compensation

Set Strategy

Standard(s)	Requirements
C. Strategic Planning	
1.C.2.a.–c.	Written strategic plan

Implement the Plan

Standard(s)	Requirements
E. Legal Requirements	
1.E.2.	Written procedures to guide personnel in responding to subpoenas, search warrants, investigations, and other legal actions
1.E.3.	Policies and written procedures on records
F. Financial Planning and Management	
1.F.2.a., b.(1), b.(3)	Written budgets
1.F.4.e.	If appropriate, financial solvency remediation plans
1.F.6.a.	Fiscal policies and procedures including internal controls
1.F.7.b.(1)	If the organization bills for services, a quarterly review of a representative sampling of records for persons served documents the comparison of services billed/actually received
1.F.9.	Written procedures for managing funds of persons served (if applicable)
1.F.10.	Annual review or audit by an independent, authorized accountant
1.F.11.	If a review or audit generates a management letter, both the letter and management's response
G. Risk Management	
1.G.1.a.	Risk management plan
1.G.3.	Written procedures regarding communications, including media relations and social media
H. Health and Safety	
1.H.2.	Written procedures that promote the safety of persons served and personnel
1.H.4.	Documentation of competency-based training in health and safety for personnel both upon hire and annually

Implement the Plan (Continued)

Standard(s)	Requirements
1.H.5.	Written emergency procedures
1.H.6.d.	Written evidence of unannounced tests of all emergency procedures
1.H.8.	Written procedures regarding critical incidents
1.H.9.	Written analysis of critical incidents
1.H.11.h.	Written emergency procedures related to transportation services
1.H.12.b.	External inspections reports
1.H.13.b.	Self-inspection reports
1.H.14.	Written procedures concerning hazardous materials
I. Human Resources	
1.I.2.	Written procedures related to verification of personnel backgrounds and credentials
1.I.5.	Documentation of personnel training provided at orientation and regular intervals
1.I.6.a., b.(2)	Job descriptions and performance evaluations
1.I.7.a., f., g.	Signed agreements, dismissal policies and written procedures, and confidentiality policies regarding the use of students or volunteers
1.I.8.b.	Personnel policies that address: employee relations, including grievance and appeal procedures, disciplinary action, and termination; employee selection, including promotions and job postings; and nondiscrimination
J. Technology	
1.J.1.	Technology and system plan
K. Rights of Persons Served	
1.K.2.	Policies on the rights of persons served
1.K.4.a.	Policy(ies) and written procedure by which persons served may make a formal complaint
1.K.4.c.	Documentation of formal complaints
1.K.5.	Annual written analysis of all formal complaints
L. Accessibility	
1.L.2.	Accessibility plan
1.L.3.	Accessibility status report

Implement the Plan (Continued)

Standard(s)	Requirements
1.L.4.d.	Documentation of requests for reasonable accommodations

Review Results

Standard(s)	Requirements
M. Performance Measurement and Management	
1.M.1.	Description of performance measurement and management system

Effect Change

Standard(s)	Requirements
N. Performance Improvement	
1.N.1.	Performance analysis
1.N.1.c.(2)	Performance improvement action plan

Section 2. General Program Standards

Standard(s)	Requirements
2.A. Program/Service Structure	
2.A.1.a.	Scope of services
2.A.3.	Entry, transition, and exit criteria
2.A.8.	Written program description that guides service delivery
2.A.11.	Policies and written procedures addressing positive approaches to behavioral interventions, when applicable
2.A.12.a.	Written procedures governing the use of special treatment interventions and restriction of rights
2.A.18.	Written procedures that specify the program provides or arranges for crisis intervention services
2.A.20.e.	Documented attendance of participants at team meetings and results of team meetings
2.A.22.	Plan and written procedures for supervision of direct service personnel
2.A.23.	Documented ongoing supervision of clinical or direct service personnel, as applicable

Section 2. General Program Standards (Continued)

Standard(s)	Requirements
2.A.24.	Policies that address handling of items brought into the program by persons served and personnel and the use of tobacco products in all locations and in all vehicles owned or operated by the organization
2.B. Screening and Access to Services	
2.B.3.	Policies and written procedures related to screening
2.B.4.	Documented screening, when conducted by the organization
2.B.6.	Documented crisis assessments
2.B.8.a. and c.	Waiting list documentation, if applicable
2.B.9.	Documented orientation for each person served
2.B.14.	Information gathered and recorded in the assessment process
2.B.15.	Written interpretive summary from assessment process
2.C. Person-Centered Plan	
2.C.1.	Written person-centered plan for each person served
2.C.2.	Specific components of person-centered plan for each person served
2.C.4.a.	Documented progress toward achievement of service/treatment objectives for the person served
2.C.5.	Personal safety plan, completed when assessment identifies a potential risk for dangerous behaviors
2.C.6.a.	When a person served has concurrent disorders or disabilities and/or co-morbidities, the person-centered plan addresses these conditions in an integrated manner
2.C.7.a.	If services are provided to persons who are medically fragile, the person-centered plan addresses how services will be provide
2.C.8.	Signed, dated progress notes
2.D. Transition/Discharge	
2.D.1.	Written procedures for referrals, transfers, inactive status, discharge, and follow-up
2.D.3.	Written transition plan
2.D.4.a.	Written transition plan is developed with the identified sources

Section 2. General Program Standards (Continued)

Standard(s)	Requirements
2.D.5.	Written discharge summary for all persons leaving services
2.D.7.	Transition plans or discharge summaries provided to external programs/services
2.E. Medication Use	
2.E.1.	Policy that identifies whether medications are used in the program and the process for persons served to obtain medications needed
2.E.2.	Documented ongoing training and education regarding medications for persons served and, when applicable, individuals and family members with legal right or identified by the persons served
2.E.3.	Written procedures for medications physically controlled by the program
2.E.4.	Documentation of all medications provided or prescribed, poison control information, and other pertinent information
2.E.5.	Written procedures for prescribing, dispensing, or administering of medications
2.E.6.	Written procedures for prescribing of medications
2.E.7.	Treatment guidelines and protocols related to prescribing of medications and medication utilization evaluation
2.E.8.	Documented annual peer review related to prescribing of medications
2.E.10.	Written procedures for dispensing or administering of medications
2.F. Nonviolent Practices	
2.F.1.	Policy that identifies how the organization will respond to aggressive or assaultive behaviors and whether and under what circumstances seclusion and restraints will be used
2.F.2.	Documented initial and ongoing competency-based training for all direct service or front-line personnel employed by the organization
2.F.3.	Documented initial and ongoing competency-based training for personnel involved in the direct administration of seclusion or restraint
2.F.4.	Plan to minimize or eliminate the use of restraints and/or seclusion, if these are used

Section 2. General Program Standards (Continued)

Standard(s)	Requirements
2.F.5.	Annual written status report on the plan for minimization or elimination of the use of seclusion and/or restraint
2.F.6.	If the organization uses seclusion or restraint, written procedures for the use of specific interventions including the identified protocols
2.F.8.	Policies on the use of seclusion or restraint
2.F.9.	Written procedures for use of seclusion or restraint
2.F.10.	Written procedures for use of seclusion or restraint
2.F.12.e.	Documented discussion following any use of seclusion or restraint
2.F.13.	Use of seclusion or restraint is always documented as a critical incident
2.F.14.	All uses of seclusion or restraint reviewed and signed off on by chief executive or designated management or supervisory staff member
2.F.15.a.	Use of seclusion or restraint recorded in the information system
2.G. Records of the Persons Served	
2.G.1.	Policies regarding information to be transmitted to other individuals or agencies and forms to authorize release of information
2.G.2.	Individual record of each person served
2.G.3.	All documents that require signatures have original or electronic signatures
2.G.4.	Individual record for each person served contains the identified elements
2.G.5.	Entries to the records of the persons served follow the organization's policy on time frames for entries
2.H. Quality Records Management	
2.H.1.	Documented quarterly records review

Section 3. Program Specific Standards

Standard(s)	Requirements
3.A. Assertive Community Treatment (ACT)	
3.A.9.	Treatment plan, reviewed quarterly and modified as necessary
3.A.11.e.	Written emergency procedures for crisis intervention services
3.A.19.b.	Regular review and documentation of symptoms as well as the response of persons served to prescribed medication treatment
3.A.23.b.	Documentation that at least 75 percent of service contacts are provided in the community, outside of the clinical office setting
3.A.29.	Documentation of information shared at organizational staff meetings
3.A.36.	Documentation of discharge, completed by identified member(s) of the treatment team
3.A.37.	Signed discharge documentation
3.B. Assessment and Referral (AR)	
3.B.1.	Policies for assessment and referral that include the identified elements
3.B.3.	Written summary of assessment and referral(s), provided to person served or legal representative when requested
3.D. Community Housing (CH)	
3.D.2.h.	Policies related to visitors, guests, and pets
3.F. Court Treatment (CT)	
3.F.1.	Policies for screening, eligibility, and case processing
3.F.4.	Written assessment for each person served that includes the identified elements
3.F.9.	Written procedures specifying that the program provides or arranges for the identified services when needed
3.F.11.	Records of the persons served that document, on an ongoing basis, the specific treatment interventions provided
3.F.17.	Monthly review of person-centered plan
3.F.18.	Updated transition plan and status tracking/monitoring, for persons sanctioned to an external setting for 30 days or more
3.F.21.	Person-centered plan for persons receiving education and training services

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.G. Crisis and Information Call Centers (CIC)	
3.G.1.	Policies and written procedures for the program
3.G.2.a.–c.	Written training plan
3.G.4.	Written procedures to ensure access during identified hours of operation
3.G.6.	Written procedures for the identified elements
3.G.9.b.	Written statement describing crisis resolution
3.G.11.b.	Written agreements, when a crisis response program uses a secondary provider for roll-over call answering or 24/7 coverage
3.G.14.	Written procedures for the identified elements
3.G.15.	Policy defining expectations regarding non-endorsement of specific referrals and fair and equitable caller-driven referrals
3.H. Crisis Intervention (CI)	
3.H.1.	Written procedure for timely engagement of the person served
3.H.2.	Written crisis assessment that includes the identified elements
3.H.3.	Initial crisis intervention plan
3.H.6.	Documentation that personnel providing mobile services are trained or certified in first aid and CPR
3.H.7.	Written emergency procedures addressing the identified elements
3.H.11.	Written procedures that guide access to inpatient services or less restrictive alternatives
3.I. Crisis Stabilization (CS)	
3.I.2.	Initial crisis stabilization plan
3.I.5.	Documented daily therapeutic interventions
3.K. Detoxification (DTX)	
3.K.1.	Medical evaluation, obtained prior to or within 24 hours of admission
3.K.2.e.	Health screening completed for each person admitted
3.K.6.	Documentation maintained by qualified personnel regarding each person's condition

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.K.9.	Written procedures addressing transfer to emergency medical services
3.L. Diversion (DVN)	
3.L.6.	Plan or written logic model that details the specific theoretical and methodological approaches to be used and how the approaches will be applied within the community
3.L.7.c.	Documentation of evaluations of programs/services and training activities
3.L.8.b.	Documented plan for individual outcomes
3.M. Employee Assistance (EA)	
3.M.3.	Written agreement with host organization
3.M.9.b.(2)	Training plan for personnel not certified
3.M.10.	Written procedures that describe the type of information the host organization may receive from the program
3.N. Health Home (HH)	
3.N.1.	Written program description covering all areas listed
3.N.3.b.	Written procedures for access to primary care or other medical services, sharing of information, and coordination of care
3.N.7.c.(2)	Assessment of service needs
3.N.7.c.(4)	Integrated person-centered plans for persons served
3.N.13.	Policies regarding initial consent for treatment
3.N.14.	Written screening procedures
3.N.15.	Health assessment screening
3.N.16.	Person-centered plan for each person served
3.N.17.	Written procedures for follow-through in response to the initial assessment
3.N.18.	Written procedures for all areas listed
3.O. Inpatient Treatment (IT)	
3.O.1.	Medical evaluation, obtained prior to or within 24 hours of admission
3.O.4.	Written daily schedule of activities

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.O.7.	Policies for inpatient treatment that include the identified elements
3.P. Integrated Behavioral Health/Primary Care (IBHPC)	
3.P.1.	Written program description that includes the identified elements
3.P.2.b.	Written procedures for colocation and coordination
3.P.10.	Policies regarding initial consent for treatment
3.P.11.	Written screening procedures
3.P.12.	Written procedures for intake assessments
3.P.13.	Individualized integrated plan regarding medical and behavioral health
3.P.14.	Written procedures for follow-through process in response to the initial assessment
3.P.15.	Written procedures for ongoing communication and collaboration
3.Q. Intensive Family-Based Services (IFB)	
3.Q.2.	Written assessment of how each family functions
3.Q.6.	Policy that demonstrates a commitment to having an identified person/team working consistently with the family
3.Q.8.	File of current community resources for appropriate referral of persons served
3.Q.10.	Contingency plan for crises
3.Q.13.	Plan for access to qualified professionals 24 hours a day, 7 days a week
3.R. Intensive Outpatient Treatment (IOP)	
3.R.8.	Review of person-centered plans for persons served at least monthly
3.S. Out-of-Home Treatment (OH)	
3.S.2.	Reunification plan for each child that includes the identified elements, when applicable
3.S.4.	Documented status of parental rights
3.S.6.	Documented provider training

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.S.11.	File of current community resources is maintained
3.S.14.a., c.	Comprehensive plan for the selection of out-of-home care providers, if applicable, and written agreement that clearly defines expectations of the organization and the out-of-home care provider
3.S.18.	Plan to regularly monitor each foster home placement
3.S.25.	Plan for access to qualified behavioral health practitioners 24 hours a day, 7 days a week
3.U. Partial Hospitalization (PH)	
3.U.3.b.	Schedule of activities
3.U.11.a.	Primary assessment of person served that includes the identified elements
3.U.12.	Person-centered plan, completed within seven days of admission and reviewed as identified
3.V. Prevention (P)	
3.V.5.	Plan or written logic model that details the specific theoretical and methodological approaches to be used and how the approaches will be applied within the community
3.V.6.c.	Documentation of evaluations of programs/services and training activities
3.V.7.	Written comprehensive curriculum for each course offered
3.W. Residential Treatment (RT)	
3.W.4.a.	Written daily schedule of activities
3.W.8.	At least a quarterly review of each person's plan, goals, and progress
3.X. Student Counseling (SC)	
3.X.1.	Written person-centered plan for each person served
3.X.10.	Discharge summaries for persons who leave the program
3.X.11.	Records of persons served
3.X.12.	Written procedures for ongoing communication and collaboration with relevant stakeholders within the educational organization

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.X.13.	Plan and written procedures that guide the program's response when a potential threat to personal or campus safety is identified
3.Z. Therapeutic Communities (TC)	
3.Z.1.	Written program plan that includes the identified elements
3.Z.10.	At least a quarterly review of each person's plan, goals, objectives, and progress
3.Z.11.a.	Written schedule of activities
3.Z.20.	In a correctional setting, written procedure for review of rule infractions

Section 4. Specialty Population Designations

Standard(s)	Requirements
4.A. Addictions Pharmacotherapy (AP)	
4.A.1.	Policies and written procedures that include the identified elements
4.A.2.	Policies addressing drug-screening practices
4.B. Children and Adolescents (CA)	
4.B.1.	Assessments of each child/adolescent served that include the identified elements
4.B.8.	Policy for obtaining criminal background checks for all persons providing direct services to children or adolescents
4.C. Consumer-Run (CR)	
4.C.1.	Policies for membership or acceptance into services
4.C.2.	Membership/acceptance criteria
4.C.3.d.	Documentation of actions taken when a person is found ineligible
4.C.5.	Signed informed consent for services obtained and maintained as required
4.C.11.	Coordinated person-centered plan for each person served based on the identified elements
4.C.12.	Coordinated person-centered plan for each person served that includes the identified elements

Section 4. Specialty Population Designations

Standard(s)	Requirements
4.C.14.	Discharge summary for each person who leaves the program
4.C.15.	Complete record maintained for each person served
4.D. Criminal Justice (CJ)	
4.D.6.	Timely assessment for each person served that includes the identified elements
4.D.8.	Person-centered plan for each person served that includes the identified elements
4.D.10.	When the program provides behavioral health services in a prison or jail setting, a transition plan that includes the identified elements
4.D.11.	Predischarge transition plans that include the identified elements
4.D.12.	Predischarge transition plans that address the identified elements
4.E. Juvenile Justice (JJ)	
4.E.5.	Timely assessments for each person served that include the identified elements
4.E.6.	Assessments that include the identified information
4.E.10.	When the program provides behavioral health services in a correctional setting, a transition plan that includes the identified elements
4.E.11.	Predischarge transition plans
4.E.19.	Policy on obtaining criminal background checks on all persons providing direct services to juveniles
4.F. Medically Complex (MC)	
4.F.1.	Program description of services that includes the identified elements
4.F.9.	Written philosophy of health and wellness for the persons served
4.F.10.	Primary assessment for each person served that includes identification of presenting health risks, health goals, and expected health benefits
4.F.11.	Based on initial and ongoing assessments, a person-centered plan of care for each person served that addresses identified needs

Section 4. Specialty Population Designations

Standard(s)	Requirements
4.F.12.	Person-centered plans of care that address how services will be provided to ensure the safety of the person served and that identify the services provided by skilled healthcare providers
4.F.13.g.	Activities to promote wellness evident in the person-centered plan for each person served
4.G. Eating Disorders (ED)	
4.G.4.	Person-centered plan for each person served that includes all of the listed requirements
4.G.5.	Transition plan for each person served that includes all of the listed requirements

Section 5. Community and Employment Services

Standard(s)	Requirements
5.A. Program/Service Structure	
5.A.1.a.	Scope of services
5.A.3.	Entry, transition, and exit criteria
5.A.8.	Policies and procedures for acceptance into services
5.A.10.	Complete record maintained for each person served
5.A.14.b.	Policy on rights restrictions (if applicable)
5.A.15.a.	Written agreement for contracted services
5.A.16.b.	Detailed history of person's criminal history, when services are provided to identified criminal offenders
5.A.17.	Policy that identifies whether the organization has any role related to medications used by persons served
5.B. Individual-Centered Service Planning, Design, and Delivery	
5.B.3.	Individualized service plan for persons served
5.B.5.	Coordinated individualized service plan for persons served
5.B.6.	Assistive technology and reasonable accommodations, addressed in individual plans
5.B.7.b.	Risk assessment results, documented in individual service plan
5.B.10.	Exit summary report

Section 5. Community and Employment Services

Standard(s)	Requirements
5.C. Community Services Principle Standards	
5.C.2.	Individualized service plans of persons served
5.D. Employment Services Principle Standards	
5.D.7.	For U.S. organizations, documentation regarding individuals receiving less than the minimum wage
5.E. Medication Monitoring and Management	
5.E.1.	Record of all medications used by the person served
5.E.2.	Written procedures for medication handling
5.E.4.	Documentation that the use of all medications by the person served is reviewed on at least an annual basis
5.E.5.	Written procedures for medication management
5.N. Community Employment Services	
Job Development (CES:JD)	
5.N.2.	Individual service plans
Employment Supports (CES:ES)	
5.N.7.b.	Backup contingency plans for support staff's absence or tardiness
5.N.14.	Policy that indicates the organization's role in providing or arranging for employment crisis intervention services, if applicable
Personnel Services to Employers (CES:PSE)	
5.N.15.	Business plan
5.N.16.	Marketing plan
5.P. Employee Development Services (EDS)	
5.P.3.a.	Course description for employee development training course
5.Q. Employment Planning Services (EPS)	
5.Q.4.	Written employment planning report
5.R. Evaluation Services	
Comprehensive Vocational Evaluation Services (CVE)	
5.R.1.	Individual evaluation plans for persons served
5.R.3.	Individual evaluation plans for persons served

Section 5. Community and Employment Services

Standard(s)	Requirements
5.R.6.b.	Written instructions for evaluators using work samples to provide assessments
5.R.9.	Evaluation report from functional capacities assessment

APPENDIX B

Operational Time Lines

The following tables list CARF standards that require activities be conducted at specific time intervals. The documents assembled as part of survey preparation should provide evidence that these activities occur.

Standards that specify an activity be conducted *at least* or *no less than* a specific time period are listed in the table for the maximum time frame within which they may occur. Standards that require a policy that includes a time frame, such as for the reporting of complaints or recording information into the records of the persons served, are not included in this appendix.

The time lines for the standards listed in the last table, *Activities to be Conducted at a Frequency Determined by the Organization*, may be influenced by various factors, such as local regulations or the needs of the organization and the persons served—e.g., the verification of personnel licenses and certifications, and certain types of personnel training. For these standards, you should identify the frequency with which these activities are scheduled. Standards that require activities be conducted on an *ongoing* or *as needed* basis are not included here. The surveyors will want to see evidence that you are following your identified time lines.

Activities to be Conducted Annually

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.A.3.k.	Review of policies guided by leadership
1.A.5.c.	Cultural competency and diversity plan reviewed for relevancy
1.B.2.g.(3), (5)–(6)	Board conducts self-assessment of the entire board, and signs written conflict of interest declaration and ethical code of conduct declaration
1.B.5.a.–b.	Review of executive leadership performance and executive leadership succession plan
1.B.6.e.(6)	Review of executive compensation records
1.B.7.	Review of governance policies
1.C.2.e.	Strategic plan reviewed for relevance
1.F.2.	Budgets are prepared and approved
1.F.10.	Review or audit of the financial statements of the organization by an independent accountant authorized by the appropriate authority
1.G.1.b.(1)	Risk management plan reviewed for relevance

Activities to be Conducted Annually (Continued)

Related Standard	Activity
1.G.2.a.	Review of organization's insurance package
1.H.4.	Personnel receive training in health and safety practices, identification of unsafe environmental factors, emergency and evacuation procedures, identification and reporting of critical incidents, reducing physical risks, and medication management, if appropriate
1.H.6.	Unannounced tests of all emergency procedures, including complete actual or simulated physical evacuation drills, tested on each shift at all locations
1.H.9.	Critical incidents are reviewed, resulting in a written analysis provided to or conducted by leadership
1.H.11.l.(1)	If transportation services are contracted, the contract is reviewed against Standard 1.H.11.a.–k.
1.H.12.	Comprehensive external health and safety inspection conducted at all facilities where the organization delivers services or provides administration on a regular and consistent basis, resulting in a written report
1.I.4.b.	Assessment of current competencies of personnel
1.I.6.a.(1)	Review of job descriptions
1.I.6.b.	Performance evaluations of directly employed personnel
1.I.6.c.	Review of all contract personnel
1.I.8.a.(2)	Review of personnel policies
1.K.1.a.(3)	Rights of persons served shared with persons served who have been in the program longer than one year
1.K.5.	Written analysis of all formal complaints that determines trends, areas needing performance improvement, and actions to be taken
1.L.3.	Written accessibility status report
1.N.1.	Performance analysis
2.A.1.c.	Review of scope of services
2.E.8.a.	Annual peer review of medications prescribed to persons served
2.F.5.	Written status report on the plan for minimization/elimination of the use of seclusion and restraint
3.A.2.c.	ACT team reviews capacity to provide integrated treatment services

Activities to be Conducted Semiannually

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.H.13.	Health and safety self-inspections conducted on each shift at all facilities where the organization delivers services or provides administration on a regular and consistent basis
2.E.5.l.	Documented assessments of abnormal involuntary movements are performed every six months for persons served receiving typical antipsychotic medications

Activities to be Conducted Quarterly

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.F.7.	Review of representative sampling of records of persons served and billing for services
2.H.1. and 2.H.2.	Quarterly professional review of service quality, appropriateness, and utilization
3.A.9.	Review of treatment plan of persons served in an Assertive Community Treatment program
3.W.8.	Review of plan of services, goals, and progress toward goals for persons served in a Residential Treatment program
3.Z.10.	Review of plan of services, goals, and progress toward goals for persons served in a Therapeutic Community

Activities to be Conducted Monthly

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.F.3.c.	Review of actual financial results
1.F.9.f.	If responsible for funds of the persons served, monthly account reconciliation
3.F.17.	Review of person-centered plan for persons served in a Court Treatment program
3.R.8.	Review of person-centered plan for persons served in an Intensive Outpatient program

Activities to be Conducted Every Other Week

Related Standard	Activity
3.U.12.b.(2)	Review of person-centered plan for persons served in a Partial Hospitalization program

Activities to be Conducted Weekly

Related Standard	Activity
3.U.17.	Weekly meetings with persons served in a Partial Hospitalization program

Activities to be Conducted Daily

Related Standard	Activity
3.A.28.	Daily staff meetings of team members in Assertive Community Treatment programs
3.D.2.e.	Daily access to nutritious meals and snacks in Community Housing programs
3.S.21.e.	Daily access to nutritious meals and snacks in Out-of-Home Treatment programs
3.W.4.h.	Daily access to nutritious meals and snacks in Residential Treatment programs
3.Z.11.c.	Daily access to nutritious meals and snacks in Therapeutic Communities

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.B.2.g.(4)	Periodic self-assessment of individual members of board
1.H.11.b.	Regular review of driving records of all drivers
1.H.11.k.	Maintenance of vehicles owned or operated by the organization
1.I.2.b.(2)	Verification of backgrounds and credentials of personnel throughout employment

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity
1.I.5.a.(2)	Personnel training at regular intervals
1.M.5.b., d.	For service delivery improvement, data collected on the persons served at appropriate intervals and at points in time following services
2.C.3.	Person-centered plan periodically reviewed and modified for relevance
3.A.19.b.	The ACT team psychiatrist regularly reviews and documents the symptoms and the response of the persons served to the prescribed medication treatment
3.D.2.a.	Regular meetings between persons served and staff members in Community Housing programs
3.F.14.	Regular interdisciplinary joint cross-training related to clinical and criminal justice issues
3.S.18.	Regular monitoring of each foster home placement in an Out-of-Home Treatment program
3.W.4.b.	Regular meetings between persons served and program personnel in Residential Treatment programs
3.X.1.f.	Regular review of person-centered plans of persons served in Student Counseling programs

APPENDIX C

Required Training

The following tables list the standards that require an organization to provide some form of education or training to personnel, persons served, and/or other stakeholders.

NOTE: *Some standards require specifically qualified or trained personnel to provide certain services or require an organization to verify or ensure that personnel have appropriate qualifications, education, and/or training but do not require the organization to directly provide the requisite education or training. Such standards are not included in this appendix. Please contact your resource specialist with any questions.*

Section 1. ASPIRE to Excellence®

Assess the Environment

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
A. Leadership				
1.A.6.c.(1)	Education on ethical codes of conduct	Personnel	No	None specified
1.A.6.c.(2)	Education on ethical codes of conduct	Stakeholders	No	None specified
1.A.8.	Education to stay current in the field	Personnel	No	None specified
B. Governance				
1.B.2.d.	Board education	Board members	No	None specified

Implement the Plan

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
F. Financial Planning and Management				
1.F.6.b.	Training related to fiscal policies and procedures	Appropriate personnel	No	Initial and ongoing
H. Health and Safety				
1.H.3.	Education designed to reduce identified physical risks	Persons served	No	None specified
1.H.4.b.(1)	Training in health and safety practices	Personnel	Yes	Upon hire and annually
1.H.4.b.(2)	Training in identification of unsafe environmental factors	Personnel	Yes	Upon hire and annually

Implement the Plan (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
1.H.4.b.(3)	Training in emergency procedures	Personnel	Yes	Upon hire and annually
1.H.4.b.(4)	Training in evacuation procedures, if applicable	Personnel	Yes	Upon hire and annually
1.H.4.b.(5)	Training in identification of critical incidents	Personnel	Yes	Upon hire and annually
1.H.4.b.(6)	Training in reporting of critical incidents	Personnel	Yes	Upon hire and annually
1.H.4.b.(7)	Training in medication management, if appropriate	Personnel	Yes	Upon hire and annually
1.H.4.b.(8)	Training in reducing physical risks	Personnel	Yes	Upon hire and annually
1.H.6.c.(4)	Necessary education and training of personnel regarding emergency procedures	Personnel	No	As needed
1.H.9.b.(5)	Necessary education and training of personnel regarding critical incidents	Personnel	No	As needed
1.H.10.b.(1)(a)	Training regarding infections	Personnel, persons served, and other stakeholders	No	None specified
1.H.10.b.(1)(b)	Training regarding communicable diseases	Personnel, persons served, and other stakeholders	No	None specified
1.H.11.g.	Training of drivers regarding the organization's transportation procedures	Personnel with driving responsibilities	No	None specified
I. Human Resources				
1.I.5.b.(1)	Training that addresses the identified competencies needed by personnel	Personnel	No	At orientation and regular intervals
1.I.5.b.(2)	Training that addresses confidentiality requirements	Personnel	No	At orientation and regular intervals
1.I.5.b.(3)	Training that addresses customer service	Personnel	No	At orientation and regular intervals

Implement the Plan (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
1.I.5.b.(4)	Training that addresses diversity	Personnel	No	At orientation and regular intervals
1.I.5.b.(5)	Training that addresses ethical codes of conduct	Personnel	No	At orientation and regular intervals
1.I.5.b.(6)	Training that addresses promoting wellness of the persons served	Personnel	No	At orientation and regular intervals
1.I.5.b.(7)	Training that addresses person-centered practice	Personnel	No	At orientation and regular intervals
1.I.5.b.(8)	Training that addresses personal privacy	Personnel	No	At orientation and regular intervals
1.I.5.b.(9)(a)	Training that addresses reporting of suspected abuse	Personnel	No	At orientation and regular intervals
1.I.5.b.(9)(b)	Training that addresses reporting of suspected neglect	Personnel	No	At orientation and regular intervals
1.I.5.b.(10)	Training that addresses rights of the persons served	Personnel	No	At orientation and regular intervals
1.I.5.b.(11)	Training that addresses rights of personnel	Personnel	No	At orientation and regular intervals
1.I.5.b.(12)	Training that addresses the unique needs of the persons served	Personnel	No	At orientation and regular intervals
1.I.7.d.	Training of students or volunteers	Students/ volunteers	No	None specified

Section 2. General Program Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.A. Program/Service Structure				
2.A.16.	Information and education relevant to the needs of the persons served	Persons served	No	None specified
2.A.19.a.	Training that includes areas that reflect the specific needs of the persons served	Personnel providing direct services	Yes	None specified
2.A.19.b.	Training that includes clinical skills that are appropriate for the position	Personnel providing direct services	Yes	None specified
2.A.19.c.	Training that includes person-centered plan development	Personnel providing direct services	Yes	None specified
2.A.19.d.	Training that includes interviewing skills	Personnel providing direct services	Yes	None specified
2.A.19.e.	Training that includes program-related research-based treatment approaches	Personnel providing direct services	Yes	None specified
2.B. Screening and Access to Services				
2.B.10.b.	Training in the use of applicable assessment tools, tests, or instruments prior to administration	Personnel conducting assessments	No	None specified
2.E. Medication Use				
2.E.2.b.(1)	Training and education regarding how the medication works	Persons served, individuals and family members with legal right or identified by person served, and personnel providing direct services	No	Ongoing
2.E.2.b.(2)	Training and education regarding the risks associated with each medicine	Same as above	No	Ongoing
2.E.2.b.(3)	Training and education regarding the intended benefits, as related to the behavior or symptom targeted by this medication	Same as above	No	Ongoing
2.E.2.b.(4)	Training and education regarding side effects	Same as above	No	Ongoing

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.E.2.b.(5)	Training and education regarding contraindications	Same as above	No	Ongoing
2.E.2.b.(6)	Training and education regarding potential implications between medications and diet/exercise	Same as above	No	Ongoing
2.E.2.b.(7)	Training and education regarding risks associated with pregnancy	Same as above	No	Ongoing
2.E.2.b.(8)	Training and education regarding the importance of taking medications as prescribed, including, when applicable, the identification of potential obstacles to adherence	Same as above	No	Ongoing
2.E.2.b.(9)	Training and education regarding the need for laboratory monitoring	Same as above	No	Ongoing
2.E.2.b.(10)	Training and education regarding the rationale for each medication	Same as above	No	Ongoing
2.E.2.b.(11)	Training and education regarding early signs of relapse related to medication efficacy	Same as above	No	Ongoing
2.E.2.b.(12)	Training and education regarding signs of nonadherence to medication prescriptions	Same as above	No	Ongoing
2.E.2.b.(13)	Training and education regarding potential drug reactions when combining prescription and nonprescription medications, including alcohol, tobacco, caffeine, illegal drugs, and alternative medications	Same as above	No	Ongoing
2.E.2.b.(14)	Training and education regarding instruction on self-administration, when applicable	Same as above	No	Ongoing
2.E.2.b.(15)	Training and education regarding wellness management and recovery planning	Same as above	No	Ongoing
2.E.2.b.(16)	Training and education regarding the availability of financial supports and resources to assist the persons served with handling the costs associated with medications	Same as above	No	Ongoing

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.F. Nonviolent Practices				
2.F.2.a.	Training in the contributing factors or causes of threatening behavior, including training on recovery and trauma-informed services and the use of personal safety plans	Direct service or front-line personnel	Yes	Initial and ongoing
2.F.2.b.	Training in the ability to recognize precursors that may lead to aggressive behaviors	Same as above	Yes	Initial and ongoing
2.F.2.c.	Training in how interpersonal interactions, including how personnel interact with each other and with the persons served, may impact the behaviors of the persons served	Same as above	Yes	Initial and ongoing
2.F.2.d.	Training in medical conditions that may contribute to aggressive behavior	Same as above	Yes	Initial and ongoing
2.F.2.e.	Training in the use of a continuum of alternative interventions	Same as above	Yes	Initial and ongoing
2.F.2.f.	Training in the prevention of threatening behaviors	Same as above	Yes	Initial and ongoing
2.F.2.g.	Training in recovery/wellness oriented relationships and practices	Same as above	Yes	Initial and ongoing
2.F.2.h.	Training in how to handle a crisis without restraints, in a supportive and respectful manner	Same as above	Yes	Initial and ongoing
2.F.3.a.	Training on when and how to restrain or seclude while minimizing risk	Personnel involved in the direct administration of seclusion or restraint	Yes	Initial and ongoing
2.F.3.b.	Training on recognizing signs of physical distress in the person who is being restrained or secluded	Same as above	Yes	Initial and ongoing
2.F.3.c.(1) and (2)	Training on the risks of seclusion or restraint to the persons served or personnel including medical and psychological risks	Same as above	Yes	Initial and ongoing
2.F.3.d.	Training on first aid and CPR	Same as above	Yes	Initial and ongoing

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.F.3.e.	Training on how to monitor and continually assess for the earliest release	Same as above	Yes	Initial and ongoing
2.F.3.f.	Training on the practice of intervention done by an individual	Same as above	Yes	Initial and ongoing
2.F.3.g.	Training on the practice of intervention done by a team	Same as above	Yes	Initial and ongoing

Section 3. Behavioral Health Core Program Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.A. Assertive Community Treatment				
3.A.22.a.	Education provided by the ACT team about the illness/disorder of the persons served	Families and other major supports of the persons served	No	None specified
3.A.22.b.	Education provided by the ACT team about the strengths and abilities of the persons served	Same as above	No	None specified
3.A.22.c.	Education provided by the ACT team about, when applicable, the role of the family in the therapeutic process	Same as above	No	None specified
3.F. Court Treatment				
3.F.14.b.	Interdisciplinary joint cross-training related to clinical and criminal justice issues	Personnel	No	Prior to the delivery of services and regularly
3.F.14.c.(1)	Training on the requirements imposed on personnel from the criminal justice system who participate on the treatment team	Personnel	No	Prior to the delivery of services and regularly
3.F.14.c.(2)	Training on safeguards that are available to personnel	Personnel	No	Prior to the delivery of services and regularly

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.G. Crisis and Information Call Centers				
3.G.2.a.–c.	Training that is guided by a written training plan, a detailed curriculum, and a post-training assessment of competency	Persons providing services	Yes	Initial and ongoing
3.G.2.d.(1) and (2)	Training that is guided by mechanisms for modeling and evaluation	Persons providing services	Yes	Initial and ongoing
3.G.2.e.(1) and (2)	Training that is guided by updating to reflect current community issues or trends and field trends or research	Persons providing services	Yes	Initial and ongoing
3.H. Crisis Intervention				
3.H.6.	Training or certification in first aid and CPR	Personnel providing mobile services	No	None specified
3.M. Employee Assistance				
3.M.1.f.	Informing and education of employees of the host organization	Persons served	No	None specified
3.M.8.b.	Training in employee assistance program-related functions	Program staff of EAP	No	None specified
3.M.13.a.	If specified in the written agreement, training in the scope of the program	Personnel	No	None specified
3.M.13.b.	If specified in the written agreement, training in the procedures for referral	Personnel	No	None specified
3.N. Health Home				
3.N.3.c.	Cross training for the most common chronic medical and behavioral illnesses prevalent in the population served	Personnel	No	None specified
3.N.7.a.	Health promotion including education, as needed	Persons served	No	None specified
3.N.7.e.(1)	Education regarding concerns applicable to the persons served	Persons served and families	No	None specified
3.N.7.e.(2)	Education or training in self-management of chronic diseases	Persons served and families	No	None specified
3.N.7.e.(3)(b)	When possible and allowed, offering education and training in response to identified concerns	Family members and significant others	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.N.12.c.(1)(a) and (b)	Education that includes health promotion, including healthy diet and exercise	Persons served, family members, or significant others	No	None specified
3.N.12.c.(2)	Education that includes wellness	Same as above	No	None specified
3.N.12.c.(3)	Education that includes resilience and recovery	Same as above	No	None specified
3.N.12.c.(4)	Education that includes the interaction between mental and physical health	Same as above	No	None specified
3.N.12.c.(5)(a)	Education that includes prevention/intervention activities including smoking cessation	Same as above	No	None specified
3.N.12.c.(5)(b)	Education that includes prevention/intervention activities including substance abuse	Same as above	No	None specified
3.N.12.c.(5)(c)	Education that includes prevention/intervention activities including increased physical activity	Same as above	No	None specified
3.N.12.c.(5)(d)	Education that includes prevention/intervention activities including obesity education	Same as above	No	None specified
3.N.12.c.(5)(e)(i)–(iii)	Education that includes prevention/intervention activities including chronic disease education as it may relate to heart disease, diabetes, and other chronic medical conditions highly prevalent among the population served	Same as above	No	None specified
3.N.12.c.(6)(a)	Education that includes self-management of identified medical conditions	Same as above	No	None specified
3.N.12.c.(6)(b)	Education that includes self-management of identified behavioral health concerns	Same as above	No	None specified
3.N.12.c.(6)(c)	Education that includes self-management of other life issues as identified by the person served	Same as above	No	None specified
3.N.12.c.(7)	Education that includes medication use	Same as above	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.P. Integrated Behavioral Health/Primary Care				
3.P.9.a.	Education that includes wellness	Persons served	No	None specified
3.P.9.b.	Education that includes resilience and recovery	Persons served	No	None specified
3.P.9.c.	Education that includes the interaction between mental and physical health	Persons served	No	None specified
3.P.9.d.(1)	Education that includes self-management of identified medical conditions	Persons served	No	None specified
3.P.9.d.(2)	Education that includes self-management of identified behavioral health concerns	Persons served	No	None specified
3.R. Intensive Outpatient Treatment				
3.R.3.	Education on wellness and recovery	Persons served	No	None specified
3.S. Out-of-Home Treatment				
3.S.5.a.	Training on attachment theory, including grief and loss	Providers	No	None specified
3.S.5.b.	Training on child growth and development	Providers	No	None specified
3.S.5.c.	Training on behavior management skills	Providers	No	None specified
3.S.5.d.	Training on learning deficits	Providers	No	None specified
3.S.5.e.	Training on cultural competency	Providers	No	None specified
3.S.5.f.	Training on the effects of placement on children	Providers	No	None specified
3.S.5.g.	Training on applicable legal issues	Providers	No	None specified
3.S.5.h.	Training on other specific needs	Providers	No	None specified
3.T. Outpatient Treatment				
3.T.2.	Education on wellness and recovery	Persons served	No	None specified
3.W. Residential Treatment				
3.W.1.i.	Education on wellness and recovery	Persons served	No	None specified
3.W.1.l.	Education/training in selection and maintenance of housing	Persons served	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.X. Student Counseling				
3.X.5.	Education on wellness and recovery	Persons served	No	None specified

Section 4. Behavioral Health Specific Population Designation Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.A. Addictions Pharmacotherapy				
4.A.2.e.(6)	Continuing education concerning urinalysis practices	Personnel	No	None specified
4.A.2.g.	Education on drug-screening practices	Personnel	No	None specified
4.A.2.j.(3)	Education on the procedures for grievances or due process related to administrative discharge	Persons served	No	None specified
4.C. Consumer-Run				
4.C.9.a.	Opportunities to enhance advocacy skills through training	Persons served	No	None specified
4.D. Criminal Justice				
4.D.5.b.	Regular interdisciplinary cross-training related to clinical and criminal justice issues	Personnel	No	Prior to the delivery of services and regularly
4.D.5.c.(1)	Training includes the requirements imposed on personnel from the criminal justice system who participate on the treatment team	Personnel	No	Prior to the delivery of services
4.D.5.c.(2)	Training on safeguards that are available to workers	Personnel	No	Prior to the delivery of services
4.D.5.c.(3)	Training on safety and security practices specific to the setting	Personnel	No	Prior to the delivery of services
4.D.5.c.(4)	Training on clinical boundaries	Personnel	No	Prior to the delivery of services
4.D.5.c.(5)	Training on correctional boundaries	Personnel	No	Prior to the delivery of services
4.D.5.c.(6)	Training on specialized clinical needs, including dual diagnoses	Personnel	No	Prior to the delivery of services

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.D.5.c.(7)	Training on therapeutic community practices and methodologies, when that core program is provided	Personnel	No	Prior to the delivery of services
4.D.13.a.	The curriculum-based program component for each person served addresses issues specific to his or her individual needs	Persons served	No	None specified
4.D.13.b.	The curriculum-based program component for each person served is consistent with his or her cognitive and learning abilities	Persons served	No	None specified
4.D.13.c.	The curriculum-based program component for each person served is consistent with the program's philosophy of treatment	Persons served	No	None specified
4.D.13.d.(1)	The curriculum-based program component for each person served includes provisions for evaluation	Persons served	No	None specified
4.D.13.d.(2)	The curriculum-based program component for each person served includes provisions for group instruction	Persons served	No	None specified
4.D.13.d.(3)	The curriculum-based program component for each person served includes provisions for individual instruction	Persons served	No	None specified
4.D.13.e.	The curriculum-based program component for each person served meets applicable federal, provincial, and state requirements	Persons served	No	None specified
4.D.14.a.	The educational program addresses the development of community living skills	Persons served	No	None specified
4.D.14.b.	The educational program addresses the development of social skills	Persons served	No	None specified
4.D.14.c	The educational program addresses the development of social supports	Persons served	No	None specified
4.D.14.d	The educational program addresses the development of vocational skills	Persons served	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.E. Juvenile Justice				
4.E.4.b.	Regular interdisciplinary cross-training related to clinical and juvenile justice issues	Personnel	No	Prior to the delivery of services and regularly
4.E.4.c.(1)	Training on the requirements imposed on personnel from the juvenile justice system who participate on the treatment team	Personnel	No	Prior to the delivery of services
4.E.4.c.(2)	Training on safeguards that are available to workers	Personnel	No	Prior to the delivery of services
4.E.4.c.(3)	Training on safety practices specific to the setting	Personnel	No	Prior to the delivery of services
4.E.14.a.	The curriculum-based program component for each person served addresses issues specific to his or her individual needs	Persons served	No	None specified
4.E.14.b.	The curriculum-based program component for each person served is consistent with his or her cognitive and learning abilities	Persons served	No	None specified
4.E.14.c.	The curriculum-based program component for each person served is consistent with the program's philosophy of treatment	Persons served	No	None specified
4.E.14.d.(1)	The curriculum-based program component for each person served includes provisions for evaluation	Persons served	No	None specified
4.E.14.d.(2)	The curriculum-based program component for each person served includes provisions for group instruction	Persons served	No	None specified
4.E.14.d.(3)	The curriculum-based program component for each person served includes provisions individual instruction	Persons served	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.E.14.e.	The curriculum-based program component for each person served meets applicable federal, provincial, and state requirements	Persons served	No	None specified
4.E.15.a.	The educational program addresses the development of community living skills	Persons served	No	None specified
4.E.15.b.	The educational program addresses the development of social skills	Persons served	No	None specified
4.E.15.c.	The educational program addresses the development of social supports	Persons served	No	None specified
4.E.15.d.	The educational program addresses the development of vocational skills	Persons served	No	None specified
4.F. Medically Complex				
4.F.19.a.(1) and (2)	The education and training program is developmentally and age appropriate	Persons served	No	None specified
4.F.19.b.(1)(a)–(c)	The education and training program includes knowledge of ability, activity, and participation	Persons served	No	None specified
4.F.19.b.(2)	The education and training program includes ability to describe and discuss any activity limitations in an age-appropriate fashion	Persons served	No	None specified
4.F.19.b.(3)	The education and training program includes conflict resolution	Persons served	No	None specified
4.F.19.b.(4)	The education and training program includes negotiation skills	Persons served	No	None specified
4.F.19.b.(5)	The education and training program includes assertiveness training	Persons served	No	None specified
4.F.19.b.(6)	The education and training program includes advocacy training	Persons served	No	None specified
4.F.19.b.(7)	The education and training program includes preparation for adolescence/adulthood	Persons served	No	None specified
4.F.19.b.(8)	The education and training program includes outcomes of decisions			

Section 5. Community and Employment Services

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
5.A. Program/Service Structure				
5.A.13.	Training in use of positive interventions	Personnel	No	Initially and annually
5.A.14.c.(2)	Training in the use of restrictive procedures (if restrictions are placed on the rights of a person served)	Personnel	No	Prior to implementation
5.F. Children and Adolescents Specific Population Designation				
5.F.9.	Educational opportunities for families	Family	No	None specified
5.F.10.	Training that covers all areas listed in the standard, as appropriate to the services provided	Personnel	No'	None specified
5.G. Child and Youth Services				
5.G.10.	Training that covers all areas listed in the standard, as appropriate to the services provided	Personnel	No	None specified
5.H. Community Housing				
5.H.6.	Skill development training necessary to live as independently as possible	Persons served	No	None specified
5.J. Personal Support Services				
5.J.2.	Training that includes all areas listed in the standard	Personnel	No	None specified
5.J.4.a.	Training in the use of adaptive devices and equipment, when applicable	Personnel	No	None specified
5.J.4.b.–d.	Training in the use of adaptive devices and equipment, when applicable	Person served, family, and caregivers	No	None specified
5.L. Services Coordination				
5.L.3.g.	Skill development services needed to enable persons served to perform daily living activities, including all areas listed in the standard	Persons served	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
5.N. Community Employment Services				
5.N.f.(1) and (2)	Education in self-directed job search and ADA rights and EEOC, as needed per individual plans of persons served	Persons served	No	Based on individual need
5.N.g.	Disability awareness education, when indicated	Employers	No	Based on individual need
5.N.26.	Training activities that address all areas listed in the standard, as needed by the person served	Persons served	No	Based on individual need
5.S. Organizational Employment Services				
5.S.2.	Training activities that address all areas listed in the standard, as needed by the person served	Persons served	No	Based on individual need

GLOSSARY

NOTE: *This glossary has been prepared for use with all CARF standards manuals. Terms have been selected for definition because they are subject to a wide range of interpretation and therefore require clarification of their usage in CARF's standards and materials. The glossary does not define practices or disciplines.*

CARF has not attempted to provide definitions that will be universally applicable. Rather, the intention is to define the meanings of the terms as they are used by CARF.

These definitions apply to all programs and services seeking accreditation. In some instances, glossary terms are used differently in different standards manuals. In such cases, the applicable manual is noted in parentheses after the term heading and before the definition.

Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Acquired brain injury: Acquired brain injury (ABI) is an insult to the brain that affects its structure or function, resulting in impairments of cognition, communication, physical function, or psychosocial behavior. ABI includes both traumatic and nontraumatic brain injury. Traumatic brain injuries may include open head injuries (e.g., gun shot wound, other penetrating injuries) or closed head injuries (e.g., blunt trauma, acceleration/deceleration injury, blast injury). Nontraumatic brain injuries may include those caused by strokes, nontraumatic hemorrhage (e.g., ruptured arterio-venous malformation, aneurysm), tumors, infectious diseases (e.g., encephalitis, meningitis), hypoxic injuries (e.g., asphyxiation, near drowning, anesthetic incidents, hypovolemia), metabolic disorders (e.g., insulin shock, liver or kidney disease), and toxin exposure (e.g., inhalation, ingestion). ABI does not include brain injuries that are congenital, degenerative, or induced by birth trauma.

Acquired impairment: An impairment that has occurred after the completion of the birthing process.

Acquisition: The purchase by one legal entity of some or all of the assets of another legal entity. In an acquisition, the purchasing entity may or may not assume some or all of the liabilities of the selling entity. Generally, the selling entity continues in existence.

Activities of daily living (ADL): The instructional area that addresses the daily tasks required to get along in life. ADL encompass a broad range of activities, including maintaining personal hygiene, preparing meals, and managing household chores.

Activity: The execution of a task or action by an individual. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF].*)

Activity limitations: Difficulties an individual may have in executing activities. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF].*)

Adaptive equipment: Equipment or devices, such as wheelchairs, walkers, communication devices, adapted utensils, and raised toilet seats, that help persons perform their activities of daily living.

Adjudicated: (Behavioral Health) Sentenced by a juvenile court or criminal court.

Administration: The act of managing or supporting management of an organization's business affairs. Business affairs include activities such as strategic planning, financial planning, and human resources management.

Adolescence: The period of life of an individual between childhood and adulthood, beginning at puberty and ending when one is legally recognized as an adult in one's state or province.

Advance directives: Specific instructions given by a person served to a care provider regarding the level and extent of care he or she wishes to receive. The intent is to aid competent adults and their families to plan and communicate in advance their decisions about medical treatment and the use of artificial life support. Included is the right to accept or refuse medical or surgical treatment. Includes psychiatric advance directives where allowed by law.

Adverse events: An untoward, undesirable, and usually unanticipated event such as a death of a person served, an employee, a volunteer, or a visitor in a provider organization. Incidents such as a fall or improper administration of medications are also considered adverse events even if there is no permanent effect on the individual or person served.

Advocacy services: Services that may include one or more of the following for persons with disabilities or other populations historically in need of advocacy:

- Personal advocacy: one-on-one advocacy to secure the rights of the person served.
- Systems advocacy: seeking to change a policy or practice that affects the person served.
- Legislative advocacy as permitted by law: seeking legislative enactments that would enhance the rights of and/or opportunities for the person served.
- Legal advocacy: using the judicial and quasi-judicial systems to protect the rights of the person served.
- Self-advocacy: enabling the person served to advocate on his/her own behalf.

Affiliation: A relationship, usually signified by a written agreement, between two organizations under the terms of which one organization agrees to provide specified services and personnel to meet the needs of the other, usually on a scheduled basis.

Affirmative enterprises: Operations designed and directed to create substantial economic opportunities for persons with disabilities.

Assessment: Process used with the person served to collect information related to his or her history and needs, preferences, strengths, and abilities in order to determine the diagnosis, appropriate services, and/or referral.

Assistive technology: Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase or improve functional capabilities of individuals.

Aversive conditioning: Procedures that are punishing, physically painful, emotionally frightening, deprivational, or put a person served at medical risk when they are used to modify behaviors.

Behavioral health: A category of medicine and rehabilitation that combines the areas of alcohol and other drug services, mental health, and psychosocial rehabilitation.

Board: See *Governing board*.

Catastrophe: A disaster or accident that immediately impacts an organization's ability to provide its programs or services or significantly impacts how the programs or services will be provided in the future.

Child/adolescent: An individual up to the age at which one is legally recognized as an adult according to state or provincial law.

Commensurate wage: A wage that is proportionate to the prevailing wage paid to experienced workers in the vicinity for essentially the same type of work. It is based on the quantity and quality of work produced by the worker with a disability compared to the work produced by experienced workers.

Communication skills: The instructional area that teaches the use of adaptive skills and assistive technology for accomplishing tasks such as reading, writing, typing, managing finances, and storing and retrieving information.

Community integration: (Aging Services) Being part of the mainstream of family and local community life, engaging in normal roles and responsibilities, and being an active and contributing member of one's social groups, local town or area, and of society as a whole.

Community relations plan: (Opioid Treatment Program) Supports program efforts to help minimize negative impact on the community, promote peaceful coexistence, and plan for change and program growth.

Community resources: A full range of resources for the resolution of personal issues such as marital, family, legal, alcohol/drug, mental health, and financial issues.

Comparative analysis: The comparison of past and present data to ascertain change, or the comparison of present data to external benchmarks. Consistent data elements facilitate comparative analysis.

Competency: The criteria established for the adequate skills, knowledge, and capacity required to perform a specific set of job functions.

Competency-based training: An approach to education that focuses on the ability to demonstrate adequate skills, knowledge, and capacity to perform a specific set of job functions.

Complaint: (Formal) The submission of an issue to an organization for resolution.

Computer access training: The instructional area that teaches the skills necessary to use specialized display equipment in order to operate computers. This includes evaluating the person served with large print, synthetic speech, and Braille access devices in order to perform word processing functions and other computer-related activities.

Concurrent physician care: Services delivered by both the rehabilitation physician and other physicians.

Concurrent services: Services delivered by multiple practitioners to the same person served during the same time period.

Congenital impairment: An impairment that is present at the completion of the birthing process.

Consolidation: The combination of two or more legal entities into a single legal entity, where the entities unite to form a new entity and the original entities cease to exist. In a consolidation, the consolidated entity has its own name and identity and acquires the assets and liabilities of the disappearing entities.

Consumer: The person served. When the person served is legally unable to exercise self-representation at any point in the decision-making process, *person served* also refers to those persons willing and able to make decisions on behalf of the person served. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the person served, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his or her own interests should be granted the right to choose whether family, significant others, or advocates may participate in the decision-making process. In standards that deal with infants, children, and/or adolescents, the family may be referenced directly as the family may serve as a person served in such situations.

Continuum of care/Continuum of services: A system of services addressing the ongoing and/or intermittent needs of persons at risk or with functional limitations resulting from disease, trauma, aging, and/or congenital and/or developmental conditions. Such a system of services may be achieved by accessing a single provider, multiple providers, and/or a network of providers. The intensity and diversity of services may vary depending on the functional and psychosocial needs of the persons served.

Core values: The essential and enduring tenets of an organization. They are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those inside the organization.

Corporate citizenship: An organization's efforts, activities, and interest in integrating, contributing, and supporting the communities where it delivers services to better address the needs of persons served.

Corporate status: The existence of an entity as a corporation under state law. Maintenance of corporate status typically requires ongoing compliance with state requirements.

Costs: The expenses incurred to acquire, produce, accomplish, and maintain organizational goals. These include both direct costs, such as those for salaries and benefits, materials, and equipment, and indirect costs, such as those for electricity, water, building maintenance, and depreciation of equipment.

Cultural competency: An organization's ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, religious, and/or social groups or sexual orientation.

Culturally normative: Providing the persons served with an opportunity to experience patterns and conditions of everyday life that match as closely as possible those patterns and conditions typical of the mainstream experience in the local society and community. This requires the use of service delivery systems and settings that adapt to the changing norms and patterns of communities in which the persons served function so as to incorporate the following features:

- Rhythms of the day, week, and year and life cycles that are "normal" or typical of the community.

- A range of choices, with personal preferences and self-determination receiving full respect and consideration.

- A variety of social interactions and settings, including family, work, and leisure settings and opportunities for personal intimacy.

- Normal economic standards.

- Life in housing typical of the local neighborhoods.

Culture: The integrated pattern of human behavior that includes the thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, social, or other group.

Customers: The persons served, families, communities, funding agencies, employers, etc., who receive or purchase services from the organization.

Data: Facts collected or assembled in a computer database, or a compilation of aggregate statistics or trends.

Demonstrate: To show, explain, or prove by evidence presented in program documentation, interviews, and behavior how an organization or a program consistently conforms to a given standard.

Debt covenants: Requirements found in loan documents that require an organization to meet certain predefined performance targets to be measured at predefined time periods. The performance targets can be financial (for example, the organization must maintain a certain level of days with cash on hand) or nonfinancial (an organization must maintain a certain occupancy level).

Detoxification treatment: (Opioid Treatment Program) Dispensing an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such period.

Discharge summary: (Aging Services, Behavioral Health, Child and Youth Services, and Opioid Treatment Program) A document prepared at discharge by the staff members designated with the responsibility for service coordination that summarizes the person's course of treatment, level of goal(s) achievement, final assessment of current condition, and recommendations and/or arrangements for further treatment and/or aftercare.

Diversion control plan: (Opioid Treatment Program) Contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and must assign specific responsibility to medical and administrative staff for implementation.

Diversity: Differences due to cognitive or physical ability, culture, ethnicity, religion, economic status, gender, age, or sexual orientation.

Durability: Maintenance or improvement over time of outcomes achieved by persons served at the time of discharge.

Duty of care: Obligation of governing board members to act with the care that an ordinarily prudent person in a similar position would use under similar circumstances. This duty requires governing board members to perform their duties in good faith and in a manner they reasonably believe to be in the organization's best interest.

Duty of loyalty: Obligation of governing board members to refrain from engaging in personal activities that would harm or take advantage of the organization. This duty prohibits governing board members from using their position of trust and confidence to further their private interests. It requires an undivided loyalty to the organization and demands that there be no conflict between a governing board member's corporate duty and self-interest.

Duty of obedience: Obligation of governing board members to perform their duties according to applicable statutes and the provisions of the organization's articles of incorporation and bylaws.

Effectiveness: Results achieved and outcomes observed for persons served. Can apply to different points in time (during, at the end of, or at points in time following services). Can apply to different domains (e.g., change in disability or impairment, function, participation in life's activities, work, and many other domains relevant to the organization.)

Efficacy: The ability to produce an effect, or effectiveness.

Efficiency: Relationship between resources used and results or outcomes obtained. Resources can include, for example, time, money, or staff/FTEs. Can apply at the level of the person served, program, or groups of persons served or at the level of the organization as a whole.

Employee-owner: An individual who delivers administration or services on behalf of an organization if such individual is also:

- with respect to a for-profit organization, a person holding an ownership interest in the organization; or
- with respect to a nonprofit organization, a person with the right to vote for the election of the organization's directors, unless that right derives solely from the person's status as a delegate or director.

Entitlements: Governmental benefits available to persons served and/or their families.

Executive leadership: The organization's principal management employee, often referred to as the chief executive officer, president, or executive director. The executive leadership is hired and evaluated directly by the organization's governing board and is responsible for leading management in conducting the organization's business and affairs.

Family/support system: (Aging Services, Continuing Care Retirement Communities, Aging Services Networks, and Medical Rehabilitation) A group of persons of multiple ages bonded by affection, biology, choice, convenience, necessity, or law for the purpose of meeting the individual needs of its members.

Family: (Behavioral Health and Employment and Community Services) A person's parents, spouse, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served.

Family of origin: Birth family or first adoptive parents.

Fee schedule: A listing of prices for services rendered. These prices may be designed for and used with third-party payers, outside funding sources, and/or the persons served, their families, and caregivers.

Functional literacy: The ability to read, comprehend, and assimilate the oral and written language and numerical information required to function in a specific work or community environment. Accommodation strategies for those with reduced functional literacy may include picture instructions and audio- or videotapes.

Governance authority: (Medical Rehabilitation and Opioid Treatment Program) The individual or group that provides direction, guidance, and oversight and approves decisions specific to the organization and its services. This is the individual or group to which the chief executive reports.

Governing board: The body vested with legal authority by state/provincial statutes to direct the business and affairs of a corporate entity. Such bodies are often referred to as boards of directors, trustees, or governors. Advisory and community relations boards and management committees do not constitute governing boards.

Governmental: Regarding any legal municipal entity including, but not limited to, city, county, state, federal, tribal, or provincial.

Grievance: A perceived cause for complaint.

Home: (Employment and Community Services) The individual's living environment as impacted by the individual's personal articles, friends, roommates, or significant others. Individuals' homes are considered central to their identity.

Host organization: Employer of an individual eligible for employee assistance program services.

Impairment: Problems in body function or structure such as a significant deviation or loss. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF].*)

Independent (board representation): The absence of conflict of interest by a governing board member with respect to any organizational transaction. A governing board member is typically independent with respect to a transaction if neither the individual nor any related person or entity benefits from the transaction or is subject to the direction or control of a person or entity that benefits from the transaction. (See definition

of *unrelated.*) For purposes of the foregoing, direction or control is often evidenced by the existence of an employment relationship or other compensation arrangement.

Indigenous: Indigenous people are the descendants—according to a common definition—of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. CARF is using the term *indigenous* as a generic term as defined by the United Nations for many years. The UN estimates that there are more than 370 million indigenous peoples spread across 70 countries worldwide. Practicing unique traditions, indigenous people retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. In some countries, there may be preference for other terms including tribes, first peoples, or Aboriginals; specific examples include Native Americans, First Nations, Métis, and Inuit.

Individual plan: An organized statement of the proposed service/treatment process to guide a provider and a person served throughout the duration of service/treatment. It identifies the input from the person served regarding goals and objectives and services to be provided, persons responsible for providing services, and input from the person served.

Information: Understanding derived from looking at facts; conclusions from looking at data.

Informed choice: A decision made by a person served that is based on sufficient experience and knowledge, including exposure, awareness, interactions, or instructional opportunities, to ensure that the choice is made with adequate awareness of the alternatives to and consequences of the options available.

Integration: (Behavioral Health) Presence and participation in the mainstream of community life. *Participation* means that the persons served maintain social relationships with family members, peers, and others in the community who do not have disabilities. In addition, the persons served have equal access to and full participation in community resources and activities available to the general public.

Integration: (Aging Services, Aging Services Networks, Continuing Care Accreditation Commission, Employment and Community Services, Medical Rehabilitation, and Vision Rehabilitation Services) The opportunity for involvement in all aspects of community life. Integration into communities, work settings, and schools provides all individuals opportunities to be active, fully participating members of those communities or environments. In integrated settings, diversity is viewed as a goal; it is recognized that diversity enriches all community members.

Interdependence: Movement from dependence toward interdependence may be demonstrated by an increase in self-sufficiency, self-advocacy, or self-determination, with offsetting decreases in artificial or paid services.

Interdisciplinary: Characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of a person's program. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

Investigation: A detailed inquiry or systematic examination by a third party into the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

Joint venture: A business undertaking by two or more legal entities in which profits, losses, and control are shared, which may or may not involve the formation of a new legal entity. If a new entity is formed, the original entities continue to exist.

Kinship care: (Child and Youth Services) Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment. (This definition is from the Child Welfare League of America [CWLA].)

Leadership: Leadership creates and sustains a focus on the persons served, the organization's core values and mission, and the pursuit of organizational and programmatic performance excellence. It is responsible for the integration of the organization's core values and performance expectations into its management system. Leadership promotes and advocates for the organization's and community's commitment to the persons served.

Linkages: Established connections and networks with a variety of agencies, companies, and persons in the community.

Living arrangements: (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility/Mental Retardation (ICF/MR), etc.

Long-term detoxification treatment: (Opioid Treatment Program) Detoxification treatment for more than 30 days but no more than 180 days.

Maladaptive behavior: Behavior that is destructive to oneself, others, or the environment, demonstrating a reduction or lack of the ability necessary to adjust to environmental demands.

Manual skills: The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

Material litigation: A legal proceeding initiated by a third party concerning the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

Medical director: (Opioid Treatment Program) A physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for

administering all medical services performed by the program either by performing them directly or delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

Medically complex: (Behavioral Health, Child and Youth Services) Persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.

- Has required at least one month of hospitalization.

- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.

- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.

- The medically complex condition of the person served presents an ongoing threat to his or her health status.

Medically fragile: (Employment and Community Services) An individual who has a serious ongoing illness or a chronic physical condition that has lasted or is anticipated to last at least 12 months or who has required at least one month of hospitalization. Additionally, this individual may require daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members. Moreover, this individual may require the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.

Medically supervised withdrawal (MSW): A medically supervised, gradual reduction or tapering of dose over time to achieve the elimination of tolerance and physical dependence to methadone or LAAM or other opioid agonists or partial agonists.

Medication control: (Aging Services, Behavioral Health, Employment and Community Services, Opioid Treatment Program) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. This would include medications self-administered by the persons served or the use of samples.

Medication management: (Aging Services, Employment and Community Services, Medical Rehabilitation, Vision Rehabilitation Services) The practice of prescribing, administering, and/or dispensing medication by qualified personnel.

It is considered management when personnel in any way effect dosage, including taking pills out of a bottle or blister pack; measuring liquids; or giving injections, suppository, or PRN medications.

Medication management: (Opioid Treatment Program) The practice of prescribing, administering, and/or dispensing any medications approved for the treatment of opioid dependence by qualified medical personnel.

Medication monitoring: (Employment and Community Services, Vision Rehabilitation Services) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. The person served must take the medication without any assistance from personnel.

Medication unit: (Opioid Treatment Program) A facility that is part of but geographically separate from an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis.

Medication use: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program) The practice of handling, prescribing, dispensing and/or administering medication to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious.

Mental status: A person's orientation, mood, affect, thought processes, developmental status, and organic brain function.

Merger: The combination of two or more legal entities into a single legal entity, where one entity continues in existence and the others cease to exist. In a merger, the surviving entity retains its name and identity and acquires the assets and liabilities of the disappearing entities.

Mission: An organization's reason for being. An effective mission statement reflects people's idealistic motivations for doing the organization's work.

Natural proportions: A principle that states that the number of persons served in any given setting, such as a work setting, should be in proportion to the number of persons with disabilities in the general population.

Natural supports: (Behavioral Health) Supports provided that assist the persons served to achieve their goals of choice and facilitate their integration into the community. Natural supports are provided by persons who are not paid staff members of a service provider but are planned, facilitated, or coordinated in partnership with such a provider.

Natural supports: (Employment and Community Services and Vision Rehabilitation Services) Supports that occur naturally in the community, at work, or in a social situation that enable the persons served to accomplish their goals in life without the use of paid supports.

Offender: An inmate, detainee, or anyone under the community supervision of a criminal justice agency.

On-the-job evaluation: An evaluation performed in a work setting located outside the organization in which a person is given the opportunity to experience the requirements necessary to do a specific job. Real work pressures are exerted by the employer, and the person's performance is evaluated by the employer and the evaluator.

Opioid agonist treatment medication: (Opioid Treatment Program) Any opioid agonist drug approved by the U.S. Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opiate addiction.

Organization: A legal entity that provides an environment within which services or programs are offered.

Orientation and Mobility (O&M): The instructional area that addresses the use of the remaining senses in combination with skill training utilizing protective techniques and assistive devices in order to travel independently in a safe, efficient, and confident manner in both familiar and unfamiliar environments.

Outcome: Result or end point of care or status achieved by a defined point following delivery of services.

Outcomes measurement and outcomes management: A systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of the individuals' satisfaction with those results. An outcomes management system measures outcomes by obtaining, aggregating, and analyzing data regarding how well the persons served are functioning after exit/discharge from a specific service. Outcomes measures should be related to the goals that recent services were designed to achieve. Other measures in the outcomes management system may include progress measures that are appropriate for long-term services (longer than six months in duration) that serve persons demonstrating a need for a slower pace in order to achieve gains or changes in functioning.

Paid work: Employment of a person served that results in the payment of wages for the production of products or provision of services. Paid work meets the state and/or federal definition of employment.

Participation: An individual's involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF].*)

Participation restrictions: Problems an individual may experience in involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF].*)

Pathological aging: Changes due to the impact of disease versus the normal aging process.

Pediatric medicine: The branch of medicine dealing with the growth, development, and care of infants, children, and adolescents and with the treatment of their diseases.

Performance indicator: A quantitative expression that can be used to evaluate key performance in relation to objectives. It is often expressed as a percent, rate, or ratio. For example, a performance indicator on return to work can be: percentage of clients in competitive employment 90 days after closure.

Performance target: Measurable level of achievement identified to show progress toward an overall objective. This could be set internally by the program, organization, or it could be a target established by an external entity. The performance target could be expressed as a certain percentage, ratio, or number to be reached.

Periodically: Occurring at intervals determined by the organization. The organization uses information about and input from the persons served and other stakeholders to determine the frequency of the intervals.

Person served: The primary consumer of services. When this person is unable to exercise self-representation at any point in the decision-making process, *person served* also refers to those willing and able to make decisions on behalf of the primary consumer. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the primary consumer, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his/her own interests should be granted the right to choose whether other members of the family, significant others, or advocates may participate in that decision-making process.

Personal care: Services and supports, including bathing, hair care, skin care, shaving, nail care, and oral hygiene; alimentary procedures to assist one with eating and with bowel and bladder management; positioning; care of adaptive personal care devices; and feminine hygiene.

Personal representative: An individual who is designated by a person served or, if appropriate, by a parent or guardian to advocate for the needs, wants, and rights of the person served.

Personnel: An individual employed full time or part time or on a contract.

Personnel: (Behavioral Health, Opioid Treatment Program) All categories of individuals who provide services in a program on a part- or full-time basis as staff members, independent contractors, volunteers, students, trainees, or interns.

Persons with severe and persistent mental illness: (Behavioral Health) Adults with a primary diagnosis of schizophrenia, psychiatric disorders, major affective disorders (such as treatment resistant major depression and bipolar disorder), or other major mental illness according to the current *Diagnostic and Statistical Manual of Mental Disorders,* which may also include a secondary diagnosis.

Pharmacotherapy: Any treatment of the persons served with prescription medications, including methadone or methadone-like drugs.

Plan: Written direction that is action oriented and related to a specific project or defined goal, either present and/or future oriented. A plan may include the steps to be taken to achieve stated goals, a time line, priorities, the resources needed and/or available for achieving the plan, and the positions or persons responsible for implementing the identified steps.

Plan of care: The document that contains the program that has been designed to meet the needs of the person served. This document is prepared with input from the team, including the person served. The plan is modified and revised, as needed, depending upon the needs of the person served.

Policy: Written course of action or guidelines adopted by leadership and reflected in actual practice.

Predicted outcomes: The outcomes established by the team at the time of the completion of the initial assessment.

Preferred practice patterns: Statements developed as a guideline for blind rehabilitation specialists that specify procedures, clinical indications for performing the procedures, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes.

Prevailing wage: A wage paid to experienced workers in the vicinity who do not have disabilities that impede them in doing the work to be performed. An experienced worker is one who has become proficient in performing a job and is not receiving entry-level wages. Prevailing wage rates must be based on work done using similar methods and equipment. The information to be recorded in documenting prevailing wage rates includes:

- The date of contact with the firm.
- The name, address, and phone number of the firm.
- The individual contacted within the firm.
- The title of the individual contacted.
- The wage range provided.
- A brief description of the work for which information is provided.
- The basis for the conclusion that the wage rate is not based on an entry-level position.

Primary care: Active, organized, structured treatment for a presenting illness.

Private homes: An apartment, duplex, house, or condominium owned, rented, or leased by a person served. The services provided by the organization in these settings may include community housing, group home, or a halfway house.

If a person served and the organization co-sign a lease for the person served for an apartment, duplex, or townhouse, this living arrangement will be considered a private home and will not be subject to some standards as noted. The

organization will not technically be considered a lessor of this private home for the person served, but will be considered a financial guarantor for the person served who is leasing his or her own private home.

Procedure: A "how to" description of actions to be taken. Not required to be written unless specified.

Prognosis: The process of projecting:

- The likelihood of a person achieving stated goals.
- The length of time necessary for the person to achieve his or her rehabilitation goals.
- The degree of independence the person is likely to achieve.
- The likelihood of the person maintaining an outcome achieved.

Program: A system of activities performed for the benefit of persons served.

Program sponsor: (Opioid Treatment Program) The person named in the application for certification as responsible for the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any medication units.

Proprietary organization: An organization that is operated for profit.

Psychoeducation: Individualized instruction and training of the persons served to increase their knowledge and understanding of their psychiatric diagnoses, prognoses, treatment, and rehabilitation in order to enhance their acceptance of these psychiatric disabilities, increase their cooperation and collaboration with treatment and rehabilitation, improve their coping skills, and favorably affect their outcomes. Such education should be consistent with the individual plans and be provided with the knowledge and support of the interdisciplinary team.

Publicly operated organization: An organization that is operated by a governmental entity (e.g., a city, county, state, provincial, or federal entity).

Qualified behavioral health practitioner: (Behavioral Health, Child and Youth Services) A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services. Persons other than a physician who are designated by a program to order seclusion or restraints must be permitted to do so by federal, state, provincial, or other regulations.

Qualified practitioner: (Child and Youth Services) A person who is certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide human services.

Reasonable accommodations: Modifications or adjustments, which are not unduly burdensome, that assist the persons served or staff members to access benefits and privileges that are equal to those enjoyed by others. Examples taken from the Americans with Disabilities Act include making existing facilities readily accessible to and usable by persons with disabilities; restructuring jobs; modifying work schedules; reassigning persons to vacant positions; acquiring or modifying equipment or assistive devices; adjusting or modifying examinations, training materials, policies, and procedures; and providing qualified readers or interpreters.

Regular: Occurring at fixed, uniform intervals of time determined by the organization. The organization assesses and uses information about and input from the persons served and other stakeholders to determine the frequency necessary.

Rehabilitation: The process of providing those comprehensive services deemed appropriate to the needs of persons with disabilities in a coordinated manner in a program or service designed to achieve objectives of improved health, welfare, and realization of the person's maximum physical, social, psychological, and vocational potential for useful and productive activity. Rehabilitation services are necessary when a person with a disability is in need of assistance and it is beyond the person's personal capacities and resources to achieve his or her maximum potential for personal, social, and economic adjustment and beyond the capabilities of the services available in the person's usual daily experience. Such assistance continues as long as the person makes significant and observable improvement.

Rehabilitation nursing services: The formalized organizational structure that delineates the appropriate accountability, staff mix, and competencies and provides a process for establishing, implementing, and maintaining patient care standards and nursing policies that are specific to rehabilitation nursing. The nursing staff includes members who provide direct care and those who provide supervision and perform support functions. This staff usually includes clinical nurse specialists, registered nurses, licensed practical (vocational) nurses, nursing assistants, and unit clerical support. Nursing services are provided under the direct supervision of a registered nurse unless supervision is otherwise defined by applicable state practice acts or provincial legislation for nursing.

Rehabilitative treatment environment: A rehabilitation setting that provides for:

- The provision of a range of choices, with personal preference and self-determination receiving full respect and consideration.
- A variety of social interactions that promote community integration.
- Treatment of a sufficient volume of persons served to ensure that there is an environment of peer support and mentorship.
- Treatment of a sufficient volume of persons served to support professional team involvement and competence.
- A physical environment conducive to enhancing the functional abilities of the persons served.

Reliability: The process of obtaining data in a consistent or reproducible manner.

Representative sampling: A group of randomly selected individuals determined through a procedure such that each person has an equal probability of inclusion in the sample. If sampling

is used, the sample should reflect the population to which the results are generalized. Although no specific percentage of persons served is required to be included in the sample, general principles of data analysis state that the larger the sample, the less the error that is expected in comparing the sample to the entire population of persons served. The number of persons sampled within each program area or subgroup should be sufficient to give confidence that the characteristics of the sample reflect the distribution of the entire population of persons served.

Residence: (Employment and Community Services) The actual building or structure in which a person lives.

Residential settings: (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility/Mental Retardation (ICF/MR), etc.

Restraint: The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person's freedom of movement. Restraint is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm.

Risk: Exposure to the chance of injury or loss. The risk can be external, such as a natural disaster, injury that occurs on the property of a program, or fire. The risk can be internal to the organization and include things such as back injuries while performing job duties, it can involve liability issues such as the sharing of information about a person served without consent, or it can jeopardize the health of those internal or external to the organization due to such things as poor or nonexistent infection control practices.

Risk factors: (Behavioral Health) Certain conditions and situations that precede and may predict the later development of behavioral health problems. Examples of risk factors may include poverty, family instability, or poor academic performance. Examples of protective factors may include an internal locus of control, a positive adult role model, and a positive outlook.

Risk factors: Aspect of personal behavior or life-style, environmental exposure, or variable or condition that increases the likelihood of an adverse outcome.

Screening: A face-to-face, computer-assisted, or telephone interview with a person served to determine his or her eligibility for services and/or proper referral for services.

Seclusion: The separation of an individual from normal program participation in an involuntary manner. The person served is in seclusion if freedom to leave the segregated room or area is denied. Voluntary time-out is not considered seclusion.

Sentinel events: An unexpected occurrence within a CARF accredited program involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

Service: Activities performed for the benefit of persons served.

Service access: The organization's capacity to provide services to those who desire it.

Service referral: The practice of arranging for a person to receive the services provided by a given professional service unit of the organization or through some other appropriate agent. This arrangement, which is usually made by the individual responsible for the program of the person served, should be documented by notation in the person's permanent record.

Short-term detoxification treatment: (Opioid Treatment Program) Detoxification treatment for no more than 30 days.

Should: Inasmuch as CARF is a standards-setting and consultative resource rather than a regulatory or enforcement agency, the term *should* is used synonymously with the term *shall*. CARF's intent is that each applicable standard and each policy within this document will be addressed

and met by organizations seeking to become accredited or maintain current accreditation.

Skilled healthcare provider: Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist).

Skilled healthcare provider: (Behavioral Health and Child and Youth Services) Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist). Can also include specifically trained natural or foster family member knowledgeable in the care of the specific individual.

Staff member: A person who is directly employed by an organization on either a full-or part-time basis.

Stakeholders: Individuals or groups who have an interest in the activities and outcomes of an organization and its programs and services. They include, but are not limited to, the persons served, families, governance or designated authority, purchasers, regulators, referral sources, personnel, employers, advocacy groups, contributors, supporters, landlords, business interests, and the community.

Strategic planning: An organization's directional framework, developed and integrated from a variety of sources, including but not limited to financial planning, environmental scans, and organizational competencies and opportunities.

Supervisor: The lead person who is responsible for an employee's job performance. A supervisor may be a manager or a person with another title.

Supports: Individuals significant to a person served and/or activities, materials, equipment, or other services designed and implemented to assist the person served. Examples include instruction, training, assistive technology, and/or removal of architectural barriers.

Team: At a minimum, the person served and the primary personnel directly involved in the participatory process of defining, refining, and meeting the person's goals. The team may also include other significant persons such as employers, family members, and/or peers at the option of the person served and the organization.

Team integration: The process of bringing individuals together or incorporating them into a collaborative team. The entire team becomes the dominant culture and decision-making body for the rehabilitation process. There is recognition of and respect for the value of information provided by an individual team member, with a focus on the interdependence and coordination of all team members. Through coordinated communication, there is accountability by the team 24 hours per day, 7 days per week for all decisions made.

Transition *(from school)*: (Employment and Community Services) The process of moving from education services to adult services, including living and working in the community.

Transition: The process of moving from one level of care or service/support to another, or leaving care or services/supports.

Transition plan: (Aging Services, Behavioral Health, Child and Youth Services, and Opioid Treatment Program) A document developed with the full participation of the person served that (a) focuses on a successful transfer/transition between program phases/levels/steps or (b) focuses on a successful transition to a community living situation. The plan will detail how the person served will maintain the gains made during services and support ongoing recovery and/or continued well-being at the next phase/level/step.

Treatment: A professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served.

Unrelated (board representation): The absence of an affiliation between a governing board member and any person or entity that benefits from any organizational transaction. For purposes of the foregoing, *affiliation* generally means a relationship that is:

- Familial;
- Characterized by control of at least a 35 percent voting, profits, or beneficial interest by the member; or
- Substantially influenced by the member.

Validity: Refers to the appropriateness, meaningfulness, and usefulness of a measure and the inferences made from it. Commonly regarded as the extent to which a test measures what it is intended to measure.

Value: The relationship between quality and cost.

Visit: Episode of service delivery to one person served on one day by one service or discipline.

Visual skills: The instructional area that addresses the needs of persons with partial vision to gain a better understanding of their eye problems through patient education and teaches them how to utilize their remaining vision effectively through the use of low vision techniques. It also includes assessment and training with special optical aids and devices designed to meet the various needs of the persons served. These needs may include reading, activities of daily living, orientation, mobility, and home repairs.

Wellness education: Learning activities that are intended to improve the patient's health status. These include but are not limited to healthcare education, self-management of medication(s), nutritional instruction, exercise programs, and training in the proper use of exercise equipment.

Youth: A person between six and eighteen years of age.

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How well did the CARF *2013 Behavioral Health Standards Manual* meet your needs?

Your comments will help us evaluate and improve the quality of this publication. Please email any comments to us at documents@carf.org.

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