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Child and Youth Services

Standards Manual

carf INTERNATIONAL

Contents

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 group of companies includes:

- CARF
- CARF Canada
- CARF Europe

Since its inception in 1966, CARF has benefited from 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 the ASPIRE to Excellence® section which relates 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.

The following icons are used in this manual 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

➢ (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 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
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 Employment Services Centres in Canada (Standards Manual Supplement)
Medical Rehabilitation	Medical Rehabilitation
Vision Rehabilitation Services	Vision Rehabilitation Services

NOTE: *Standards manuals become effective on July 1, 2015, 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: *For Business and Services Management Network, DMEPOS, One-Stop Career Center, and Vision Rehabilitation Services, the survey preparation workbook is incorporated into the standards manuals.*

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 a survey application constitutes the organization's agreement to adhere to the CARF policies and procedures that are in effect on the date on which the survey application 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 survey application, 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 program/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 program/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 Nonaccreditation 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 survey application.	The organization submits the survey application via Customer Connect, **customerconnect.carf.org**. ■ The survey application 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 survey application, required supporting documents, and a nonrefundable application 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 survey application on the date that corresponds with their accreditation expiration month (see page 13). ■ The submission of the completed survey application indicates the organization's desire for the survey and its agreement to all terms and conditions contained therein. ■ If any information in the survey application changes after submission, CARF should be notified immediately.
STEP 4	
CARF invoices for the survey fee.	After reviewing all information contained in the survey application, 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.

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 survey application

The survey application 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 survey application for completion and submission to CARF. Resurvey organizations are notified of the survey application automatically.

The survey application is submitted with the nonrefundable application 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 survey application 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	Survey application due to CARF no later than	*Expiration Month
*Jul/Aug	Feb. 28	Aug
*Jul/Aug	Mar 31	Sept
Aug/Sept	Apr 30	Oct
Sept/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 a survey application received after the due date is at risk for a delay in survey time frame. Organizations are encouraged to submit their survey application at least ten business days before the indicated due date. Submission of the completed survey application confirms the organization's agreement to all terms and conditions contained therein. If any information in the survey application changes after submission, CARF should be notified in writing immediately.

Selection of Programs and Services to be Surveyed

In the survey application, 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 survey application 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 survey application 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 survey application 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 survey application 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 a survey application 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 survey application 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 survey application 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 provide services 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 various languages from the Resources section of Customer Connect (**customerconnect.carf.org**) in an editable format so that organizations may make adjustments (such as font, color, and size) to ensure the poster is accessible for all persons served. 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. While provision of such information in advance of the survey is at the discretion of the organization, it can help facilitate an efficient and consultative on-site survey.

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.

NOTE: *During an original survey the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey; during a resurvey the organization is expected to demonstrate conformance to all applicable standards throughout the entire period since its last survey.*

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 stakeholders 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, or immediately after 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 for improvement identified in the previous report and for evidence of conformance to standards throughout the tenure of accreditation, and for 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 Nonaccreditation 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 a survey application 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 survey application, 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 that it is not confidential or protected by law, including, but not limited to:

1. Whether CARF has received a survey application 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. As required by law or contract.

For convenient access to information, CARF includes on its website 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 survey application 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 survey application to CARF with a nonrefundable application 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 survey application 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 survey application, 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 survey application and application 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 survey application and request for an extension after the date the survey application 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 Non-accreditation 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 Non-accreditation, 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 Non-accreditation 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. In the case of an organization that disputes the accreditation decision from a resurvey following a Provisional Accreditation, the organization must demonstrate that it is functioning at the level of a Three-Year Accreditation for the Nonaccreditation decision to be rejected on review or appeal.

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

CHANGES IN THE 2015 MANUAL

Section 1. ASPIRE to Excellence®

1.H. Health and Safety

■ The applicable standards information at the beginning of this section has been revised for clarity. Definitions of all italicized terms can be found in the Glossary.

■ In Standard 1.H.5., element c.(3) regarding sheltering in place is new and the text of element c.(4) has been modified from *the safety of evacuees* to *the safety of all persons involved.*

■ In Standard 1.H.7.d., the text including the analysis has been added to clarify documentation requirements regarding tests of emergency procedures.

■ In Standard 1.H.12., previous element l.(2) regarding training of drivers on the unique needs of persons served has been reworded slightly and moved to new element g.(2) and now applies to all drivers who provide transportation for persons served rather than only to contracted drivers.

1.I. Human Resources

■ In Standard 1.I.2., element a.(2) has been restructured and element a.(2)(b) is new to address reciprocity when services are provided across state/province/jurisdiction lines.

1.J. Technology

■ Standard 1.J.1. has been revised slightly for clarity and elements c. and d., requiring the plan be *reviewed annually* and *updated as needed,* are new.

■ Previous Standard 1.J.2. has been deleted.

■ Standards 1.J.2.–8. are new and address service delivery via the use of information and communication technologies.

1.M. Performance Measurement and Management

■ Text of Standard 1.M.3.a.(2) has been revised from accessibility status reports to accessibility information.

Terminology changes in Sections 2, 3, and 4

Throughout Section 2, 3 and 4 minor modifications have been made for clarity in some standards when language regarding: *parents guardians*, *legal representatives* and *caregivers* is used.

Section 2. General Program Standards

Minor modifications were made in the Applicability Table at the beginning of the section for the following programs: Assessment/Referral, Child/Youth Day Care, Crisis and Information Call Centers, and Promotion/Prevention.

2.A. Program/Service Structure

■ Standard 2.A.20. has been revised to include *policies* along with *written procedures.* Previous elements in a. are now included in the intent statement and previous element b. regarding unplanned absences was deleted as the concept is covered in Standard 1.I.1.

■ Throughout the Peer Support Services subsection (Standards 2.A.37.–43.) the term "peer supporters" has been changed to *peer support specialists*, and the applicable standards information for these standards has been updated to indicate that they apply only when an organization *employs* peer support specialists.

2.B. Screening and Access to Services

■ Standard 2.B.2. is new to require demonstrated efforts to minimize the times between first contact, screening, and

admission or referral. Subsequent standards in this section have been renumbered.

2.E. Medication Use

- The stem of Standard 2.E.6. has been reworded slightly for clarity.
- In Standard 2.E.8., element b. is new to specify that the peer review is conducted by a qualified professional with legal prescribing authority or a pharmacist. Subsequent elements have been renumbered.

2.F. Nonviolent Practices

- The stem of Standard 2.F.6. has been reworded slightly for clarity.
- Standard 2.F.15. has been restructured and element b.(1) is new to include that the use of seclusion and restraint is reviewed at least annually.

Section 3. Child and Youth Services Core Program Standards

3.D. Case Management/Services Coordination

- Standard 3.D.6. has been deleted. Subsequent standards in this section have been renumbered.

3.E. Child/Youth Day Care

- Standard 3.E.3., elements a., c., and f. have been deleted as these concepts are covered in Standard 2.A.12.

3.H. Community Transition

- Standard 3.H.18. regarding a written discharge summary is new.

3.K. Counseling/Outpatient

- This section was titled "Counseling" in the 2014 manual; the section name has been changed to "Counseling/Outpatient" and the program description and the standards have been revised and updated based on input from the field.

3.L. Crisis Programs

- Previous sections 3.L. Crisis and Information Call Centers and 3.M. Crisis Intervention have been combined into one section.

3.M. Day Treatment

- This section was 3.N. in the 2014 manual. The program description and the standards in this section have been revised and updated based on input from the field.

3.N. Detoxification

- This section was 3.O. in the 2014 manual.

3.O. Diversion/Intervention

- This section was 3.P. in the 2014 manual.

3.P. Early Childhood Development

- This section was 3.Q. in the 2014 manual.

3.Q. Foster Care

- This section was 3.R. in the 2014 manual.

3.R. Group Home Care

- This section was 3.S. in the 2014 manual.

3.S. Health Home

- This section is new.

3.T. Home and Community Services

- Previous Standard 10. has been deleted from this section and subsequent standards have been renumbered. Elements of this standard are now included in new Standard 1.J.2.

3.V. Intensive Outpatient Treatment

- The program description and the standards in this section have been revised and updated based on input from the field.

3.Z. Support and Facilitation

- Standard 3.Z.2. has been revised and expanded to maximize the opportunity for persons served to participate in the program.

Glossary

The following terms have been added:

- Administrative location.
- Community settings.
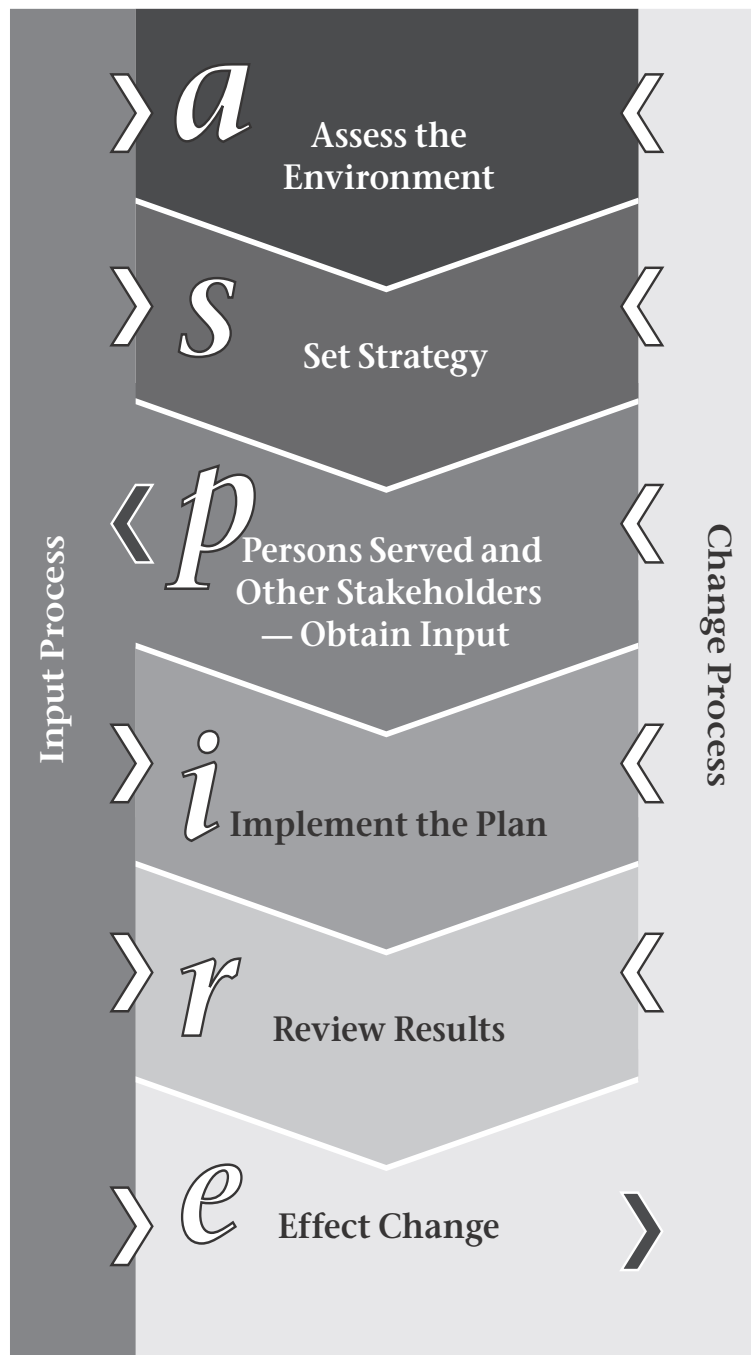- Controlled/operated.
- Donated location/space.

The following terms have been modified:

- Family.
- Indigenous.

ASPIRE to Excellence®

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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

Input Process

Change Process

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.**
  l. **Health and safety.**

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

3.a.(1) As the organization's 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.

3.d. 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.g. 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.

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.

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

The organization has a system which 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 has awareness of the diversity of its various stakeholders and assesses their strengths and challenges. Diversity awareness includes a review of the demographics of the service population in contrast with the demographics of the service community. What are the population trends? Is the service population reflecting those trends? The organization has cultural knowledge of personnel, persons served, and other stakeholders to include areas such as spiritual beliefs, holidays, dietary regulations or preferences, clothing, attitudes toward impairments, language preferences, health beliefs, role of family members in decision making, beliefs about disability, family values, experiences of bias, and degree of and attitudes about acculturation. 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, and increased satisfaction of stakeholders.

Examples of demonstrating cross-cultural competency skills may include how and when to use interpreters, how to elicit whether and which family members should be involved in decision making, how to analyze data to track progress in addressing disparities as well as by recruiting board members and hiring persons who reflect the demographics 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. Content of training could include discussion of culture, race, ethnicity, age, gender, sexual orientation, gender identity and gender expression, spiritual beliefs, socioeconomic status, literacy, and language. Content may include the role these factors play in terms of interactions with others (personnel and peers), affect on the service needs of the persons served, and possible impact on job functions of personnel. Training might focus on the cultures and spiritual beliefs of the countries of origin, specifically 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, students, and volunteers 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. Coaching and mentoring received by personnel could be offered and documented as a way of facilitating transfer of knowledge gained in formal training experiences into day-to-day practice.

5.b.(3) Gender may include both gender identity and gender expression.

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 other professional, educational and advocacy organization websites provide information

related to diversity and cultural competency. These include:

- 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**

- SAMSHA Treatment Improvement Protocol (TIP) 59: **http://store.samhsa.gov/product/ TIP-59-Improving-Cultural-Competence/ SMA14-4849**

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 fundraising.

            (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 fundraising 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. **Implementation of a policy on corporate compliance that has been adopted by the organization's leadership.**

   b. **Written designation of a staff member to serve as the organization's compliance officer who:**

      (1) **Monitors matters pertaining to corporate compliance.**

      (2) **Conducts corporate compliance risk assessments.**

      (3) **Reports on matters pertaining to corporate compliance.**

   c. **Training of personnel on corporate compliance, including:**

      (1) **Role of the compliance officer.**

      (2) **The organization's procedures for allegations of fraud, waste, abuse and other wrongdoing.**

   d. **Internal auditing activities.**

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.

7.d. Internal auditing activities include audits that would reasonably uncover improper conduct and/or billing errors.

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. These systems should be guided by regulations provided by the Centers for Medicaid and Medicare (CMS), and consistent with Section 6401 of the Patient Protection and Affordable Care Act of 2010.

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.

7.a. A policy on corporate compliance typically articulates the organization's strong ethical culture and commitment to compliance with all applicable laws, regulations, and requirements. The role of the compliance officer may be defined, including the compliance officer's access to top-level leadership and/or the governing board.

7.b.(1) The compliance officer may perform compliance related activities or monitor activities delegated to other personnel.

7.b.(2) Compliance risk assessment activities can be included in the organization's risk management activities.

7.b.(3) The compliance officer reports to top-level leadership regarding compliance related activities, results of internal auditing activities, and results of investigations from reports of suspected fraud, waste, and abuse from organizational personnel.

7.d. The internal auditing activities should be designed to evaluate the organization's compliance with federal requirements as well as determining the effectiveness of the compliance program.

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 account-ability mechanisms. These mechanisms include, but are not limited to, an adopted governance framework defined by written governance poli-cies 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 dele-gated 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 respon-sibilities under the domain of public trust, and as such, it understands its corporate responsibil-ity 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 survey application 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 composed 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

See the Glossary for the definition of *strategic planning*.

1.f. Capabilities can include succession planning for key positions in administration, finance, and service delivery. Succession planning might address people within the organization who could move into key positions, as well as highlight the need or opportunity to identify potential leaders external to the organization or even external to the field.

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. Consideration of your community demographics is important in planning as changes in demographics directly impact the population your programs serve. Consider as an example an organization that was started more than 30 years ago in a very rural area, which has become industrial or has experienced a settlement of a large immigrant population. Such a demographic change affects many areas including finances and expectations of the community members.

1.i. External stakeholders may include educational institutions.

1.k. An organization evaluates changes in public funding from legislation, such as the Patient Protection and Affordable Care Act 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 laptop computers and/or tablets 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.a. Input used is directly related to Standard 1.D.1. in which input is gathered from all stakeholders using a variety of mechanisms.

2.b.(2) An organization is better able to define success with proactive long-term financial planning measures. Since the future financial position of an organization is impacted by ever changing marketplace factors such as coding, payment,

reimbursement, and costs, the strategic plan might include information reflecting long-term financial planning to support the goals and priorities identified. Points in the future might be one year, two years or other points in time depending on regulatory and business factors impacting the organization.

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.

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 and HITECH 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.a. Confidential administrative records could include personnel records, contracts, budgets, billing information, legal information, and other protected or sensitive information and 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 sub-section. 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 regarding administrative records and 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) Expenses.
            (iii) Capital expenditures.

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

(c) **Comparison to historical performance.**

(d) **Consideration of necessary cash flow.**

(e) **Consideration of external environment information.**

(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 services throughout the region at the time or it could also mean comparison to similar business activities that are operated.
- Practices in service delivery or business management that are becoming more widespread and could impact the program.

An organization can demonstrate that consideration 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 accomplish 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 entities 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 stakeholders 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 nonfinancial 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 reasonable 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 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 countries outside the United States, 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 organization 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 organization'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

When determining applicability, please refer to the Glossary for the definitions and clarification of all *italicized* terms.

Standards in this subsection apply to all locations of an organization that meet the following descriptions, unless an identified exception applies:

- Locations owned/leased by the organization that are:
  - Used for delivery of the programs or services seeking accreditation.

    or

  - *Administrative locations* where personnel related to the programs or services seeking accreditation are located.

- *Donated locations/space* that are *controlled/operated* by the organization and are:
  - Used for the delivery of the programs or services seeking accreditation.

    or

  - *Administrative locations* where personnel related to the programs or services seeking accreditation are located.

Identified exceptions:

Standards 1.H.7., 1.H.13., and 1.H.14. are NOT applied to locations that meet any of the following criteria:

- *Private homes* of persons served.
- *Community settings* that are not owned/leased or *controlled/operated* by the organization.
- Used solely by an *employee-owner* for administration and no other persons or

personnel are located, meet, or are served at the location.

- Used by the organization for service delivery one hour or less in any week.
- Used by the organization for administration by less than the equivalent of one full-time employee in any week.

Please contact your CARF resource specialist if you have questions or need further clarification.

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, as follows:**
      (1) **When evacuation is appropriate.**
      (2) **Complete evacuation from the physical facility.**
      (3) **When sheltering in place is appropriate.**
      (4) **The safety of all persons involved.**
      (5) **Accounting for all persons involved.**
      (6) **Temporary shelter, when applicable.**

(7) **Identification of essential services.**

(8) **Continuation of essential services.**

(9) **Emergency phone numbers.**

(10) **Notification of the appropriate emergency authorities.**

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

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.

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.c.(6) Temporary shelter is typically needed if the organization provides a residential/housing, 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.(7)–(8) Essential services may include the provision of medications, residential or other housing support services, or assistance with daily living requirements.

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.ready.gov/are-you-ready-guide**
- **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/limb-loss-resource-center/resources-by-topic/emergency-preparedness/index.html** 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. The organization has evacuation routes that are:
   a. Accessible.
   b. Understandable to:
      (1) Persons served.
      (2) Personnel.
      (3) Other stakeholders, including visitors.

Examples

6.a. 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.

1.H. **7. 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, including the analysis.

   NOTE: *This standard does not apply to services in this standards manual that are provided in private homes or 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.

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. 8. 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

8.a. First aid expertise may include CPR, universal precautions or other safety training.

8.b. 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, medical, or correctional setting, personnel within the program/service site could be used.

8.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 a 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. 9. 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 critical 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 that are applicable to its operations, 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.

Written procedures include 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.

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 written procedures determining what format and where the documentation of incidents is to be maintained. Licensing agencies may 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.

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

1.H. **10. 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

If critical incidents are analyzed at the level of the larger entity or organization, there is still a process to review, analyze, and address the data

associated with critical incidents specific to the programs/services seeking accreditation. Analyzing critical incidents at the level of the program/service could identify program/service specific causes, trends, actions, prevention of recurrence, and education needs that may differ from the rest of the organization. The written analysis might be a separate report or contained within the organizationwide report.

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 administration, transportation, program 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 the behavior of the person served, 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 analysis is to enable the development of actions for improvement to prevent similar events from occurring in the future. Once an analysis 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.

10.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. **11. 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.

🍁 **11.b.(2)** In Canada this may be referred to as routine practices.

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.

11.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/province/territory and by program type.

11.b.(3)(a) The persons served will be provided with training based on individual needs such as accident prevention, risk-taking behavior, or drug use.

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**, Infection Prevention and Control Canada **www.ipac-canada.org**, or state or provincial/territorial departments of health outbreak manuals.

Applicable Standards

Standard 1.H.12. applies only to programs that provide transportation for the persons served.

Note: *This standard does not apply to vehicles used only for transporting materials.*

1.H. **12.** **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:
      (1) The organization's transportation procedures.
      (2) The unique needs of the persons served.
   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, an annual review of the contract against elements a. through k. of this standard.

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

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

12.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.

12.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.

Other safety equipment could include cell phones, flares and cones, flashlights, disposable cameras, fire extinguishers, tire gauges, jack and lug wrench, spare fuses, and jumper cables.

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

12.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. **13. 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.

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

■ 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 health system, parent corporation, or system of care) 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 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.

■ 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.

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

13.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. 14. Comprehensive health and safety self-inspections:

    a. Are conducted at least semiannually 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 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. **15. 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.

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):**
         (a) **With primary sources.**
         (b) **When applicable, in all states/provinces or other jurisdictions where personnel will deliver services.**

b. **Time frames for verification of back-grounds 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.a.(2)(b) If personnel deliver services in more than one state/province or jurisdiction, the organization is knowledgeable about reciprocity of licensure and how this would impact service delivery in person or via use of information and communication technologies.

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. Organizations may elect to hire an external firm that specializes in license verifications, background checks, and review of exclusions lists.

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

2.a.(2)(a) 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) **Reporting of:**
         (a) **Suspected abuse.**
         (b) **Suspected neglect.**
      (9) **Rights of the persons served.**
      (10) **Rights of personnel.**
      (11) **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.
        (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.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.

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.

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.J.

1. The organization implements a technology and system plan that:
   a. **Includes:**
      (1) **Hardware.**
      (2) **Software.**
      (3) **Security.**
      (4) **Confidentiality.**
      (5) **Backup policies.**
      (6) **Assistive technology.**
      (7) **Disaster recovery preparedness.**
      (8) **Virus protection.**
   b. **Supports:**
      (1) **Information management.**
      (2) **Performance improvement activities for:**
         (a) **Program/service delivery.**
         (b) **Business functions.**
   c. **Is reviewed at least annually for relevance.**
   d. **Is updated as needed.**

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 does not have any technology, this written plan would address how the organization is strategically moving in that direction. A system could be a single desktop computer or a network of multiple computers.

SECTION 1.J. TECHNOLOGY

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.

1.a.(6) Assistive technology may include electronic medical records, a Wii® game console, eBook readers (e.g., Kindle®, Nook®, or iPad®), screen reading software for computers; adaptive telephones; wander guard equipment; sensors on doors; adaptive mouse devices for using computers; voice recognition software.

The organization may implement a system of handheld devices for access and entries to the chart/record of the person served and would want to consider whether the screen size, font, etc. are adequate for ease of access and use by staff.

The organization reviews the technology used to see if it is accessible for persons with visual impairments or if additional options need to be available.

The organization may explore options for access to tablets or internet access to incorporate new technology for use by persons served, such as recorded cueing strategies in community integration and vocational programming.

Standards for Service Delivery Using Information and Communication Technologies

Applicable Standards

If the organization uses information and communication technologies (ICT) to deliver services, Standards J.2. through J.8. apply.

Description

Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, telemental health, telerehabilitation, telespeech, etc. Based on the individualized plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served, family/support system members, and other providers in remote settings. The use of technology for strictly informational purposes does not qualify as providing services via the use of information and communication technologies.

The provision of services via information and communication technologies may:

■ Include services such as assessment, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.

■ Involve a variety of professionals such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.

■ Encompass settings such as:

– Hospitals, clinics, professional offices, and other organization-based settings.

– Schools, work sites, libraries, community centers, and other community settings.

– Congregate living, individual homes, and other residential settings.

1.J. 2. The organization implements written procedures:
  a. That address:
    (1) Consent of the person served.
    (2) Audio recording, video recording, and photographing the person served.
    (3) Decision making about when to use information and communication technologies versus face-to-face services.
    (4) Decision making about when to use monitoring devices.
  b. To confirm prior to the start of each session that all necessary technology and/or equipment:
    (1) Is available at:
      (a) Originating site.
      (b) Remote site.
    (2) Functions properly at:
      (a) Originating site.
      (b) Remote site.

Intent Statements

2.a.(1) The organization's procedures include obtaining written consent to participate in service delivery via information and communication technologies when applicable.

1.J. 3. As appropriate, personnel who deliver services via information and communication technologies receive competency-based training on equipment:
  a. Features.
  b. Set up.
  c. Use.
  d. Maintenance.
  e. Safety considerations.
  f. Infection control.
  g. Troubleshooting.

Intent Statements

For service delivery to be effective, personnel are trained to use equipment and technology to deliver services as well as to guide persons served, members of the family/support system, and others in the remote setting on its use.

Examples

3.f. Infection control addresses equipment used at the originating site and the remote site. For example:

- Equipment that touches any part of the body or is used to look into someone's eyes, ears, or mouth is properly sanitized between each use.
- The person served and family members in the home are instructed in proper hand washing technique, shielding coughs and sneezes, and the use, if necessary, of gloves or masks to minimize risks associated with sharing equipment.
- When the person served is using a computer at a school or library, the keyboard, mouse, and headset are cleaned appropriately before they are used.

1.J. 4. As appropriate, instruction and training are provided:
  a. To:
    (1) Persons served.
    (2) Members of the family/support system.
    (3) Others.
  b. On equipment:
    (1) Features.
    (2) Set up.
    (3) Use.
    (4) Maintenance.
    (5) Safety considerations.
    (6) Infection control.
    (7) Troubleshooting.

1.J. 5. Service delivery includes:

    a. Online information 24 hours a day, 7 days a week.

    b. Personnel to provide assistance with accessing services provided by the organization.

    c. Based on identified need:

        (1) An appropriate facilitator at the site where the person served is located.

        (2) Modification to:

            (a) Treatment techniques/ interventions.

            (b) Equipment.

            (c) Materials.

            (d) Environment of the remote site, including:

                (i) Accessibility.

                (ii) Privacy.

                (iii) Usability of equipment.

Examples

5.a. Online information may include:

- A description of the services offered via information and communication technologies, providers, referral process, etc.

- Technology requirements such as high-speed internet access, computer headset with microphone, webcam, etc.

- Contact information for scheduling or technical support, e.g., the person or department to contact, phone number, and/or email address.

- Information to support or supplement the services provided, e.g., home exercise programs, forms to use for tracking information, when to seek emergency care or assistance between scheduled sessions, a calendar of group sessions, etc.

5.c.(1) Depending on the purpose of the session and the needs of the person served, professional personnel, support personnel, family members, or caregivers might function in the role of facilitator.

1.J. 6. Prior to the start of each session:

    a. All participants in the session are identified, including those at:

        (1) Originating site.

        (2) Remote site.

    b. The organization provides information that is relevant to the session.

Examples

6.b. Information may be shared on the credentials of the provider, structure and timing of services, record keeping, scheduling, contact between sessions, privacy and security, potential risks, confidentiality, billing, rights and responsibilities, etc.

1.J. 7. The organization maintains equipment in accordance with manufacturers' recommendations.

1.J. 8. Emergency procedures address the unique aspects of service delivery via information and communication technologies, including:

    a. The provider becoming familiar with the emergency procedures of the remote site, if the procedures exist.

    b. Identification of local emergency resources, including phone numbers.

Examples

When the person served is located at an organization or a community setting the provider becomes familiar with the procedures of that setting in the event there is an emergency involving the person served. In the absence of emergency procedures for the setting where the person served is located, or when the person served is in his or her own home, the provider has immediate access to emergency contact information for the person served and information on local emergency resources, including their phone numbers.

Additional Resources

- American Telemedicine Association: **www.americantelemed.org**
- VA Telehealth Services: **www.tele-health.va.gov/real-time**
- International Journal of Telerehabilitation: t**elerehab.pitt.edu/ojs/index.php/Telerehab**
- US Department of Health and Human Services Health Resources and Services Administration: **www.hrsa.gov/ruralhealth/about/telehealth/telehealth.html**
- Department of Health and Human Services Centers for Medicare & Medicaid Services Telehealth Services: **www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf**
- Center for Connected Health Policy National Telehealth Policy Resource Center: **http://cchpca.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.

- Technology and system plan
- Backup policies
- Performance improvement plans
- Written procedures for the use of information and communication technologies, if applicable
- Records of equipment maintenance in accordance with manufacturer's instructions, if applicable
- Emergency procedures that address service delivery via information and communication technologies, if applicable

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., prevention or residential) or the condition of the person served. The method used for communication should reflect the needs of the person served and may include verbal presentation, large print or pictures, movies, translation into a different language, a 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. Physical abuse also includes food/nutritional restrictions as a form of punishment. 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 child and youth services program, the policy regarding authorization for the release of information conforms to Standard 2.G.6.

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 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. **4.** **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
- Written analysis of all formal complaints

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) Technology.**
  - **(8) Transportation.**
  - **(9) Community integration, when appropriate.**
  - **(10) 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, a need for child-sized furniture and fixtures, 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 "people 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.(8) 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.(9) 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.(10) 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:**

a. **Includes, for all identified barriers:**

(1) **Actions to be taken.**

(2) **Time lines.**

b. **Is reviewed at least annually for relevance, including:**

(1) **Progress made in the removal of identified barriers.**

(2) **Areas needing improvement.**

c. **Is updated as needed.**

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.** **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

When a request for a reasonable accommodation, the organization is not automatically required to 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.

In Canadian Secure Services programs, the organization has a process in place to consider requests for leaves of absence.

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 review of accessibility plan
- 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 symptom 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 persons 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 identify permanency planning as important to the well-being of a person served. The organization chooses to collect placement rate, moves in care, and time to achieve permanent placement.

- 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 information.**
     (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) **Strategic planning information.**
     (11) **Field trends, including research findings, if applicable.**
     (12) **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

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 system to ensure that the characteristics of persons served are included. However, when the 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 demographically representative sample represents the persons the program served, or intended to serve, by 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.**

Examples

Data are collected and aggregated at the level of each individual program/service seeking accreditation. This is important for analysis that can therefore identify performance differences between programs and target specific improvements.

5.d. For follow-up, organizations may attempt to contact each person or a representative sampling of persons who have left services/supports.

Refer to the Glossary for the definition of *representative sampling*.

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

❧ For organizations that work with the National Outcomes Matrix (NOM) requirement, data on the indicators listed at **http://www.cecw-cepb.ca/sites/default/files/publications/en/NationalOutcomesMatrix09.pdf** should be collected.

6.b.(1) Effectiveness measures address the quality of care through measuring change over time.

Specific effectiveness measures for child and youth programs can include the following:

- Maintenance of abstinence.
- Community integration.
- Reduction in placement breakdowns.
- Reduction or elimination of negative involvement with the criminal justice system.
- Improvement of physical health.
- Improvement in school functioning.
- Reduction in dropout rate.
- Increase in kinship placements.
- Reduction in number of out-of-home placements.
- Reduction of symptoms.
- Increase in the level of psychological functioning.
- Increase in self-esteem.
- Acceptance rate of participants into a program.
- Reduction in teen pregnancy and early parenthood.
- 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.
- Improvement in appropriate referrals for educational assessments.
- 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 to inquiries for service.
- Unplanned service discharge "abandonment or drop out rate".
- Time taken to set a first or subsequent appointment.
- 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 needs of the person served and their family?
- 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.

Satisfaction data are collected from the child/youth served as appropriate to age and ability as well as from family or other caregivers. 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 video-tapes. 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

Child and Youth Services General Program Standards

Description

NOTE: *Throughout this manual the term* person(s) served *is used in a broad context, as defined in the Glossary, to mean the child/youth and/or family served, and may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. In this manual the term* child/youth served *is used where a standard specifically addresses children/youths; in these instances the standard may also include separate requirements related to other persons served such as the child's/youth's parents, family members, a legal guardian, or other legal representative. Please contact CARF with any questions about how to interpret the standards.*

For an organization to achieve quality services, the philosophical foundation of child- and family-centered care practices must be demonstrated. Children/youths and families are involved in the design, implementation, delivery, and ongoing evaluation of applicable services offered by the organization. A commitment to quality and the involvement of the persons served span the entire time that they 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 person served. The persons served have the opportunity to transition easily through a system of care.

The guiding principles include:

- Child/youth and family driven services.
- Promotion of resiliency.
- Cultural and linguistic competence.
- Strengths-based approach.
- Focus on whole person in context of family and community.
- Trauma-informed, where applicable.

Applicable Standards

The standards in Section 2 typically apply to all of the programs and services in Section 3, with some exceptions. Please refer to the following table to determine the standards in Section 2 that are applicable to the programs or services for which your organization is seeking accreditation.

2.A. Program/ Service Structure	2.B. Screening and Access to Services	2.C. Indiv- idualized Plan	2.D. Transition/ Discharge	2.E. Medica- tion Use	2.F. Nonvio- lent Practices	2.G. Records of the Persons Served	2.H. Quality Records Review
Adoption — page 159							
apply all	not applicable	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all except 2.G.3.	not applicable
Assessment/Referral — page 166							
apply*	apply*	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply*	apply*
Behavioral Consultation — page 167							
apply all	apply 2.B.1.–10.	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply 2.G.3,	apply 2.H.1., 2., 4., and 5.
Case Management— page 171							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Child/Youth Day Care — page 173							
apply all*	apply 2.B.1.–6.	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	not applicable	not applicable
Child/Youth Protection — page 177							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Community Housing and Shelters — page 182							
apply all	apply 2.B.1–8.	not applicable	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	not applicable
Community Transition — page 186							
apply all	apply all	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all

2.A. Program/ Service Structure	2.B. Screening and Access to Services	2.C. Indiv- idualized Plan	2.D. Transition/ Discharge	2.E. Medica- tion Use	2.F. Nonvio- lent Practices	2.G. Records of the Persons Served	2.H. Quality Records Review
Community Youth Development — page 193							
apply all	apply 2.B.1–6.	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Congregate Care — page 196							
apply all	apply 2.B.1–8.	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	not applicable
Counseling/Outpatient — page 200							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Crisis and Information Call Centers — page 202							
apply 2.A.1.–12., 15.–17., and 19.–21.	apply*	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply*	apply*
Crisis Intervention — page 205							
apply*	apply*	apply*	apply*	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply*	apply*
Day Treatment — page 207							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Detoxification — page 209							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Diversion/Intervention — page 212							
apply all	apply 2.B.1.–6.*	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	not applicable	not applicable

2.A. Program/ Service Structure	2.B. Screening and Access to Services	2.C. Indiv- idualized Plan	2.D. Transition/ Discharge	2.E. Medica- tion Use	2.F. Nonvio- lent Practices	2.G. Records of the Persons Served	2.H. Quality Records Review
Early Childhood Development — page 215							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Foster Family and Kinship Care — page 219							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Group Home Care — page 229							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Health Homes — page 233							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Home and Community Services — page 241							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Intensive Family-Based Services — page 252							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Intensive Outpatient Treatment — page 254							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all

2.A. Program/ Service Structure	2.B. Screening and Access to Services	2.C. Indiv- idualized Plan	2.D. Transition/ Discharge	2.E. Medica- tion Use	2.F. Nonvio- lent Practices	2.G. Records of the Persons Served	2.H. Quality Records Review
Promotion/Prevention — page 257							
apply* 2.A.1.–12., 14., 16., 19.–22., 24., 30., and 32.	not applicable	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	not applicable	not applicable
Residential Treatment — page 260							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Respite — page 263							
apply	apply 2.B.1.–7.; apply 2.B.8.–14.*	apply*	apply*	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply 2.G.1., 2., and 4.–6.	apply*
Specialized or Treatment Foster Care— page 224							
apply all	apply all	apply all	apply all	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	apply all	apply all
Support and Facilitation — page 260							
apply all	apply 2.B.1.–8.	not applicable	not applicable	apply 2.E.1.– 2.; all others as applicable	apply 2.F.1.– 2.; all others as applicable	not applicable	not applicable
* Note of exception: These sections are noted because the standards will be applied, but from the framework of applying standards to programs of brief duration. For such programs, it is likely that information will not be gained and documented to the same extent as programs of longer duration. For example, the assessments, individual treatment and transition plans, and records will not reflect the in-depth information seen in longer-term or intensive programs. For further interpretation, contact CARF toll-free at (888) 281-6531.							

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.

The organization, where appropriate, provides information to the child/youth served and in collaboration with the parent and/or legal representative.

Child- and family-centered care includes the following:

- Recognition that, when possible, the family is the constant in the child's/youth's life, while the service systems and personnel within those systems fluctuate.

- Facilitation of family-professional collaboration at all levels of care.

- Sharing of unbiased and complete information about a child's/youth's care on an ongoing basis, in an appropriate and supportive manner.

- Implementation of appropriate policies and programs that are comprehensive and provide necessary support to meet the needs of children/youths and families.

- Recognition of child/youth and family strengths and individuality and respect for different methods of coping.

- Understanding and incorporating the developmental needs of children/youths and families into service systems.

- Assurance that the design of health and social service delivery systems is flexible, accessible, and responsive to the needs of children/youth and families.

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.

1.b. Training programs often use websites to post information regarding fees as well as hours and days of classes.

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. Training programs often provide or give access to study space, texts, and web-based resources to support the curriculum.

2.A. 3. Based on the scope of each program/service provided, the organization documents its:
   a. Entry criteria.
   b. Transition criteria, if applicable.
   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. Transition may not always occur based on the nature of the program/service.

Examples

While a program/service may use terms that are different than those above, the concepts are the same. The program may develop their own criteria or base their criteria on best practices within the field including: diagnoses, ASAM Level of Care Criteria, medical necessity, or Children's Global Assessment of Functioning.

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.

Training programs often outline the specific admission criteria such as: prerequisite coursework, minimum grades, and preferred background.

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, contract termination, criteria graduation, 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 persons served 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 be informed as to reasons for ineligibility without specific consent.

4.c. When an individual is not accepted into a training program, suggestions are made to improve his or her future successful admission.

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, such as Trauma Informed Care practices.

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; electronic medical records, or other electronic means.

2.A. **8. 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.

8.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.

2.A. **9. When services are provided from or within a mobile unit, written procedures are implemented that address, at a minimum, the unique aspects of the following areas related to mobile settings:**

a. **Responsibilities of:**

(1) **Drivers.**

(2) **Service providers.**

b. **Confidentiality of:**

(1) **Records of persons served.**

(2) **Communication.**

c. **Privacy related to service delivery.**

d. **Accessibility.**

e. **Availability of information on resources to address needs unable to be met at the mobile setting.**

f. **Security of:**

(1) **Medications provided from or within the mobile unit, when applicable.**

(2) **Equipment and supplies used in service provision.**

(3) **The mobile unit when not in use.**

g. **Safety of:**

(1) **Records of persons served.**

(2) **Personnel.**

h. **Maintenance of:**

(1) **Equipment.**

(2) **Vehicles.**

Intent Statements

Mobile unit services are services provided from a vehicle such as a motor home or van that functions as a site for the program/service seeking accreditation.

Examples

9.b. Written procedures address confidentiality related to the use of mobile technology for documentation and telephonic communication about the persons served.

9.d. The mobile unit:

■ Provides adequate space for persons served to approach and move around inside of it.

■ Is equipped with a ramp, handrails, and adaptive equipment for use by personnel and/or persons served.

■ Operates from a location where there is ample parking.

■ Operates from a location that limits exposure to the sun and noise in the environment such as traffic noise.

9.f.(3) Security of the mobile unit when it is not in use might address the location where the unit is parked overnight and/or between stops, locking the unit, protection of records, and the use of security personnel or surveillance systems to monitor the unit.

9.g. Safety considerations might include communication systems available, availability of emergency procedures in the mobile unit, what to do in the event of an emergency situation, determination of the location where the mobile unit provides services, and minimum personnel that must be present during hours of operation.

9.h. Maintenance of mobile units might include keeping logs of mileage, gasoline use, oil changes, and tire wear.

2.A. **10.** **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.

10.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.

10.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.

In a Healthy Families America program, the population description identifies key demographic information such as number of resident live births per year, number of women of child-bearing age, and number of single parents.

10.e. Special populations may children/youths with dual disorders or developmental disabilities; juvenile offenders; lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youths; pregnant youths; infants born with drug addictions; separated children seeking asylum; or homeless children/youths. Mechanisms to address needs of the special population could include psychoeducational classes, use of affirmations, pet therapy, art or music therapy, mentoring, and protocols for reinforcing positive thinking and behaviors.

🍁 **10.e.** In Canada, Secure Service programs include the following items in the written program description to address the special needs of this population: provisions for granting a leave of absence, for securing personal belongings, and for ensuring that children/youths who have not had a medical examination within the last year are seen by an appropriate healthcare professional.

2.A. **11.** **The program implements policies and written procedures for collaboration in decision making through:**

a. **Involving the following in all applicable phases of services:**

(1) **The child/youth.**

(2) **The family.**

b. **Providing information to facilitate collaboration that is:**

(1) **Relevant.**

(2) **Accessible.**

c. **Ensuring that the service process and the information presented is understood by:**

(1) **The child/youth.**

(2) **The family.**

d. **Setting time lines for exchange of information.**

Intent Statements

Policies and procedures for collaboration between the program and persons served support a person-centered approach and emphasizes the partnership for achieving established outcomes.

Exceptions may exist for the exclusion of family involvement that is justified and appropriate. Exclusions may be justified when parental rights have been terminated or temporarily removed, when there are restrictions on visitation or involvement with the child/youth, or when a family member's involvement in the particular phase of the program is deemed by the professional(s) providing services to be detrimental.

Examples

11.b.(1) Information that may be relevant for persons served to collaborate effectively may include: applicable laws and regulations that impact program services and participation and community resources. Information may be provided in a variety of ways. The program may offer these services itself, or they may be available in the community. The program may maintain lists of external services with key contact information.

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.

🍁 In Canada, when appropriate, collaboration or notification must occur with the indigenous community.

2.A. 12. Services are designed and implemented to:

a. **Build on:**
   (1) **Individual strengths.**
   (2) **Family strengths.**
b. **Build resilience.**
c. **Support the recovery, health, or well-being of the persons served.**
d. **Ensure safety of the persons served.**
e. **Enhance the quality of life of the persons served.**
f. **Restore and/or improve functioning.**

g. **Support the integration of the persons served into the community.**
h. **Promote permanency, as applicable.**
i. **Reflect awareness of the following characteristics of each person served:**
   (1) **Physical.**
   (2) **Developmental.**
   (3) **Cultural.**
   (4) **Spiritual.**
   (5) **Behavioral.**
   (6) **Emotional.**

Examples

The program's written description and schedule may demonstrate elements of design and implementation.

12.a. This may include the ability to cope and to deal with problems.

12.b. This may include skill-building activities to strengthen the child's/youth's ability to overcome risk factors, challenges, or obstacles.

12.d. First aid responders are specifically trained for a child/youth population, including child CPR.

12.c. Recovery focuses on the development of new meaning and purpose as individuals or families grow beyond the problems and concerns that led them to seek services; e.g., family violence, trauma, mental illness, or addiction.

12.g. This may include the supports available at discharge to home or alternative community placement and school.

12.h. Promoting permanency may include concurrent case planning for both reunification and adoption.

12.i.(3)–(4) Recognition of the norms, customs, and holidays of various cultural groups. This may be evidenced in the available selection of reading materials, pictures, room décor, and toys.

2.A. 13. When the program is identified as a treatment program, it identifies:

a. **Treatment modalities.**
b. **The credentials of staff qualified to provide treatment.**

2.A. 14. **Based on the characteristics of the persons served, the following are provided:**

    a. **Designated space.**

    b. **Equipment.**

    c. **Furniture.**

    d. **Materials.**

Intent Statements

The program considers individual characteristics of the persons served, such as their cognitive level, interests, concerns, and cultural and developmental needs.

14.a. Providing designated space does not require that the space be exclusively used or maintained for children/youths. The expectation is that the organization, at a minimum, identifies space that can be adapted as needed to serve this population.

Examples

In a program that serves teens as well as young children, the program accommodates the needs of the varied age groups, including furniture that is appropriately sized and the types of toys and games, reading materials, arts and crafts, music, and videos that are available.

2.A. 15. **The program provides or arranges for the following services/supports, as needed, for each person served:**

    a. **Advocacy.**

    b. **Counseling/support services.**

    c. **Family education.**

    d. **Family support, including:**

        (1) **Parent/child interactions.**

        (2) **Parent-to-parent interactions.**

        (3) **Family-to-family interactions.**

    e. **Sibling/peer support.**

    f. **Peer/peer support.**

Intent Statements

Services/supports could occur through local provider networks, the internet, or other community services.

Efforts should be made to recognize culturally specific support groups.

Examples

15.a. Examples could include training families to advocate for the public education rights of their child/youth, for payment for services or equipment, or for inclusion in community activities.

Such groups could include:

- Children and Youth Advocate.
- Alcoholics Anonymous or other 12-step groups, such as Alanon/Alateen.
- The local children and youth help line.
- The local chapter of the Federation for Children and Families.
- Family Resource Center.
- The local chapter of the National Alliance for the Mentally Ill.
- The local Mental Health Association.
- Continuing education.
- English as a Second Language (ESL)
- Parents Anonymous or Circle of Parents.
- Emotions Anonymous.
- Adoption organizations and/or support groups.
- Youth development programs.
- Court Appointed Special Advocate Association (CASA)
- Parent Teacher Associations (PTA)
- Children and Adults with Attention Deficit Disorders (CHADD)

2.A. 16. **The program implements written procedures for the provision of crisis intervention services.**

Intent Statements

The program may have its own on-call or direct crisis response service or it may contract or collaborate with area providers that offer crisis intervention services.

2.A. 17. **The program implements procedures for coordination and ongoing communication between internal and external service providers.**

Intent Statements

Depending on the needs of the persons served and the types of programs provided, procedures may be an informal process or a defined system of information sharing.

Examples

Service providers may include:

- Internal team members and other programs within the organization.
- External providers, such as case management, crisis intervention, inpatient or residential treatment.
- Local schools.
- Healthcare.
- Employers, educational or vocational services, or community housing.
- Community support or respite services.
- Social services, including foster care or the child welfare system.
- Legal entities, such as juvenile justice, law enforcement, or drug courts.
- Volunteers.
- Other contracted service providers.

2.A. **18.** **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.

🍁 In accordance with the needs of the persons served and/or expectations of the stakeholders, direct interaction includes face-to-face contact with the persons served.

Examples

18.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. **19.** **For personnel providing direct services, the organization:**

a. **Provides or arranges for:**

(1) **Assessment of competency.**

(2) **Competency-based training.**

b. **Includes the following in its assessment of competency and competency-based training:**

(1) **Areas that reflect the specific needs of the persons served.**

(2) **Clinical skills that are appropriate to the position.**

(3) **Person-centered plan development/implementation.**

(4) **Interviewing skills.**

(5) **Program-related research-based 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, planning, 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.

Competency-based training may be provided through inservice or access to external resources.

19.b. Includes trauma informed care principles and practices, as appropriate.

19.b.(4) May include motivational interviewing.

2.A. **20. The organization has a policy 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 contracted personnel) are provided with appropriate supervision or direction. Because of labor relations concerns, procedures may differ when the organization uses contracted personnel.

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, where they may receive feedback to enhance their skills.

2.A. **21. Documented ongoing supervision of direct service personnel addresses:**
   a. **Accuracy of assessment skills, when applicable.**
   b. **Proficiency of referral skills, when applicable.**
   c. **The appropriateness of the services or supports selected relative to the specific needs of each person served.**
   d. **Service effectiveness as reflected by the persons served meeting their individual goals.**
   e. **The provision of feedback that enhances the skills of direct service personnel.**
   f. **Issues of:**
      (1) **Ethics.**
      (2) **Legal requirements.**
      (3) **Boundaries.**
      (4) **Self care.**
      (5) **Secondary trauma.**
   g. **Service documentation issues identified through ongoing compliance review.**
   h. **Cultural competency issues.**
   i. **Model fidelity, when implementing evidence-based practices.**

Intent Statements

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 service supervisors.

Personnel includes full- or part-time employees, independent contractors or consultants, or individuals with other formal arrangements. When direct service staff are consultants or independent contractors, expectations may be identified in written agreement.

Examples

Supervision may occur through the supervisor's participation in service planning meetings, organizational staff meetings, side-by-side sessions with the persons served, or one-to-one meetings between the supervisor and personnel.

In a Healthy Families America program, supervision of direct service staff occurs weekly, and a ratio of one supervisor to six direct service staff is not exceeded.

21.d. Supervision addressing effectiveness may include case load reviews.

21.e. May include information on best practices, or identify areas for needed professional growth.

2.A. **22. The program implements policies and written procedures that address positive approaches to behavioral interventions, including:**
   a. **An emphasis on building positive relationships with the persons served.**
   b. **Evaluation of the environment.**
   c. **Staff interaction with the persons served that:**
      (1) **Promotes de-escalation.**
      (2) **Manages behavior.**
      (3) **Strengthens self-regulation.**
   d. **Development of a personal safety plan for each person served on an individual basis, when indicated.**

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 strength-based approach and a system that nurtures personal growth and dignity.

2.A. **23. 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

23.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.

Examples

23.a. Crisis intervention procedures may include the use of seclusion, restraint, or therapeutic holds.

23.b. Special treatment interventions may include the loss of phone and visitation privileges. This standard includes all interventions used, as appropriate to the person served, including involuntary emergency medication.

23.b.(2) Restrictions of rights may include limiting access to mail.

23.c. Examples of intrusive procedures may include strip searches or pat downs.

2.A. **24. The program does not exclude children or youths 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/youths are not excluded from services solely because they are involved in the juvenile justice system.

2.A. **25. The program implements policies and procedures that address:**
   a. **The handling of items brought into the program:**
      (1) **By:**
         (a) **Persons served.**
         (b) **Personnel.**
      (2) **Including:**
         (a) **Illegal drugs.**
         (b) **Legal drugs.**
         (c) **Prescription medication.**
         (d) **Weapons.**
   b. **The use of tobacco products in all:**
      (1) **Locations.**
      (2) **Vehicles owned or operated by the organization.**

Examples

25.a.(2)(a) Illegal drugs include street drugs and alcohol (if under the legal drinking age). When applicable, this includes drug paraphernalia.

25.a.(2)(b) Legal drugs may include over-the-counter drugs, vitamins, herbs, and alcohol.

25.a.(2)(d) Weapons includes ammunition and explosives.

25.b. Tobacco products include chewing tobacco, shisha, nicotine gum, electronic and green cigarettes.

2.A. **26. When needed, assistive technology is used and reasonable accommodations made in:**
   a. **The development of services and supports.**
   b. **The ongoing provision of services.**

Intent Statements

The organization considers reasonable accommodations and uses assistive technology to convey information about services. Assistive technology may be provided by the organization, or it may be provided by referral to other local resources. Reasonable accommodations may be necessary to fully access services and enable the persons served to participate in the organization's activities. Technology needs are addressed in the individualized service plan. If a person served needs services that are not available from the organization, referrals to other services are suggested.

Examples

Accommodations and technology may include the use of communication devices, videos, audio recordings, pictures, and materials in the primary language of the persons served. When necessary, the program also provides education on technology applications.

2.A. **27. When applicable, training in the use of adaptive devices, toys, and equipment is provided to:**
   a. **Personnel.**
   b. **The child/youth.**
   c. **The family.**
   d. **Caregivers.**
   e. **Others.**

Examples

27.e. This may include respite caregivers, friends, and community group leaders of activities the child/youth participates in.

2.A. **28. The program obtains appropriate medical consultation regarding medically related policies or procedures developed by the program.**

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 pharmacotherapy, seclusion and restraint, or other medically related issues.

2.A. **29. 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.

2.A. **30. The program implements a policy and written procedures for:**
   a. **Obtaining criminal background checks on all persons providing direct services to children or youths.**
   b. **Acting on the results of the background checks.**

Intent Statements

Persons providing direct services include personnel, students, interns, volunteers, or contracted providers of direct service. The provision of direct services includes transportation.

Examples

30.a. Background checks may include fingerprinting and FBI criminal history checks, vulnerable sector checks, statutory checks, and vetting.

Background checks may be conducted prior to employment for new personnel, at the time of job change when beginning to work with children or youths, or prior to an accreditation survey for existing personnel.

30.a. In Canada, depending on provincial/territorial/tribal requirements, a criminal record check and a child welfare information system check may be required to meet this standard.

2.A. **31. The program measures service satisfaction in at least the following areas:**
   a. **Relevance of information provided.**
   b. **Inclusion and participation of the child/youth in the team process.**
   c. **Inclusion and participation of the family in the team process.**
   d. **Service delivery.**
   e. **Outcomes achieved.**
   f. **Transition to setting(s) of choice.**
   g. **Adequate resources and supports needed to maintain gains achieved.**

Intent Statements

The program measures service satisfaction for the child/youth served as well as the family/legal guardians or significant others involved in the life of the child/youth.

2.A. **32. To elicit input from the persons served, when possible, service satisfaction surveys are:**
   a. **Age appropriate.**
   b. **Appropriate to the person's developmental level.**
   c. **Linguistically and culturally appropriate.**

Standards for Residential Services

Applicable Standards

When residential services are provided, Standards 33.–36. will be applied.

Residential services include:

- Community housing and shelters.
- Congregate care programs.
- Detoxification.
- Foster family and kinship care programs.
- Group homes.

- Residential treatment programs.
- Respite programs that provide overnight care.
- Specialized to treatment foster care provided in facilities that are owned, rented, or leased by the organization.

2.A. **33. For residential services provided in 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 residential facility around the clock and able to respond to emergencies quickly.

If there are times when there are no persons served in the facility, staff may be off site but need to be available, such as in a group home during school hours when no children/youth remain in the facility.

2.A. **34. Each person served in a residential setting has his or her own personal space that:**
   a. **Respects privacy.**
   b. **Promotes personal security.**
   c. **Promotes personal safety.**

Intent Statements

Personal space primarily refers to bedrooms and bathrooms; however, consideration regarding storage space of personal belongings is also included.

2.A. **35. There are separate areas for beds for persons served in residential settings according to their:**
   a. **Age.**
   b. **Gender identity.**
   c. **Developmental needs.**
   d. **Other considerations.**

Intent Statements

Because of the unique needs of children/youths in residential settings, the program provides either individual sleeping quarters or, if shared,

sleeping quarters apart from adults and members of the opposite sex, including separation based on developmental levels and gender identity.

When sleeping quarters are shared, they take into consideration any active sexual behaviors, gender identity, age, developmental functioning levels, and history of abuse.

A child/youth is provided with his or her own bed. When parent-child treatment is provided, the same sleeping areas may be appropriate.

35.d. In settings where services are provided on both a voluntary and involuntary basis, the program ensures that the needs and rights of both populations are addressed.

Examples

35.d. Other considerations may include a child who sleep walks or has enuresis, encopresis, or night terrors.

2.A. **36. The program provides opportunities for and encourages visits, when appropriate and in compliance with applicable laws and court orders, with:**
   a. **Family members and/or significant others.**
   b. **Peers.**

Peer Support Services

Peer support services (inclusive of youth or family supports) can include a wide range of planned activities to assist persons served in exercising control over their own lives and their recovery or resilience-building process. Peer support may include peer mentoring or coaching, resource connecting, facilitating and leading recovery, educational and support groups, advocating for the person/family served, and/or building community supports.

Because peer supports are guided by a foundation of lived experience, peer support specialists are persons who share with others based on that experience to encourage, motivate and support persons served and/or their families. They may be referred to as youth or family support specialists or mentors, recovery coaches, guides, peer resource specialists, peer service interventionists, or similar titles.

Peer and youth support services are designed to have persons with lived experience work directly with persons served. Family support services are designed to have persons who have lived experience through their family member's participation in services directly work with the family of persons served.

Applicable Standards

When an organization employs peer support specialists in any of the core programs seeking accreditation, the following standards must be applied in addition to other applicable standards in Section 1, Sections 2.A.–H., and the specific program standards and a specific population designation (if applicable).

2.A. **37. The organization implements policies and procedures that are inclusive of a peer workforce.**

Intent Statements

The organization's policies and procedures are written with consideration of the various personnel it utilizes, such as professional staff, peer support staff, direct care staff, nondirect care staff, volunteer staff, contract staff, and interns.

2.A. **38. Peer support specialists assist in peer support services:**
   a. **Design.**
   b. **Development.**
   c. **Implementation.**

Intent Statements

The organization involves members of the peer support workforce in the process of designing and implementing these services to ensure that the peer support expertise is included. The organization should be able to demonstrate how it collected the input of the peer support workforce in design, development, and implementation.

2.A. **39. The organization demonstrates a climate of recovery and/or resilience building by:**
   a. **Respecting the unique role of peer support specialists.**
   b. **Training personnel on the role of peer support specialists.**

Intent Statements

39.b. All personnel will have a clear understanding of the unique role of peer support specialists and how their role differs from the roles of other clinical and direct service team members.

2.A. **40. Peer support specialists receive documented competency-based training that:**
   a. **Is based on a recognized peer-support curriculum or a curriculum designed and developed with the input of peer support specialists.**
   b. **Is provided with the involvement of peer support specialists, as applicable.**
   c. **Includes:**
      (1) **Initial training on the following topics:**
         (a) **Personal advocacy.**
         (b) **Engagement.**
         (c) **Recovery and resiliency principles.**
         (d) **Community supports/connections.**
         (e) **The effective use of sharing life experiences.**
         (f) **Parenting skills, as applicable.**
      (2) **Ongoing training on current practices in peer support services.**
   d. **Is provided in a manner that is:**
      (1) **Understandable.**
      (2) **Appropriate to the developmental age of the peer support specialist being trained.**

Intent Statements

The organization ensures that the peer support workforce is adequately trained to perform the

work assigned. When the organization provides its own training, it should seek curriculum from nationally recognized sources such as SAMSHA, the Psychosocial Rehabilitation Association, the Certification Commission for Family Support, or other competent source. When the organization hires Certified Peer Specialists (or other peer support specialists with an equivalent credential), it is accepted that the peer support specialist has received appropriate initial training.

2.A. **41. The organization's written ethical codes of conduct specifically address boundaries related to peer support services.**

Examples

This may include how peer support specialists' boundaries with persons served differ from those of personnel in areas such as sharing meals, attending social events, sharing lived experience, social media connections, and communication (electronic and other).

2.A. **42. Based on the needs and preferences of the persons served, peer support:**

   a. **Is provided consistent with or complementary to the person's identified plan, when applicable.**
   b. **Includes the following direct service activities performed by peer support specialists, as applicable:**
      (1) **Engaging the person served.**
      (2) **Supporting personal recovery goals or building on resiliency.**
      (3) **Community networking.**
      (4) **Advocating with and for the person served.**
      (5) **Parenting skills.**
      (6) **Mentoring.**
      (7) **Bridging or navigating.**
   c. **Includes the following educational activities for the persons served, as applicable:**
      (1) **Self advocacy.**
      (2) **Wellness.**
      (3) **Life skills.**

      (4) **Goal setting.**
      (5) **Decision-making skills.**

Intent Statements

Direct service activities may be provided individually or in a group setting and may be provided face to face, telephonically, or electronically.

Examples

42.b.(2) Peer support specialists can share their personal success stories, serve as role models, or help the persons served to articulate their personal goals and identify means to reach those goals. Peer support specialists can help the person served make new friends and begin to build alternative social networks.

42.b.(3) Community networking may include social, recreational, spiritual, educational, or vocational linkages. Peer support specialists encourage and support participation in self-help groups and provide specific information about various groups that may be helpful to the person served.

42.b.(6) Mentoring involves supporting an individual's efforts to achieve his/her goals through coaching, encouraging, providing positive guidance, sharing life experiences, and offering feedback to assist with personal development.

42.b.(7) Navigating includes assisting the person served to find and access services/benefits and to make appeals and respond to denials if needed. Bridging refers to efforts made to make cooperative connections between the person served and others and create ties to those who may be helpful to them in a variety of ways. It can also involve helping to resolve differences and reduce barriers.

42.c.(3) Life skills are basic skills used to handle problems and questions commonly encountered in daily life. This could include problem solving, accepting responsibility, money management, and honoring commitments. Self-care skills such as cooking, cleaning, laundry, and shopping are also essential life skills.

2.A. **43. Peer support services are provided in locations that meet the needs of persons served.**

Examples

Peer support services may be provided in the community, outpatient or inpatient settings, recovery community organizations or centers, the home of the person or family served, churches, child welfare organizations, recovery homes, drug courts, pre-release jail and prison programs, parole and probation programs, behavioral health agencies, HIV/AIDS support centers, medical centers, and/or other social service centers.

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 the scope of services
- Documentation of entry, transition, and exit criteria
- A written program description for each core program seeking accreditation
- Policies and written procedure for collaboration in decision making
- Written procedures for the provision of crisis intervention services
- Documentation of the participants at team meetings
- Documentation of the results of team meetings
- Written procedures for the supervision of direct service personnel
- Documentation of ongoing supervision of direct service personnel
- Policies and written procedures that address positive approaches to behavioral interventions
- Documentation of individual personal safety plans for persons served, as needed

- Policies promoting the rights of the persons served that address: the use of crisis intervention procedures; written procedures governing the use of special treatment interventions and restrictions of rights; and methods to ensure that intrusive procedures are administered in a safe manner
- Policies that address the handling of items brought into the program by the persons served and personnel
- Policy and written procedures for obtaining criminal background checks on all persons providing direct services to children or youths
- Documentation of satisfaction surveys
- Policies inclusive of a peer workforce
- Documentation of competency-based training for peer support specialists
- Written ethical codes of conduct that specifically address boundaries related to peer support services

B. Screening and Access to Services

Description

The process of screening and assessment is designed 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 strengths, needs, abilities, and preferences of each person served. Assessment data may be gathered through various means including face-to-face contact, telehealth, or from external resources.

2.B. **1. The program implements policies and written procedures that:**
   a. **Define access to services.**
   b. **Include:**
      (1) **How admissions will be prioritized.**
      (2) **Who is responsible for making admission decisions.**
      (3) **Exclusionary or ineligibility criteria.**

Intent Statements

The program determines which persons it is qualified to serve. When this determination is formalized and in writing, it significantly minimizes subjectivity during the screening or admission process.

Clearly written and defined policies and procedures regarding access to services reduces the need to exercise subjective judgment in making a decision regarding whether a particular program is applicable to a person's needs.

The policies and procedures address both initial admission of a person and subsequent readmissions when applicable. Some programs may admit persons on a voluntary and/or involuntary basis, which will be clarified in the policies and written procedures.

2.B. **2. The program demonstrates efforts to minimize the times between first contact, screening, and admission or referral.**

Examples

The program is able to describe the activities it has implemented to decrease wait times for services from initial contact to engagement in care. If an organization has implemented an open access system for admissions, it can still demonstrate how it reduces wait times for referral into care.

2.B. **3. For the persons served to make informed choices about services, the program provides information regarding:**
   a. **The philosophy of the program.**
   b. **The array of service or activities provided.**
   c. **The qualifications of staff to provide services.**
   d. **Disclosure of any potential conflicts of interest.**
   e. **Outcomes performance.**
   f. **Costs of services, if applicable.**

Intent Statements

In order to be informed, make choices, and be involved, the persons served should be able to get accurate and current information about the program's potential to deliver services relevant to their needs and desires.

Information is provided about the service options available, support approaches to a service need, and the volume of services an organization can support, which may be number of persons, geographical coverage, etc.

The organization presents information in line with its ethical practices, which directly relates to its divulgence of potential conflicts of interest.

Taken as a whole, this standard is part of the organization's public information activity. Organizations have the responsibility to respond to all requests from the public concerning 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.

3.f. This includes an explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization. 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.

2.B.   **4.** **If screening is conducted by the program, it:**
   a. **Includes a review of each person's eligibility for admission based on the person's:**
      (1) **Presenting need(s).**
      (2) **Legal eligibility criteria, when applicable.**
   b. **Assesses for the:**
      (1) **Appropriateness of available services.**
      (2) **Availability of funding sources.**
   c. **Identifies whether the program can provide the services needed.**
   d. **Includes:**
      (1) **An interview with the person(s) to be served, family member(s), or referral source.**
      (2) **When appropriate, a preadmission, on-site visit to the organization and its programs by the person(s) to be served.**
   e. **When applicable, ensures that:**
      (1) **Screening instruments are uniformly administered.**
      (2) **Personnel are trained on use of screening instruments prior to administration.**

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.d.(1) An interview can be done face-to-face, via telephone interview, or by other technological means.

4.e.(1) Screening could include use of standardized or informal instruments.

2.B.   **5.** **If screening identifies an urgent and critical need, appropriate action is:**
   a. **Taken immediately.**
   b. **Documented.**

2.B.   **6.** **When a person is found ineligible for services, the program:**
   a. **Maintains documentation of these actions.**
   b. **Implements a procedure for redetermining eligibility, if applicable.**

Intent Statements

The program gathers data on persons who seek services or admission and are found ineligible. 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.

6.b. Some programs may require a specific time period to pass before accepting a reapplication, while others may allow reapplication only if the circumstances related to the reason for ineligibility change. Some programs may not allow for reapplication by persons who have been found ineligible for services.

2.B.   **7.** **If a waiting list is maintained:**
   a. **Written procedures are in place.**
   b. **Information documents the person's:**
      (1) **Needs, including severity.**
      (2) **Length of time on the list.**
   c. **The program maintains current waiting list information through:**
      (1) **Continual review and updating of the list.**
      (2) **Contact with the persons on the list based on their needs.**

d. Documentation of all contacts with the persons on the waiting list is maintained.

e. Information is shared with the persons on the waiting list regarding available service options.

f. Procedures are implemented for referral to necessary care, including medical and crisis care, for persons on the waiting list.

g. The waiting list information is incorporated in the organization's information management system.

Intent Statements

The use of a waiting list involves an active review process that leads to a determination of eligibility based on the program's entrance/admission criteria.

Referral lists are different than waiting lists in that referral lists include all persons referred for services. Such lists are not necessarily used to determine the sequence of admission.

In the United States, in certain situations, such as under Centers for Medicare and Medicaid Services (CMS) waivers, there may be requirements that there be no waiting list.

Examples

7.c.(1) Review of a waiting list may be documented in meeting minutes or by signing and dating the list itself to indicate review.

7.e. Evidence of referrals or other actions taken may be included on the waiting list itself or documented in a referral log.

7.f. 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.

Orientation

2.B. **8.** Each person admitted to services receives an orientation that:

a. Is appropriate to his or her current status and the services provided.

b. Is understandable to the person served.

c. Is documented.

d. Identifies the person responsible for service coordination.

e. Includes:

(1) The program's:
  (a) Expectations.
  (b) Hours of operation.
  (c) Access to after-hour services.
  (d) Code of ethics.
  (e) Philosophy of behavioral interventions.
  (f) Confidentiality policy.
  (g) Requirements for follow-up for a mandated person served, regardless of discharge outcome.

(2) An explanation of the:
  (a) Rights and responsibilities of the person served.
  (b) Grievance and appeal procedures.
  (c) Ways in which input is given.
  (d) Information that may be used for:
    (i) Research.
    (ii) Billing.
    (iii) Reporting.
    (iv) Evaluation.
  (e) Administrative discharge criteria.

(3) When applicable, a description of:

    (a) The purpose and process of the assessment.

    (b) How the individualized plan will be developed.

    (c) The person's participation in goal development and achievement.

(4) A copy of the program rules provided to the person served that identifies:

    (a) Any restrictions the program may place on the person served.

    (b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the person served.

    (c) Means by which the person served may regain rights or privileges that have been restricted.

(5) The program's policies, when applicable, regarding:

    (a) The use of seclusion or restraint.

    (b) Use of tobacco products.

    (c) Illegal or legal drugs brought into the program.

    (d) Weapons brought into the program.

(6) An explanation of the program's procedures, when applicable, regarding:

    (a) Expectations for court appearances.

    (b) Identification of therapeutic interventions for:

        (i) Sanctions.

        (ii) Incentives.

(7) Information regarding transition criteria and procedures.

    f. Familiarizes the person served with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits, when applicable.

Intent Statements

This standard is related to the involvement of the persons served and their understanding of exactly what will happen as services are delivered. The extensiveness of the orientation considers the age and developmental functioning level of each person served, as well as the types of services to be provided. If at intake a person served is not in a condition where he or she is able or willing to review the orientation material, arrangements would be made to review the material at a later time.

Evidence of conformance to this standard may be found in documentation and through interviews with personnel and persons served during the site survey.

Examples

8.e.(2)(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 persons served. Input may be given through groups or individual sessions, suggestion boxes, surveys, grievance forms, etc.

8.e.(2)(e) Administrative discharge criteria may include a medical hospitalization while a person is enrolled in the program and therefore unable to continue program participation.

8.e.(4)(a) Program restrictions may include changes in frequency of recreational or leisure activities and the use of lock downs.

8.e.(4)(c) This may include restitution.

8.e.(6)(a) Programs may serve persons who are actively involved in the judicial system whether related to criminal activity or child welfare/family courts. These persons are informed about the program's involvement in facilitating the court appearance.

8.e.(6)(b) Some programs that serve persons who are court ordered or mandated to services have sanctions and/or incentives built into the program, such as attendance, satisfactory progress, or program completion; therefore, successful program completion may have a direct effect on their judicial status.

Assessment

2.B. **9.** **The program continuously conducts assessments or obtains assessment information for each person served:**

   a. **In a manner that is respectful and considerate of his or her specific needs.**

   b. **That identifies:**

      (1) **The expectations of the person served.**

      (2) **The identified needs and issues of the person served.**

   c. **That provides for the use of assistive technology or resources, as needed, in the assessment process.**

   d. **That is responsive to the changing needs of the person served.**

   e. **That includes provisions for communicating the results of the assessments to:**

      (1) **The person(s) served.**

      (2) **Relevant personnel.**

      (3) **Appropriate others.**

   f. **That provides the basis for legally required notification, when applicable.**

   g. **Using valid and reliable assessment tools, when possible.**

Intent Statements

Assessment information may be 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. In short-term programs, such as Assessment and Referral or Crisis Intervention, the information may be collected only in an immediate manner.

9.b. This part of the assessment identifies what the person served wants or why the person is coming for services.

Examples

9.a. Areas to consider may include:

- Age or developmental level.
- Gender.
- Sexual orientation.
- Social preferences.
- Cultural background.
- Psychological characteristics.
- Physical condition.
- Spiritual beliefs.

9.e.(3) This could include, with appropriate consent, caregivers and external support persons.

9.f. Notification may include child protective services, committing or referring courts, a tribal authorities identified under the Indian Child Welfare Act, or juvenile delinquency workers.

2.B. **10.** **Assessments are conducted by qualified personnel who are:**

   a. **Knowledgeable to assess the specific needs of the person served.**

   b. **Trained in the use of applicable tools, tests, or instruments prior to administration.**

Intent Statements

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 on relevant legal or regulating guidelines. Surveyors on site may ask to review any government, funding, or other regulatory body's requirements for certain positions.

2.B. 11. The assessments include information obtained from:
  a. The person served.
  b. Family members, when applicable and permitted.
  c. Friends and peers, when appropriate and permitted.
  d. Other appropriate and permitted collateral sources.

Intent Statements

11.b. Families may provide a wealth of information that drives the design and delivery of services. This information will be valuable to the organization in providing services that satisfy the needs and desires of the persons and families served.

11.d. This information is obtained with the permission of the child/youth served unless a legal relationship indicates contact without permission, such as a parent of a minor child.

Examples

11.d. Collateral sources may include:
  ■ Guardians or other legal representatives.
  ■ Teachers.
  ■ Social workers.
  ■ Delinquency workers.
  ■ Physicians.
  ■ Court-appointed representatives.

2.B. 12. The primary assessment gathers sufficient information to develop an individualized, person-centered plan for each person served, including information about:
  a. The individual's:
    (1) Presenting problems.
    (2) Urgent needs, including:
      (a) Suicide risk.
      (b) Violence risk.
    (3) Other needs.
    (4) Personal strengths.
    (5) Abilities and/or interests.
    (6) Preferences.
    (7) Age.
    (8) Gender.
    (9) Developmental history, including:
      (a) Prenatal exposures.
      (b) Milestones.
    (10) Culture.
    (11) Ethnicity.
    (12) Spiritual beliefs.
    (13) Family history and relationships.
    (14) Previous service history, when applicable.
    (15) Current level of:
      (a) Language functioning, including:
         (i) Speech.
        (ii) Hearing.
      (b) Visual functioning.
    (16) Co-occurring disabilities and/or disorders.
    (17) Need for and availability of social supports.
    (18) Parental/guardian custodial status.
    (19) Parent's/guardian's ability and willingness to participate in services, when applicable.
    (20) Gender identification, sexual orientation, gender expression.
    (21) Incidents of:
      (a) Abuse.
      (b) Neglect.
      (c) Violence.
      (d) Trauma.
    (22) Medical status.
    (23) Immunization record.
    (24) Medication use profile, including:
      (a) Prescription and non-prescription.
      (b) Efficacy of medications used.
      (c) Allergies or adverse reactions.

(25) **Mental health status, including:**

    (a) **Current level of functioning.**

    (b) **Current behaviors of concern, including:**

       (i) **Risk-taking behaviors.**

       (ii) **Fire setting.**

       (iii) **Cruelty to animals.**

       (iv) **Life stressors.**

    (c) **Alcohol, tobacco, and other drug use, abuse, or dependence.**

(26) **Educational experiences, including.**

    (a) **Placements.**

    (b) **Performance.**

    (c) **Learning ability.**

(27) **Environmental surroundings.**

(28) **Legal involvement.**

(29) **Peer relationships.**

(30) **Employment/vocational status.**

b. **The family's:**

(1) **Presenting problems.**

(2) **Strengths.**

(3) **Needs.**

(4) **Abilities.**

(5) **Preferences.**

(6) **Culture.**

(7) **Ethnicity.**

(8) **Spiritual beliefs.**

(9) **Relationships among family members.**

(10) **Relationships with other persons.**

(11) **Medical history and current status.**

(12) **Behavioral health history and current status.**

(13) **Legal history.**

(14) **History of:**

    (a) **Abuse.**

    (b) **Neglect.**

    (c) **Trauma.**

    (d) **Violence.**

(15) **Educational history and functioning.**

(16) **Employment history.**

(17) **Financial status.**

Intent Statements

The organization collects an adequate amount of information to provide appropriate and safe service(s), including obtaining as much information as possible about a child's/youth's family, whether or not the family members are currently involved in the child's/youth's life.

In short-term programs (such as Assessment and Referral or Crisis Intervention), or a targeted case management program such as Healthy Families America, the amount of information collected may be limited by time or the condition of the person served or the nature of service being provided. The type of information collected may also be limited by state/provincial/territorial/tribal or federal legislation.

In Canadian programs where laws or regulations prohibit the collection of specifically identified information (such as Counseling, Secure Services, and Protection of Children Abusing Drugs), an abbreviated assessment is allowed.

12.a.(2)(a) 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.

12.a.(3) In a Healthy Families America program this includes the identified criteria for service need and/or build resiliency, and improve overall functioning.

12.a.(16) It is particularly important to identify any co-occurring disabilities/disorders, including primary care issues that may impact the services provided to the child/youth served.

12.a.(22) Canadian Secure Services programs identify the need for an evaluation by a healthcare professional if there is no record of a medical exam within the last year.

12.a.(23) The assessment includes a determination of the status of the child's/youth's immunizations. A copy of the immunization record is not required. Organizations can note when a child/youth is enrolled in a school where verification of immunization is legally required.

Examples

12.a.(2) Urgent needs may include a safe, secure, and observable space; ongoing observation; and removal of items that could potentially be used to cause harm.

12.a.(3) Other needs may include liabilities, weaknesses, and what the child/youth needs to recover and/or build resiliency, and improve overall functioning.

12.a.(4) Personal strengths may include assets, resources, and natural positive attributes.

12.a.(5) Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

12.a.(6) Preferences are those things the child/youth served feels will enhance his or her treatment experience.

12.a.(9) Prenatal exposures may include alcohol, tobacco, or other drugs as well as environmental stressors while in utero such as domestic violence, natural disasters, war, and other traumas.

12.a.(14) Previous data may include:

- Family assessments or genograms.
- Psychiatric assessments.
- Diagnostic information.
- Psychological assessments.
- Child welfare assessments.
- Service or treatment information.
- Pharmacotherapy, including efficacy of current or previously used medication(s).
- Hospitalizations.
- Alcohol and other drug services.
- Pertinent medical care.
- Community programs.
- Educational involvement, including expulsions or suspensions when applicable.
- Ecomapping.
- Asset mapping.

12.a.(21) It is important to identify whether the incidents of abuse, neglect, violence, and/or trauma were witnessed or experienced as a victim or perpetrator.

12.a.(25)(a) Because children/youths function differently in different settings, this includes the functioning of the child/youth in various environments including, as applicable, at home, at school, at work, and in the community. Current level of functioning may include:

- Cognitive functioning.
- Emotional functioning.
- Social functioning.

12.a.(25)(b) Although the assessment will be looking for risk throughout the areas being assessed, this is referencing behaviors that might not be addressed in other parts of the assessment but that could be indicative of problems such as having unprotected sex, promiscuity, runaway behaviors, gang involvement, texting while driving, speeding, or driving under the influence.

12.a.(30) May include formal training for employment apprenticeships.

12.b.(16) May include job titles, number of positions, and longevity of employment.

2.B. **13. The primary assessment:**

    a. Is conducted within established time frames.

    b. Results in the preparation of an interpretive summary that:

        (1) Is based on the assessment data.

        (2) Is used in the development of the individualized plan.

        (3) Identifies any:

            (a) Co-occurring disabilities/ disorders.

            (b) Ecological factors that should be addressed in the development of the individualized plan.

    c. Is communicated and provided to the person served in an understandable manner.

Intent Statements

13.b. The interpretive summary is written by the staff member assigned to integrate and interpret from a broader perspective all history and assessment information collected.

Examples

13.a. In a Healthy Families America program, the primary assessment is conducted prenatally or within the first two weeks after the birth of the baby.

13.b. The interpretive summary could address:

- The central theme(s) apparent in the presentation of the person served.

- Histories and assessments (medical, psycho-social, 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.

- Professional opinions regarding both positive and negative factors likely to affect the person's course of services and outcomes after discharge.

- Recommended services, 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 services and expected focus (goals) with recommendations.

13.b.(3)(b) Ecological factors could include war, famine, or natural disasters.

2.B. **14. Reassessments, when appropriate, are conducted or obtained in accordance with the program's established time frames or when otherwise indicated.**

Intent Statements

Reassessments may not be applicable in short-term programs, such as Assessment and Referral, or when a person served leaves a program shortly after admission.

Examples

Reassessment may be indicated following a significant change in status/functioning, a major life change or stressor, the accomplishment of significant goals, a referral to a court system, or detention.

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 define access to services, which includes the prioritization of admissions, responsibility for admission decisions and any ineligibility or exclusionary criteria

- Documentation of actions taken when an urgent and critical need is identified by screening

- Documentation of ineligibility for services

- Waiting lists and relevant written procedures, if applicable

- Documentation of contacts made with persons on the waiting list

- Documentation of orientation

- A copy of the rules of the program

- Policies, when applicable, concerning use of seclusion or restraint; use of tobacco products; illegal or legal drugs brought into the program; and weapons brought into the program

- Initial and ongoing assessments

- An interpretive summary based on the assessment data

C. Individualized Plan

Description

Each person served is actively involved in and has a significant role in the individual planning process and has a major role in determining the direction of the individualized plan. The individualized plan contains goals and objectives that incorporate the unique strengths, needs, abilities, and preferences of the persons served, as well as identified challenges and problems. Individualized plans may consider the significance of traumatic events.

2.C. **1.** The individualized plan:

   a. **Is developed with the active participation of the person served.**

   b. **Is prepared using the information from:**

      (1) **The primary assessment.**

      (2) **The interpretive summary.**

   c. **Is based on the person's:**

      (1) **Strengths.**

      (2) **Needs.**

      (3) **Abilities.**

      (4) **Preferences.**

   d. **Is focused on the person's inclusion and integration into:**

      (1) **The community.**

      (2) **His or her family, when appropriate.**

      (3) **Natural support systems.**

      (4) **An educational setting, when applicable.**

      (5) **Other needed services.**

   e. **Is inclusive of family/support system participation, when applicable and permitted.**

   f. **Addresses the following needs, as identified:**

      (1) **Healthcare.**

      (2) **Medications.**

      (3) **Safety.**

      (4) **Educational.**

      (5) **Emotional/behavioral.**

      (6) **Developmental.**

      (7) **Living situation.**

      (8) **Social and leisure.**

      (9) **Spiritual.**

      (10) **Cultural.**

      (11) **Financial.**

      (12) **Legal.**

      (13) **Others.**

   g. **Is detailed and:**

      (1) **Specifies the services to be provided by the program.**

      (2) **Identifies any needs beyond the scope of the program.**

      (3) **Specifies referrals for additional services.**

   h. **Communicated to the person served in a manner that is understandable.**

   i. **Provided to the person served, when possible.**

Intent Statements

Although CARF does not prescribe any particular form or format to be used for the individualized plan, this standard has specific requirements with regard to the components of the plan and how to develop and review it.

This standard requires both integration and inclusion, which means that the individual is present at and participates in integrated settings and situations.

The organization may not provide services to address all needs, but identified needs are addressed in planning and can be met by referrals to other organizations.

Examples

1.d.(3) Natural supports may include extended family, friends, volunteer organizations, self-help or support groups, and churches or other religious/spiritual supports.

1.f.(7) Living situation refers to the home or placement of where the child/youth may move to; such as kinship care, foster care, adoption, group home, shelter, independent living, or supported housing.

1.f.(13) Other identified needs may include self-care skills, peer relations, sexuality, employment, and housing.

2.C. **2. The individualized plan includes the following components:**
  a. **Goals that are:**
    (1) **Expressed in the words of the person(s) served.**
    (2) **Reflective of the informed choice of the:**
      (a) **Child/youth served.**
      (b) **Parent(s)/legal guardian, if applicable.**
    (3) **Appropriate to the person's culture.**
    (4) **Appropriate to the person's age.**
    (5) **Based upon the person's:**
      (a) **Strengths.**
      (b) **Needs.**
      (c) **Abilities.**
      (d) **Preferences.**
  b. **Specific service objectives that are:**
    (1) **Reflective of the expectations of:**
      (a) **The person served.**
      (b) **The service team.**
    (2) **Reflective of the person's:**
      (a) **Age.**
      (b) **Development.**
      (c) **Culture.**
      (d) **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 setting.**
  c. **Identification of:**
    (1) **Specific service interventions to be used.**
    (2) **Frequency of using specific interventions.**
  d. **The estimated duration of services.**
    e. **Information on, or conditions for, transition to other services.**
    f. **When applicable, identification of:**
      (1) **Legal requirements.**
      (2) **Legally imposed fees.**

Intent Statements

The individualized plan may vary in size and complexity based on the types of services provided. In a short-term crisis program, such as Crisis Intervention, the plan may address only the immediate stabilization of the person served and the transition to other services.

The individualized plan is directly linked to the assessment process through the interpretive summary. Within the individualized plan the required elements of goals, objectives, and interventions also demonstrate a connection to the assessment. The coordination of goals, objectives, and interventions form the basis of measuring successful outcomes for the person served.

The individualized plan includes two 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.

The second component of the plan provides the blueprint for individual service development and is consistent with the outcomes expected by the person served, the family when applicable, and the organization. This includes the development of service objectives that are measurable and time specific.

Examples

2.c.(1) Specific service interventions may include family therapy, family finding, life skills training, psychosocial education, behavioral modification, vocational skills training, nutritional counseling, recreational activities, study skills development, and anger management.

2.C. 3. When applicable, a personal safety plan:

a. **Is completed as soon as possible after admission.**

b. **Includes:**

(1) **Triggers, including assessment of the risk for dangerous behaviors.**

(2) **Current coping skills.**

(3) **Warning signs.**

(4) **Preferred interventions.**

(5) **Advance directives, when available.**

Intent Statements

To adequately respond to an urgent safety need of a person served, the program collects available information upon admission or as soon as possible. The plan identifies how to recognize and respond to a person with escalating behavior in a manner that is safe, effective, and clinically responsible.

A personal safety plan may be referred to as a crisis intervention or behavioral management treatment plan, or it may be referred to as an advance directive. A personal safety plan may be included as a component of the individualized plan.

Examples

3.b. The personal safety plan considers various triggers inclusive of persons, places, dates/times or events and interventions may be customized as appropriate.

2.C. 4. To determine continued relevance, the individualized plan is:

a. **Reviewed with the person served:**

(1) **Based on his or her request for a modification.**

(2) **In accordance with identified time frames.**

b. **Modified as needed.**

Intent Statements

Services are kept relevant to the person served by ensuring his or her active participation. The program establishes its methods to define "timely" and establishes identified time frame for reviews.

2.C. 5. Based on the needs of the person served, services include the development of:

a. **Skills for self-regulation.**

b. **Cognitive skills.**

c. **Social skills.**

d. **Social supports.**

e. **Community living and life skills.**

f. **Vocational skills.**

Examples

5.a. Self-regulation skills may include learning patience, such as not speaking while others are, or impulse control, such as refraining from acting out anger or moderating food intake.

5.b. Cognitive skills may include communication (reading, writing, and speaking) and physical (sensory, developmental, and mobility).

5.e. Community living and life skills may include interpersonal, behavioral, recreational, leisure, and cultural awareness.

2.C. 6. When the services disrupt the child's or youth'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.

2.C. 7. Based on the needs of each child/youth, or as required by law:

a. **An educational specialist is a member of the service team.**

b. **Services are consistent with his or her individual education plan.**

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.

2.C. **8.** **If educational services are provided, they:**

a. **Are appropriate to the child/youth served.**

b. **Meet all applicable statutory 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/youth served.

Educational services provided could include evaluation, group instruction, individual tutoring, licensed school training, simulated classroom training, transitional classroom training, youth career development, and vocational programs for youths.

Examples

8.c. This may include use of technology such as web-based educational programs.

2.C. **9.** **When applicable, information is exchanged between the program and the school system, including:**

a. **Reciprocal inservices between school personnel and program personnel.**

b. **Release of necessary school and/or work information, when authorized.**

c. **Participation in educational planning by program personnel.**

d. **Preparation of the school for transition of the child/youth from the program to school.**

e. **Assessment of modifications and adaptations of the environment.**

f. **Preparation for transition from school to work and/or vocational training.**

g. **Involvement in planning for transitional or supported living programs.**

2.C. **10.** **When the person served has co-occurring disabilities/disorders:**

a. **The individualized plan specifically addresses those issues 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 co-occurring disabilities/disorders.**

Intent Statements

Given the incidence of co-occurring disabilities/disorders, effectively addressing co-occurring disorders is critical to successful achievement of outcomes. When the assessment identifies co-occurring needs, they are addressed either through provision of service by the organization or referral to other providers. Efforts are made to fully integrate or coordinate needed services.

Examples

Co-occurring issues may be psychiatric, psychological, medical, developmental, physical, or emotional.

2.C. **11.** **If services are provided to persons who have intensive medical needs:**

a. **Services are provided in coordination with the person's primary care physician.**

b. **The individualized plan specifically addresses how services will be provided in a manner that ensures the safety of the person.**

c. **Services related to the person's intensive medical needs are provided by skilled healthcare providers.**

d. **Services are provided in accordance with all regulatory requirements.**

Intent Statements

11.b. Services to individuals with intensive medical needs should include specific measures to prevent injury, abuse, and neglect.

11.c. See the Glossary for the definition of *skilled healthcare provider*.

11.d. Regulatory requirements that might apply include Medicaid rules.

Examples

Intensive medical needs could include short-term serious injuries, the risk of experiencing withdrawal symptoms in response to substance removal, or long-term medical conditions requiring staff support and attention.

2.C. **12.** **Progress notes or recordings:**
   a. **Are:**
      (1) **Signed.**
      (2) **Dated.**
   b. **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 of services and specific interventions that support the individualized plan.**
      (4) **Movement to other levels of care.**

Intent Statements

12.a. Documentation into the record of the person served is signed and dated by each individual making an entry. The use of initials would not meet the intent of the standard. 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.

12.a.(2) *Dated* refers to the month, day, and year, but does not require the specific time of day.

12.b. 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 child/youth served that may impact the course of treatment or ser-

vice, and the specific services and interventions that the organization has provided.

Examples

12.b.(1) May include SOAP (subjective, objective, assessment, and plan) notes.

2.C. **13.** **A designated individual(s) assists in coordinating services for each person served by:**
   a. **Assuming responsibility for ensuring the implementation of the individualized plan.**
   b. **Ensuring that the person served is oriented to the 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 individuals.**
   h. **Facilitating the transition process, including arrangements for follow-up services.**
   i. **Involving the person's family/support system, when applicable or permitted.**
   j. **Coordinating services provided outside of the organization.**

Intent Statements

13.h. Includes the transition of the person served from one program to another within the same organization.

Examples

The individual or individuals who coordinate services may be employees 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.

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.

- Individualized plans and plan reviews for the persons served
- Primary assessments and reassessments
- Interpretive summaries
- Personal safety plans, when applicable
- Documentation of progress notes
- Authorizations for release of information, when applicable

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, reunification, re-entry in a juvenile justice system, or transition to adulthood.

The transition plan is a supportive document that includes information about the person's progress and describes the completion of goals and the efficacy of services provided. It is prepared to ensure a seamless transition to another level of care, another component of care, or an after care program.

A discharge summary, identifying reasons for discharge, is completed when the person leaves services for any reason (planned discharge, against medical advice, no show, infringement of program rules, aging out, etc.).

Just as the assessment is critical to the success of treatment, transition services are critical for the support of the individual's ongoing well-being. The organization proactively attempts to contact the person served after formal transition or discharge to gather needed information related to his or her postdischarge status. The organization reviews the postdischarge information to determine the effectiveness of its services and whether additional services were needed.

The transition plan and/or discharge summary may be included in a combined document or as part of the individualized plan as long as it is clear whether the information relates to a transition or discharge planning.

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.

    g. Identifying:

        (1) When transition planning will occur.

        (2) Where the following are documented.

            (a) Transitional planning.

            (b) Discharge summary.

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.

2.D. **2. When indicated, transition/discharge planning is:**

    a. Initiated with the person served at the beginning of services, or as soon as appropriate.

    b. Included in the planning and service delivery process.

Intent Statements

Transition planning may be initiated prior to or at the onset of services as part of the development of the individualized plan. In some programs, transition may include transfer to an inactive status.

Any type of transition is often pivotal for children/youths and may place additional stressors on the persons served, the organization, and the community. Therefore, adequate preparation for transition requires giving more than routine notice that a child/youth is nearing completion of the program. There must be early and active involvement of the child/youth served, his or her family, referral sources, and other community agencies that will be involved with the child/youth after he or she leaves the program. Transition services are also critical for adolescents who are reaching the age of majority and will require ongoing services in adulthood.

Transition planning for children/youths with cognitive disabilities should pay particular attention to include family members or other supports that will be needed after the program has been completed. Children/youths and their families are given supports to explore other options that are available and connected with resources for growth, such as self-advocacy groups.

2.D. **3. To support transition, youths who will be leaving the services system as independent adults are engaged in a structured planning process:**

    a. **At least one year prior to discharge, when possible.**

    b. **That ensures discharge to a safe, stable living situation.**

    c. **That includes an identified follow-up period, during which aftercare services and supports are available directly or through referral.**

Intent Statements

Transition services are particularly critical for youths who are reaching the age of majority and may require ongoing services in adulthood. Youths are actively engaged in a transition planning process that provides for stability and seeks to prevent homelessness and lack of employment or educational supports. It is understood that the program may have no control over the final discharge location, given that the young adult leaving services has full legal capacity to choose the location of his or her discharge and may not follow the program's recommendations to help ensure a safe, stable living environment.

2.D. **4. The written transition plan:**

    a. **Is prepared or updated to ensure a seamless transition when a person served is transferred to another level of care, another component of care, an aftercare program, or prepares for reunification or a planned discharge.**

    b. **Is developed with the input and participation of:**

        (1) **The person served.**

        (2) **The family/support system, when applicable and permitted.**

        (3) **Personnel.**

        (4) **The referral source, when appropriate and permitted.**

        (5) **Other community services, when appropriate and permitted.**

    c. **Identifies the person's:**

        (1) **Current well-being.**

        (2) **Gains achieved.**

        (3) **Need for support systems or other types of services that will assist in continuing his or her well-being or community integration.**

    d. **Includes:**

        (1) **Educational status.**

        (2) **Educational goals.**

        (3) **When applicable, employment preparation and career planning.**

        (4) **A housing plan for youths making the transition to independence.**

        (5) **Information on the person's health needs, including:**

            (a) **Physical.**

            (b) **Behavioral.**

            (c) **Medications, when applicable.**

        (6) **Referral source information.**

        (7) **Communication of information on options available if additional services are needed.**

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

See the Glossary for the definition of *transition plan*. The transition plan may be identified as another title such as continuing care plan, referral plan, discharge plan, or aftercare plan. Transition planning may be documented in progress notes, through a revision of the person's plan, or in a separate document.

In some programs, a similar plan may be prepared when a person served is placed on inactive status. There may be times when the transition plan is incorporated into the individualized service plan or treatment plan of the person served.

It is recognized that there may be times when the person chooses to abruptly leave a program and transition planning is not possible. In those cases, documentation would include a discharge summary.

4.b.(5) Any individuals or organizations actively involved with the person served who may be able to contribute to a successful transition should be consulted, when allowed.

4.d.(6) Referral source information may include contact name, telephone number, locations, hours, and days of services.

2.D. **5.** **Documented information provided to external programs/services to support the transition plan includes:**
   a. **The child's/youth's identified:**
      (1) **Strengths.**
      (2) **Needs.**
      (3) **Abilities.**
      (4) **Preferences.**
   b. **As applicable, the family's identified:**
      (1) **Strengths.**
      (2) **Needs.**
      (3) **Abilities.**
      (4) **Preferences.**

Intent Statements

It is important to identify and pass on information about a person's strengths, needs, abilities, and preferences to other service providers to ensure continuity of care. This may be done by sharing the transition plan, the discharge summary, or other comparable documents.

Examples

Personal strengths may include assets, resources, and natural positive attributes.

Individualized needs may include liabilities, weaknesses, and what the person needs to recover.

Abilities and/or interests may include skills, aptitudes, capabilities, talents, and competencies.

Preferences are those things the person served feel will enhance his or her service/treatment experience.

2.D. **6.** **When transition includes a plan for reunification, it is:**
   a. **Initiated as early as possible.**
   b. **Involves the following in the planning process:**
      (1) **The child/youth served.**
      (2) **The family of the child/youth served.**
      (3) **The out-of-home provider.**
      (4) **Other stakeholders.**
   c. **Promotes and maintains continuity of life-long relationships.**
   d. **Maintains and strengthens the child's/youth's connection with the extended family and the community.**

Intent Statements

6.d. In some communities, such as indigenous, this would include the extended family or other identified community representative.

2.D. **7.** **Individuals who participate in the development of the transition plan receive copies of the plan, when permitted.**

Intent Statements

Considering privacy and confidentiality requirements, a copy of the plan is provided to transition planning participants when beneficial to the person served, as an assist to the referral source and/or the receiving program(s).

2.D. **8.** **When a person served moves to a school or other community service, information about the new service is provided, as appropriate and applicable, to:**
   a. **The person served.**
   b. **The family/support system.**

Intent Statements

With a continued focus on the family and its role in the person's life, information about new

services, alternative settings and strategies, etc., is provided to assist in such transitions and to help provide service continuity.

2.D. **9.** **When the transition plan indicates the need for additional services or supports, follow-up includes:**
   a. **Maintaining the continuity and coordination of needed services.**
   b. **Offering or referring to needed services, when possible.**
   c. **Implementing formal protocols for transition from the child/youth service system to an adult service system according to all applicable governmental policies and statutory requirements.**

Examples

Follow-up also occurs when a person served is placed on inactive status. Follow-up may occur through direct contact, on-line contact, or other means.

2.D. **10.** **When an unplanned transition or discharge occurs, follow-up, when possible, is conducted:**
   a. **To provide necessary notifications.**
   b. **To determine with the person served whether further services are needed.**
   c. **To offer or refer to needed services.**
   d. **As soon as possible.**

Examples

Unplanned transitions or discharges may include early discharge due to family relocation, administrative discharge for medical hospitalization, arrest, or an urgent need for higher level of services.

11.b. Necessary notifications may include community case workers, probation officers, and external community providers.

2.D. **11.** **For all persons leaving services, a written discharge summary is prepared that:**
   a. **Includes the date of admission.**
   b. **Identifies the presenting condition.**

   c. **Describes the services provided.**
   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 at last contact.**
   g. **Lists recommendations for services or supports.**
   h. **Includes the date of discharge from the program.**
   i. **Includes information on medication(s) prescribed or administered, when applicable.**

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

11.d. This could include gains achieved by the person during program participation, strides made by the person in the recovery process, or any positive movement toward well-being.

11.g. Recommendations include referral source information, contact name, telephone number, and hours and days of operation.

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, transition to other services, and discharge
- Written transition plans
- Documentation of information provided to external programs/services to support the transition plans
- Reunification plans, if applicable
- 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 apply Standard 2.E.2. based on the population served and the programs or services provided.

- If an organization controls medications, Standard 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 and that training is provided that covers all of the pertinent areas of medication management.

If a program seeking accreditation does not provide medication control, prescribing, dispensing, or administering, it would not be required to provide ongoing training and education regarding medications to the persons served or any family members. Training and education regarding medications should be provided to personnel providing direct service to the persons served in all programs seeking accreditation.

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 medi-

cations 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.k. Procedures for laboratory and other tests should be in accordance with established practices in medicine. As a resource, the American Psychiatric Association (**www.psych.org**) and the American Diabetes Association (**www.diabetes.org**) have published joint consensus papers identifying the frequency and types of laboratory tests and metabolic screenings appropriate for persons prescribed antipsychotic medications.

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 implements 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 contraindications. 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. **By a qualified professional with legal prescribing authority, or a pharmacist.**

c. **On a representative sample of records of persons for whom prescriptions were provided.**

d. **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.**

e. **To determine if:**

(1) **The presence of side effects, unusual effects, and contraindications were identified and addressed.**

(2) **Necessary tests were conducted.**

f. To identify:

(1) The use of multiple simultaneous medications.

(2) Medication interactions.

Intent Statements

The peer review is conducted by a qualified professional with legal prescribing authority, or a pharmacist, 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 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.d.(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.

2.E. **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 child and youth services, 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, consider-

ation 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 apply Standard 2.F.2. 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, redirection, 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) Time lines 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 pro-active 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 time lines.

(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 are implemented and 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*.

🍁 **Note:** *Includes youth worker in Canada.*

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.**

Examples

14.c. When the management review determines the use of seclusion or restraint was not performed within the applicable policies/procedures, corrective actions are taken to prevent a recurrence.

2.F. **15. The use of seclusion or restraint is:**

a. **Recorded in the information system.**

b. **Reviewed:**

(1) **At least annually.**

(2) **For:**

(a) **Analysis of patterns of use.**

(b) **History of use by personnel.**

(c) **Environmental contributing factors.**

(d) **Assessment of program design contributing factors.**

c. **Used for performance improvement.**

Intent Statements

The organization determines its frequency of analysis of patterns of use of seclusion or restraint; however, it should be done at least annually in order to be 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 Person 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.

2.G. **1. The individual record communicates information in a manner that is:**
   a. **Organized.**
   b. **Clear.**
   c. **Complete.**
   d. **Current.**
   e. **Legible.**

Intent Statements

Records are organized in a systematic way to ensure that information is readily accessible. CARF does not prescribe any particular type of organizing or filing system.

1.c. Complete refers to a central record containing all information regarding all services the person served receives. This is considered the main record. Complete records include all items listed in Standard 2.G.3., including notations regarding any information that was not available or not applicable for the person served.

2.G. **2. All documents contained in the record that are generated by the organization and 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. A document with an original signature that is scanned into the record could also be used.

2.G. **3.** **The individual record includes:**

a. **The date of admission.**

b. **Information about the person's personal representative, conservator, guardian, and/or representative payee, if any of these have been appointed, including his or her:**

   (1) Name.

   (2) Address.

   (3) Telephone number.

c. **Information about the person to contact in the event of an emergency, including his or her:**

   (1) Name.

   (2) Address.

   (3) 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 person's primary care physician, including, when available, his or her:**

   (1) Name.

   (2) Address.

   (3) Telephone number.

g. **Healthcare reimbursement information, if applicable.**

h. **As applicable, the person's:**

   (1) Safety plan.

   (2) Reunification or permanency information.

   (3) Court orders or other legal documents.

   (4) Health history and current status.

   (5) Current medications.

   (6) Preadmission screening, when conducted.

   (7) Documentation of orientation.

   (8) Assessments.

   (9) Individualized plan, including reviews.

   (10) Services received.

   (11) Consents.

   (12) Authorizations for release of information.

   (13) Transition plan.

i. **A written discharge summary when services are no longer being provided.**

j. **Correspondence pertinent to the person served.**

k. **Documentation of internal or external referrals.**

Examples

3.h.(3) Includes documentation of parental rights, court orders for shelter, or out-of-home placement, when applicable.

3.h.(8) In a Healthy Families America program, the record of the family served includes written assessment information that clearly and uniformly summarizes identified criteria for service need.

3.h.(11) Consents may include consent to receive treatment or services, consent to the use of medications, and consent for transportation of the person served.

3.h.(13) A transition plan may not be appropriate when a person left services without notice.

3.i. A discharge summary exists for all persons who have left an organization's services.

2.G. **4.** **Entries to the records of the person served follow the organization's policy that specifies time frames for entries.**

Intent Statements

Clearly defined time frames for admission notes, assessments, individual plans, and progress notes are important for comprehensive and efficient service provision. Each program establishes in writing the time frame for each specific type of entry, and there is evidence that personnel follow that time frame. Time frames may be based on funding source or legal/regulatory requirements.

2.G. **5.** **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 maintained with the same degree of protection and confidentiality as the main record.**

Intent Statements

5.a. Although duplicate records may be maintained at multiple sites, a central record is kept current and complete.

2.G. **6.** **The program 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 comply with all applicable laws.**

Intent Statements

Programs submitting or maintaining information in electronic formats regarding the persons served need to pay particular attention to requirements of the HIPAA in the United States (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 program 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

Authorizations for release of information identify:

- The name of the person about whom information is to be released.
- The content to be released.
- To whom the information is to be released.
- The purpose for which the information is to be released.
- The date on which the release is signed.
- The date, event, or condition upon which the authorization expires.
- Information as to how and when the authorization can be revoked.
- The signature of the person who is legally authorized to sign the release.

6.b. 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.

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 of persons served
- A policy that specifies time frames for entries to the records of the persons served
- Any duplicate files or reports, if applicable
- Policies regarding information to be transmitted to other individuals or agencies

H. Quality Records Review

Description

The program 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 program in improving the quality of services provided to each person served.

2.H. **1. The program conducts a documented review of the services provided at least quarterly that addresses:**
   a. **The quality of service delivery as evidenced by the record of the person served.**
   b. **Appropriateness of services.**
   c. **Patterns of service utilization.**
   d. **Model fidelity, when an evidence-based practice is identified.**

Intent Statements

The procedures for review of services include:

■ Oversight of the review process by the management of the program.

■ Use of individual reviewers who carry out professional functions and who may be either internal or external to the program. A committee is not required to carry out the professional reviews.

■ In small programs 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.

Examples

1.d. In programs that use evidenced-based practices, the quarterly review includes key components of the model. This might include frequency of services, delivery of specific curriculum, or implementation of specific protocols for handling particular behaviors.

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.**

Intent Statements

In a program with short lengths of stay, or in situations where the records will not be available following discharge, the review may include records of persons discharged during the current quarter as well as persons currently being served. The survey team will review current and closed records for each program seeking accreditation.

A demographically representative sample represents persons the program serves, or intends to serve, and may include age, gender, ethnicity, linguistic needs, locations, and type or severity of disability or disorder.

2.H. **3. The review addresses whether:**
   a. **The person served was:**
      (1) **Provided with a complete orientation.**
      (2) **Actively involved in making informed choices regarding the services received.**
   b. **Confidential information was released according to applicable laws/regulations.**
   c. **The assessments of the person served were:**
      (1) **Thorough.**
      (2) **Complete.**
      (3) **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.   **Services provided reflect the goals and objectives of the individualized plan.**

f.   **The actual services reflect:**

   (1)   **Appropriate level of care.**

   (2)   **Reasonable duration.**

g.   **When applicable, the following have been completed:**

   (1)   **Transition plan.**

   (2)   **Discharge summary.**

h.   **Services were documented in accordance with the organization's policy.**

i.   **The individualized plan was reviewed and updated in accordance with the organization's policy.**

j.   **When applicable, billing reflects only the services provided to the person served.**

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 direct services personnel (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.

When short-term or brief services such as assessment and referral or crisis intervention are provided, the review addresses only those portions of this standard that are applicable.

2.H.   **4.   When records are selected for review, the person responsible for providing the service/treatment is not:**

a.   **Solely responsible for the selection of his or her records to be reviewed.**

b.   **A reviewer of his or her records.**

Intent Statements

If there is a limited number of qualified personnel available to perform the review, creative means may be used. For example, if there is only one therapist on staff, an organization may invite another similarly qualified individual who works in the area to review the quality of the individual-

ized plans. The organization should consider applicable confidentiality regulations with regard to who can assist in the review of services and any confidentiality assurances necessary for the review to be completed.

2.H.   **5.   The program demonstrates that the information collected from the review process is:**

a.   **Reported to applicable personnel.**

b.   **Used to identify training needs.**

c.   **Used to improve the quality of its services.**

Intent Statements

The program is able to provide examples of how the information gathered from professional reviews is used for program improvement. 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 changes.

Examples

5.a. The program may report review results to applicable personnel during supervision meetings or following the review.

5.c. Quality improvement may be demonstrated through:

■   Revisions to overall program 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 the performance improvement system to more accurately track the outcomes, progress, or effectiveness of a program for those 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.

- 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

Child and Youth Services Core Program Standards

A. Adoption

Description

Adoption programs are inclusive of open, closed, customary, and international adoptions as well as other permanent custody or care arrangements and provide children/youths with legal and social stability. Customary adoption is a traditional indigenous practice recognized by the community that gives a child/youth a permanent parent-child relationship with someone other than the child's/youth's birth parent(s). Adoption programs ideally provide continuity of life-long relationships and maintain cultural identity.

The adoption program promotes the active participation of all affected by the permanent placement, including the foster family, birth family, extended family, adoptive family, child/youth, advocate, caregivers, members of indigenous or other communities of origin, or other individuals who are significant to the child/youth. Services are based on the best interest of the child/youth.

Programs can be delivered by public or indigenous child/youth welfare authorities, private licensed agencies, or licensed individuals.

Signatories to the UN Convention on the Rights of the Child must meet the identified requirements. These organizations must ensure the child's/youth's fundamental right to identity, family, and culture is addressed. When applicable, programs must also conform to the requirements of the Indian Child Welfare Act, Adoption and Safe Families Act, Multi-Ethnic Placement Act, Interethnic Adoption Provisions Act, Fostering Connections, Hague Convention, and the Act to Promote Safe and Stable Families, as well as all other applicable regulatory requirements.

Applicable Standards

An organization seeking accreditation for an adoption program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.A. **1. As applicable, the program implements policies and written procedures related to:**
   a. **Special needs adoptions.**
   b. **Open adoptions.**
   c. **Closed adoptions.**
   d. **International adoptions.**
   e. **How cultural issues relevant to the persons served will be addressed.**
   f. **Adoptee relationships with:**
      (1) **Siblings.**
      (2) **Extended families.**
      (3) **Birth parent(s).**
      (4) **Previous foster families or other caregivers.**
      (5) **Significant others.**
   g. **The child's/youth's active role in the adoption process, ensuring that it:**
      (1) **Is age appropriate.**
      (2) **Includes an understanding of and agreement to the adoption.**
   h. **The role of the birth parent(s) in the adoption process.**
   i. **Eligibility criteria for adoptive applicants.**

Examples

1.e. This may include how the adoptee maintains the relationship with persons of their native culture.

3.A. **2.** **The program utilizes written agreements that clearly define:**

   a. **The expectations of the:**

   (1) **Adoptee, when applicable.**

   (2) **Birth parent(s), when applicable.**

   (3) **Adoptive family.**

   (4) **Foster family, when applicable.**

   (5) **Program.**

   b. **The legal rights of all involved.**

   c. **All applicable fees.**

Intent Statements

Written agreements are signed by program staff and other parties involved, as applicable.

Examples

2.a.(5) Items often included in written agreements include training requirements, support availability during preplacement visits, and post-adoptive finalization.

3.A. **3.** **The program confirms that the child/youth is legally available for permanent placement.**

3.A. **4.** **The program complies with all local/ state/provincial/territorial/national requirements as they apply to indigenous children/youths.**

Intent Statements

The program demonstrates a process of due diligence that ensures all requirements are met. The process should cover procedures for registration, placement, and adoption.

Recruitment

3.A. **5.** **As part of the adoptive parent recruitment process, the program:**

   a. **Consistently maintains the dignity of the child/youth.**

   b. **Promotes broad public awareness to find appropriate families to meet the needs of the children/youths.**

   c. **Ensures continuous recruitment using a variety of methods.**

   d. **Responds to inquiries in a timely fashion.**

   e. **Demonstrates a comprehensive plan for the selection of families.**

   f. **Maintains a broad selection of families to ensure the needs of each child/youth will be met.**

Intent Statements

Recruitment may take into consideration single parents, same sex couples, ages of parent(s), financial status, culture, ethnicity, and other issues.

Examples

5.f. The program strives to include a variety of families to meet any special needs of children/ youths, which may include disabilities, mental health challenges, sibling groups, medical conditions, and cultural diversity.

Assessment

3.A. **6.** **The program demonstrates a thorough process to determine the appropriateness of prospective families to adopt:**

   a. **That includes:**

   (1) **An educational component.**

   (2) **A home study.**

   (3) **Determination of readiness to adopt.**

   (4) **A thorough criminal background check that meets all applicable legal and regulatory requirements.**

   (5) **A formal approval conducted by a team.**

   (6) **Being conducted in accordance with all applicable legal and regulatory requirements.**

   b. **That is shared with prospective adoptive families.**

Intent Statements

The program conducts a formal assessment of prospective families and ensures that prospective adoptive parents understand the unique needs of

the child(ren)/youth(s) to be adopted; the aspects of child/youth adoption, including the other individuals that may be involved in the child's/youth's life; and that other organizations may continue to be involved in the process.

Examples

6.a.(4) While criminal record checks is a broad category, examples may include National Criminal Intelligence Services (NCIS), Vulnerable Sector Screening, state/provincial/territorial Child Abuse and Neglect Registries, Federal Bureau of Investigations, fingerprint checks, sex offender registries, and others as appropriate.

3.A. **7.** **The program collects information related to the child/youth to be placed by conducting assessments that include the following:**

a. **Strengths.**

b. **Needs.**

c. **Abilities.**

d. **Preferences.**

e. **Historical and current health information, including:**
   (1) **Medical information.**
   (2) **Mental health information.**
   (3) **Substance use information.**
   (4) **Trauma history.**

f. **Behavioral issues.**

g. **Relationships with:**
   (1) **Family.**
   (2) **Peers.**
   (3) **Others.**

h. **Family and personal history, including:**
   (1) **Birth information.**
   (2) **Family history.**
   (3) **Family strengths.**
   (4) **Cultural information.**
   (5) **Connections and supports.**

i. **Family health and social history, including:**
   (1) **Mental health.**
   (2) **Substance use.**
   (3) **Criminal history.**

j. **Placement history.**

k. **Education.**

l. **Juvenile justice.**

Intent Statements

The collection of assessment information when the adoption involves an infant should be as complete as possible; there is recognition that some information may not be available.

Many different assessment instruments can be used to collect thorough information from a child/youth to ensure an adoptive family will be well equipped to provide for the child/youth and respond to his or her individual needs.

Examples

🍁 Ontario, Canada uses a SAFE Assessment (Structured Analysis Family Evaluation).

7.e.(2) Mental health information may include history of violence or self injurious behaviors

7.f. Behavioral issues may include social functioning, aggressiveness, ability to follow directions, and tendency for running away.

7.h.(4) Cultural information may include spirituality, ethnicity, and beliefs.

3.A. **8.** **Information collected from the birth parent(s), when available, includes:**

a. **Health history.**

b. **Identification of siblings and other relatives.**

c. **Social history.**

d. **Ethnicity.**

e. **Education/employment.**

f. **Physical descriptions.**

g. **Availability of photos or other memorabilia that can be shared.**

h. **Other information the birth parent(s) wants the child/youth to know.**

Intent Statements

Information collected from birth parent(s) is intended to offer the child/youth a sense of connectedness to his or her family of origin as well as assist in matching the child/youth with a potential adoptive family.

Examples

8.a. Health history includes medical, mental health, and addictions.

8.c. Social history includes legal/criminal history and traits/characteristics such as details about unique mannerisms of the birth parent(s).

8.h. Other information that birth parents may want to share with the child/youth could include a personal note/letter, photos, circumstances about the adoption, or their feelings about the adoption.

3.A. **9.** **When the program provides services to birth parents, the following are included:**
   a. **Information on alternatives to adoption.**
   b. **Education.**
   c. **Counseling.**
   d. **Support.**

Examples

9.d. Support may include referrals to community resources.

Training

3.A. **10.** **Training is provided through a standardized process, as appropriate:**
   a. **To:**
      (1) **Personnel.**
      (2) **Birth parents.**
      (3) **Adoptive parents.**
      (4) **Prospective adoptive parents.**
      (5) **Adoptees.**
      (6) **Applicable family members.**
   b. **That includes, when applicable:**
      (1) **Attachment theory.**
      (2) **Grief and loss.**
      (3) **Trauma stress.**
      (4) **Adoption issues.**
      (5) **The possibility of mental health issues and potential resources.**
      (6) **The impact of child abuse and neglect.**
      (7) **Child/youth growth and development.**
      (8) **Brain development.**
      (9) **Behavior management skills.**
      (10) **Learning styles.**
      (11) **Cultural sensitivity and responsiveness.**
      (12) **The effects of placement on children.**
      (13) **Applicable legal issues and court procedures.**
      (14) **Methods of communication.**
      (15) **Available services and supports.**
      (16) **Other specific needs.**

Intent Statements

The training subject areas should consider the relevant material for each of the trainee groups. Training topics may be specific to a particular phase of the adoption process. Training may include a variety of methods including the use of triad members to facilitate trainings, films, classes, and panel discussions.

Examples

10.b.(4) This may include stages of adoption, why adoption may be chosen, post-adoption depression, and lifelong adoption issues.

10.b.(16) In international adoptions, training may include information to facilitate settlement into a new geographical location.

Placement

3.A. **11.** **Matching the child/youth to an adoptive family:**
   a. **Is conducted by a team.**
   b. **Includes all information gathered in the assessment process.**
   c. **Considers the following, when possible:**
      (1) **Realistic expectations.**
      (2) **Extended family.**
      (3) **Placement with siblings.**
      (4) **Members of the community of origin.**
      (5) **Culture.**
      (6) **Spirituality.**

(7) Gender, sexual orientation, and gender expression.

(8) Ethnicity.

Intent Statements

11.a. To ensure that matching decisions are not completed by a sole person, a team approach should be used. In direct consent adoption, birth parent(s) may elect to match the adoptive parents.

Examples

11.c.(1) Realistic expectations are dependent on the needs and complexities of each child/youth and the families identified as potential matches.

11.c.(5) Culture includes diversity as it relates to age, socioeconomic status, and language; and it addresses sensitivity in the areas of language, dress, traditions, notions of modesty, eye contact, health values, help-seeking behaviors, work ethics, spiritual values, attitudes regarding treatment of mental illness and addictions or substance use disorders, concepts of status, and issues of privacy and personal boundaries.

3.A. **12. Based on the needs of the child/youth, the program:**

a. Advocates for the placement of children/youths with their siblings.

b. When placement with siblings is not possible, advocates for and facilitates the planning of ongoing visits and contacts with siblings, as appropriate.

Examples

Strategies for facilitating ongoing visits include adoptive families and children/youths planning for sleep-overs and joint vacations, meals, and other activities. Telephone calls, letters, and social networking are methods of ongoing communication.

3.A. **13. When applicable, pre-placement visits are:**

a. Part of the placement process.

b. Conducted over a sufficient period of time to meet the needs of the:

(1) Child/youth.

(2) Prospective adoptive family.

(3) Birth parent(s).

3.A. **14. When legally permissible, the program provides open and full disclosure of information gathered during the assessment process to the:**

a. Child/youth or adoptee.

b. Adoptive family.

c. Birth parents.

Examples

Information provided to the adoptee may be in the form of a life book, pictures, or other personal items or stories to create special meaning to the child/youth.

3.A. **15. The program:**

a. Initiates transition planning at the earliest point in services.

b. Ensures that caregivers and/or significant others are involved in:

(1) Preparing the child/youth for placement in the adoptive home.

(2) Transitioning the child/youth to the adoptive home.

Examples

Assistance for the child/youth during the transition period may include counseling and linkages to schools and community supports.

3.A. **16. The program provides assistance to caregivers in dealing with the emotional aspects of the transition of the child/youth.**

Examples

Caregivers may include foster parents, families providing kinship care, or program staff from residential type placements.

3.A. **17.** Prior to permanent placement, unless prohibited, the program:
  a. Applies for financial support(s) as needed for the adoptive family.
  b. Works with the adoptive family to secure comprehensive post-placement supports.

Examples

17.b. This may include joining adoption support groups and parent/family organizations.

Post-Adoption Services

3.A. **18.** The program provides post-adoption services and supports to the adoptive family as needed to create and sustain permanent, strong family relationships.

3.A. **19.** When the program becomes aware of an adoption disruption or dissolution, it:
  a. Reassesses prior placement for suitability.
  b. Provides counseling support or referrals to appropriate agencies to:
    (1) The child/youth.
    (2) The adoptive family.
    (3) The birth parent(s), when applicable.
  c. Tracks the events.
  d. Analyzes the events for performance improvement.

3.A. **20.** If applicable, the program provides timely search and reunion services or referrals:
  a. To:
    (1) Adult adoptees.
    (2) Birth parents.
    (3) Adoptive parents of minors.
  b. Including, when appropriate, legally available information regarding the:
    (1) Birth family.
    (2) Adoption circumstances.
    (3) Adoptive family.
  c. Based on their individual needs for support and assistance.

3.A. **21.** When legal and appropriate, information that is provided to the program after the adoption to update medical information is provided to the:
  a. Adoptive family.
  b. Adoptee.
  c. Birth family.

Records

3.A. **22.** The individual record for each child/youth served includes:
  a. The opening date of the case.
  b. Information about the person(s) accessing services, including:
    (1) Name.
    (2) Address.
    (3) Telephone number.
  c. The name of the person currently coordinating the services of the child/youth served.
  d. The location of any other records.
  e. As applicable, the child's/youth's:
    (1) Court orders or other legal documents.
    (2) Assessments.

(3) **Updates.**

(4) **Home study, including reviews.**

f. **Correspondence pertinent to the persons served.**

g. **Authorizations for release of information.**

h. **Documentation of internal or external referrals.**

i. **Documentation of all training provided to the:**

(1) **Adoptive family.**

(2) **Birth family.**

(3) **Adoptee.**

j. **Written adoption agreement.**

k. **Case notes.**

l. **Closing summary.**

Examples

22.b. In addition to the typical person(s) accessing services, this may include a personal representative, conservator, guardian, or representative payee, if any of these have been appointed.

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 adoption, including details contained in Standard 1. of this subsection

■ Written adoption agreements that clearly define the expectations and legal rights of all involved in the adoption process and all applicable fees

■ Legal documentation confirming the child/youth is available for adoption

■ Documented information collected from the birth parent(s), when available

■ Documented home study; determination of readiness to adopt; thorough criminal background check; and a formal approval conducted by a team to determine the appropriateness of prospective families to adopt

■ Assessments of the child/youth and family

■ A comprehensive plan for the selection of adoptive families

■ Transition plans

■ Documentation of adoption disruptions and analysis for performance improvement, when applicable

■ Individual records for the children/youths served

B. Assessment and Referral

Description

Assessment and referral programs provide a variety of activities, including prescreening, screening, 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. Assessment and referral may include hotlines, "warmlines," or resource referral systems, such as "211" or "First Call for Help."

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 case management, counseling, 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, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in 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.

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 person served.

   (2) Provide follow-up, when indicated.

Examples

2.c. 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:**

   a. **The person served.**

   b. **The referral source, when applicable.**

Intent Statements

Written information is provided to assist with planning, problem solving, and reporting to the 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, that include:
  - Method(s) for identifying the appropriate level of care and linkages to emergency and/or crisis intervention as needed
  - Identification of the use of valid, reliable, or standardized assessment tools, tests or instruments
- Community resource information
- Written summary of the assessment and referral, when requested
- Records of persons served

C. Behavioral Consultation

Description

In behavioral consultation programs emphasis is placed on the reduction or elimination of problematic behaviors. The focus of the program is to replace inappropriate behaviors with positive behaviors or increase the ability of the person served to express more effective and appropriate behaviors. Behavioral strategies are used to teach the person other means to deal with targeted behaviors and the environment to ensure that inappropriate behaviors are discouraged and positive behaviors are learned and maintained. This may include services to persons with eating disorders or those who exhibit self-injurious behaviors.

Applicable Standards

An organization seeking accreditation for a behavioral consultation program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.C. **1.** **The program's personnel:**

   a. **Demonstrate their skill, knowledge, and application of:**

      (1) **Behavioral strategies and techniques.**

      (2) **Applicable evidence-based practices.**

   b. **Provide to those involved with the person served:**

      (1) **Support.**

      (2) **Training.**

Examples

1.b.(2) Behavioral consultants provide training to the person's support team which includes:

- Theory, as applicable.
- A review of written behavioral strategies/ instructions.

■ An application of the strategies/instructions using:
  – Written/verbal scenarios.
  – Role play.
  – Training with the person served in real-life settings, as appropriate.

3.C. **2. The program staff involved in the person's life are trained on specific behavior management techniques.**

3.C. **3. The program plan is modeled for all involved with the intent to extinguish inappropriate behaviors as soon as possible, based on the needs of the person served.**

3.C. **4. The program facilitates monthly team meetings with all involved in the person's individual plan.**

Intent Statements

Although team members are expected to meet monthly, information may be shared by external contact with others involved in the person's plan.

3.C. **5. Behavioral strategies are consistent across a variety of environments familiar to the person served.**

Examples

The program demonstrates efforts to ensure the consistent implementation of behavioral strategies in applicable settings, such as:

■ Family environment.
■ School/educational environments.
■ Community environments important to the person served and his or her family.

3.C. **6. Contact occurs with the persons served:**
   a. Through:
      (1) Formal involvement.
      (2) Direct observation.
   b. To ensure progress is made.

3.C. **7. Behavioral assessments are completed and include input, as appropriate, from:**
   a. The person served.
   b. The parents/legal guardians or caregivers of the person served.
   c. The person's teacher(s) or other educational staff members.
   d. The extended family that is involved in the life of the person served.
   e. Other stakeholders that are involved in the person's life.

3.C. **8. When dealing with problem behaviors, the program conducts functional assessments that:**
   a. Describe the problem behavior.
   b. Define potential environmental or setting events.
   c. Define immediate antecedents for occurrences and nonoccurrences of the problem behavior.
   d. Identify the consequences or outcomes of the problem behaviors.
   e. Identify functional alternative behaviors to the problem behavior.
   f. Identify the primary ways the person served communicates with other individuals.
   g. Identify actions that support what the person served should and should not do.
   h. Identify reinforcers.
   i. Identify the history of the problem behavior, the programs that have been attempted to decrease or eliminate them, and the effects of those programs.
   j. Develop summary statements for each major predictor and/or consequence.
   k. Include results that are incorporated into the development of behavioral strategies.

3.C. **9.** The program takes into consideration the following needs of the person served, as appropriate:
  a. Health.
  b. Safety.
  c. Educational.
  d. Emotional.
  e. Physical.
  f. Social.
  g. Leisure.
  h. Spiritual/cultural.
  i. Others, as identified.

3.C. **10.** The program provides behavioral strategies, as needed and appropriate:
  a. That:
    (1) Are based on assessments.
    (2) Include training.
  b. To:
    (1) The person served.
    (2) The family.
    (3) Other support persons.
  c. In the following areas:
    (1) Motor skills.
    (2) Physical skills and fitness.
    (3) Academic skills.
    (4) Intellectual development.
    (5) Communication skills, including language development.
    (6) Creative skills.
    (7) Daily living skills.
    (8) Community awareness.
    (9) Safety skills.
    (10) Self care skills.
    (11) Identity development.

3.C. **11.** Written behavioral strategies:
  a. Are developed with involvement from key individuals in the person's life.
  b. Include:
    (1) Consents.
    (2) A rationale for the use of the strategies.
    (3) A definition of targeted behavior.
    (4) Clearly stated, measurable behavioral goals.
    (5) A summary of baseline data, where applicable.
    (6) A list of materials or resources needed to implement the strategies.
    (7) Procedural instructions for implementing the strategies.

3.C. **12.** Implementation of the behavioral strategies:
  a. Occurs after training.
  b. Includes:
    (1) Clarification of roles.
    (2) Formal data collection methods.

Intent Statements

Collection of data while in the program will provide direction on strategies used in the plan.

3.C. **13.** Behavioral consultants demonstrate ongoing, formal monitoring of the implemented strategies by:
  a. Regularly collecting, summarizing, and reviewing empirical data.
  b. Sharing data summaries with team members.
  c. Being available for consultation and to directly observe implementation of the behavioral strategies.
  d. Regularly meeting with team members.

e. **Addressing barriers to the effective implementation of behavioral strategies.**

f. **Revising behavioral strategies, when needed, in order to maximize their effectiveness.**

3.C. **14.** **Policies and written procedures address the use of behavioral treatments, including:**

a. **The appropriate use of reward systems.**

b. **Acceptable and unacceptable interventions.**

c. **Prohibition of punishment.**

Intent Statements

Policies and procedures reflect the language from established international ethical guidelines on the use of behavioral treatments.

3.C. **15.** **If consultation in Early Intensive Behavior Intervention (EIBI) is provided, the program:**

a. **Continually develops a curriculum to meet the needs of the persons served.**

b. **Provides curriculum training to:**

(1) **Families.**

(2) **Intervention workers.**

(3) **Other applicable individuals.**

c. **Oversees the implementation of a formalized curriculum.**

d. **Monitors progress on curriculum goals.**

e. **Works directly with the person served.**

f. **Reassesses the persons served at regular intervals.**

g. **Trains interveners in behavioral management theory and practical 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.

- Program plans, based on the needs of the persons served, to extinguish inappropriate behaviors

- Behavioral assessments

- Functional assessments

- Written behavioral strategies

- Documentation of data collected with summary that demonstrates formal monitoring of the behavioral strategy

- Policies and written procedures that address the use of behavioral treatments

- Documentation of continuous development of a curriculum if consultation in Early Intensive Behavior Intervention (EIBI) is provided

D. Case Management/ Services Coordination

Description

Case management/services coordination provides goal-oriented and individualized supports through assessment, planning, linkage, advocacy, coordination, and monitoring activities. It is focused on achieving individualized goals for the persons served. Successful case management/services coordination assists persons served to achieve their goals through communicating and collaborating with other service providers. 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 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 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 Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.D. 1. The person served is linked to services and resources to achieve goals/objectives as identified in his or her individualized plan.

Intent Statements

The services and resources may be formal and/or informal.

3.D. 2. Personnel providing case management/ services coordination have a working knowledge of relevant and available:
   a. Services that are appropriate for the needs of the persons served.
   b. Support systems that are appropriate to the lives of the persons served.

Intent Statements

To provide the linkages, coordination, and supports needed by the persons served, case managers demonstrate knowledge of child development, attachment theory, trauma-informed care, healthcare, social services, employment, housing, recreational opportunities, and other services and systems.

Examples

Services may include tutoring, counseling, mentoring, vocational rehabilitation, job training, healthcare, and financial assistance.

Support systems could include youth development and leadership programs; religious organizations; lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) support groups and youth centers; scouts; Big Brothers Big Sisters; Alateen; Youthmove; and sports teams.

3.D. 3. Based on the needs identified through the assessment of the person served, case management/services coordination includes:
   a. Activities carried out in collaboration with:
      (1) The person served.
      (2) The family/support system, as applicable.
   b. Outreach to encourage the participation of the person served.

c. **Coordination of, or assistance with, crisis intervention and stabilization services, as appropriate.**
d. **Optimizing resources and opportunities through:**
   (1) **Community linkages.**
   (2) **Enhanced social support networks.**
e. **Assistance with:**
   (1) **Accessing transportation.**
   (2) **Securing safe housing that is reflective of the person's:**
      (a) **Needs.**
      (b) **Abilities.**
      (c) **Preferences.**
   (3) **Exploring employment or other meaningful activities.**
f. **Evidence of linkage with necessary and appropriate:**
   (1) **Financial services.**
   (2) **Medical or other healthcare.**
   (3) **Other community services.**

Intent Statements

These case management activities are carried out in partnership and collaboration with the persons served. All the elements listed in this standard are available in the delivery of case management services.

All services that are available may not be provided to every person served; however, the services are available, and the program has the capability to offer these case management services.

Examples

3.b. In some programs, such as Healthy Families America, guidelines specify a variety of positive outreach methods and are used to build trust, engage the parent(s)/legal guardian(s) or child/youth served in services, and maintain ongoing involvement.

3.d.(1) Community linkages may include family resource centers and parent link centers.

3.d.(2) This may include Big Brothers Big Sisters, LGBTQ youth centers, Gay, Lesbian and Straight Education Network (GLSEN), scouts, sports teams, and faith-based youth groups.

3.f. For an adolescent moving toward independence, these may include budgeting, meal planning, personal care, housekeeping, or home maintenance.

3.f.(2) Medical or other healthcare includes the coordination of the healthcare of the person 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. For adolescents, this may include pregnancy prevention and HIV/STD resources and supports.

3.D. **4. The program provides case management activities in locations that meet the needs of the persons served.**

Intent Statements

Service locations should consider the person's desire for privacy and need for accessibility when the person is uncomfortable in his or her residence or in a public location.

Examples

Such locations may include residences, safe houses, correctional settings, shelters, community resource sites, hospitals, schools, medical or other service sites, and virtual locations.

3.D. **5. The intensity of case management is based on the needs of the person served as identified in his or her individualized plan.**

Intent Statements

The intensity of case management and the frequency of contact are individualized and clearly defined.

Some programs, such as Healthy Families America, have clearly defined criteria for increasing and decreasing the intensity of services. Programs that use an evidence-based practice model for case management/services coordination may follow the model's guidelines for the intensity of the services.

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 are served and their specific needs.

3.D. **6. When there are multiple case management providers:**

　　a. A primary case manager is identified.

　　b. There is coordination to facilitate continuity of care.

Intent Statements

When a person served is receiving case management services from multiple providers, there is coordination among providers to ensure that services are not unnecessarily duplicated and that each service adds value.

3.D. **7. With the permission of the person served, personnel provide advocacy, which includes:**

　　a. Sharing feedback regarding the services received with the agencies and organizations providing the services.

　　b. Empowering the person served to share feedback regarding the services received.

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 plans for the persons served

- Written procedures to guide ongoing coordination and communication among relevant internal and external service providers

- Documentation of coordination and communication among relevant internal and external service providers

- Records of persons served

E. Child/Youth Day Care

Description

A child/youth day care program provides care, development, and supervision for an identified portion of the day. Services are provided to children/youths temporarily entrusted to the program during the parent's/guardian's/caregiver's involvement at work, school, or other short-term activity. Day care programs may be located in a freestanding facility or in a designated area within a school or other community setting.

Applicable Standards

An organization seeking accreditation for a child/youth day care program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.E. **1. The program is directed by an individual who:**

　　a. Is a qualified practitioner.

　　b. Has specialized knowledge and competencies that meet the needs of the children/youth served.

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

3.E. **2. Program personnel receive competency-based training to meet the identified needs of the children/youths served that covers:**

　　a. Attachment theory.

　　b. Grief and loss.

　　c. Child growth and development.

　　d. Group dynamics.

　　e. Health and nutrition.

　　f. Behavior management skills.

　　g. Learning theory and strategies.

　　h. Cultural competency.

　　i. The effects of separation on children.

j. Applicable legal issues.

k. Methods of communication.

l. Other specific needs.

Examples

2.c. Includes readiness to learn, brain development, and social, emotional, and cognitive development.

2.g. Includes age-specific curriculum and activities. Methods of communication may include teacher-child interactions, non-verbal communication, and communication with families including telephonic and electronic.

2.j. Includes mandatory reporting of child maltreatment.

2.l. Additional needs may include medical or physical needs or the use of assistive technology.

3.E. **3. The program addresses the needs of each child/youth served in the following areas:**

a. **Education.**

b. **Growth.**

c. **Social and leisure activities.**

d. **Identified medical needs, including allergies.**

e. **Others, as identified.**

Examples

3.a. Educational needs may include using a variety of instructional strategies, responding to curiosity, problem solving, and encouraging creativity and imaginative play.

3.a.–c. The program provides opportunities for the child/youth served to have one-on-one time with personnel as well as time in group settings.

3.E. **4. Parents or legal guardians are informed of the following:**

a. **Fees.**

b. **Hours, including part time or drop in.**

c. **Program structure, including activities.**

d. **Program staffing.**

e. **Withdrawal notification requirements.**

f. **Policies regarding acceptance which include:**

(1) **Age.**

(2) **Children/youths with illnesses.**

(3) **Children/youths with special needs.**

g. **Policies regarding late pickup.**

h. **Child/youth guidance methods used, including that:**

(1) **Guidance action to be taken is reasonable in the circumstances.**

(2) **No physical punishment will be used under any circumstances.**

i. **Mandatory reporting requirements.**

j. **An update on the child's/youth's day, including identification of issues that may have arisen.**

Intent Statements

The program provides parents or legal guardians of the child/youth information about the program prior to enrollment and at appropriate times throughout participation in the program.

3.E. **5. Prior to the initiation of services, parents or legal representatives identify in writing the persons approved to:**

a. **Have contact with the child/youth while at the program.**

b. **Pick up the child/youth from the program.**

3.E. **6. Children/youths are, at all times while present at or involved in activities arranged by the program, under adequate supervision to provide for their:**

a. **Development.**

b. **Safety.**

c. **Health.**

d. **Well-being.**

Intent Statements

Adequate supervision may be defined by licensure requirements, program policy, or state-specific quality rating instruments (QRIs), however the program should consider this a

minimum and should identify circumstances that would require higher levels of supervision.

Examples

Additional adult supervision is required for all age groups when activities are scheduled outside the facility.

3.E. **7.** **The program's activities support the encouragement of:**
   a. **Motor skill development.**
   b. **Physical development.**
   c. **Physical fitness.**
   d. **Social development.**
   e. **Intellectual development.**
   f. **Literacy.**
   g. **Speech and language development.**
   h. **Creativity.**
   i. **Emotional health.**
   j. **Cognitive skills.**
   k. **Safety issues.**
   l. **Self care.**
   m. **Identity development.**
   n. **Play.**

Examples

7.d. Social development may include building healthy relationships with peers and adults.

3.E. **8.** **The program's learning environment recognizes the following identified needs of the child/youth:**
   a. **Cultural.**
   b. **Spiritual.**
   c. **Age.**
   d. **Gender.**
   e. **Developmental.**
   f. **Physical.**
   g. **Health.**
   h. **Social.**

Examples

8.g. Health needs may include medical, psychological and emotional.

3.E. **9.** **The program's daily activities are flexible enough to handle the following needs of the child/youth:**
   a. **Sleep or quiet time.**
   b. **Group and individual play.**
   c. **Variety.**

Intent Statements

9.c. The program activities follow a schedule but also allows for variations that provide children/youth with opportunities to experience and adapt to change.

Examples

Activities may include housekeeping, dress up, water and sand play, blocks, books, and puzzles.

3.E. **10.** **The program provides healthcare only:**
   a. **With written consent of the parent or legal representative.**
   b. **If the healthcare to be provided is first aid.**

3.E. **11.** **Nutritious meals and snacks are provided:**
   a. **By the program, unless the parents/legal guardians or caregivers are required to furnish.**
   b. **At appropriate times and in sufficient quantities in accordance with the needs of the child/youth.**
   c. **Consistent with any applicable requirements.**

3.E. **12.** **Consent for the transportation of a child/youth served to and from any activity away from the day care setting is:**
   a. **Obtained at admission.**
   b. **Approved in writing by a parent or legal representative.**

3.E. 13. In the case of an accident, illness, or injury involving a child/youth, the program:

    a. Connects the child/youth with needed medical attention in a timely manner.

    b. Notifies a parent and/or other legal representative.

3.E. 14. When a child/youth becomes ill and the condition may be infectious, until he or she can be safely removed from the program, he or she is:

    a. Kept as far away as practical from the other children/youths.

    b. Monitored by a staff member for changes in status.

3.E. 15. Current contact information, including telephone numbers, of the following are kept readily available at the day care site:

    a. Parent/legal guardian and backup emergency contact.

    b. All personnel, including substitute personnel.

    c. The poison control contact.

    d. The fire department.

    e. Police department.

    f. Ambulance.

    g. Nearest health facility and/or identified physician.

    h. Child abuse and neglect reporting agency.

3.E. 16. The program records the following information:

    a. The child's/youth's daily attendance, including arrival and departure times.

    b. The arrival and departure times of personnel, including hours spent providing care.

    c. Issues that may have arisen during the child's/youth's stay.

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 regarding acceptance into the program
- Policies regarding late pickup
- Written identification of persons approved to have contact with the child/youth while at the program and who can pick up the child/youth from the program
- Written consents of parents/legal representatives to provide healthcare or first aid, if applicable
- Written approvals from parents/legal representatives to transport a child/youth to and from any activities away from the day care site, if applicable
- Current contact information for parents/emergency contacts; all personnel; poison control; fire department; police department; ambulance; nearest health facility or identified physician; and child abuse/neglect reporting agency
- Documentation of daily attendance of children/youths, including arrival and departure times
- Documentation of the arrival and departure times of personnel, including hours spent providing care
- Documentation of issues that arose during the child's/youth's stay

F. Child/Youth Protection

Description

The primary purpose of child/youth protection programs is to protect the safety and well-being of children/youths as they are entitled to protection from abuse, neglect, and harm or threat of harm. The guiding principles of child/youth protection services include choosing the least intrusive measures while maintaining the child's/youth's safety and well-being; preserving the child's/youth's kinship ties and attachment to the extended family and other persons of importance to the child/youth; involving the family and community in all aspects of services provided, as circumstances allow; and using concurrent planning with all stakeholders.

Services provided by this program reflect the principle that the family, and the family's community, has the primary responsibility for the care, upbringing, and protection of their children/youths. If, with available supports, a family can provide a safe and nurturing environment for a child/youth, these services are provided. If removal of the child/youth is necessary to maintain the child's/youth's safety and well-being, case management focuses on both the child/youth and the family and demonstrates the importance of establishing permanence for the child/youth as soon as possible.

Applicable Standards

An organization seeking accreditation for a child/youth protection program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.F.   **1. The program has policies and procedures that identify:**
   a. **Roles.**
   b. **Responsibilities.**
   c. **Legal requirements.**
   d. **Methods for communication.**

Intent Statements

Policies and procedures identify the roles of the various responsible agencies as well as methods of communication.

3.F.   **2. Competency-based training for the program's personnel includes:**
   a. **How to recognize abuse and neglect.**
   b. **How to respond to a disclosure of abuse and/or neglect from a child/youth.**
   c. **How to report criminal abuse and neglect.**
   d. **How to determine the appropriateness of interventions.**
   e. **How to conduct an investigation, including the roles of all service providers.**
   f. **The rules governing the sharing of information among service providers.**
   g. **The importance of collaboration among all those working with the children/youths and the family.**

Examples

2.b. Including creating immediate safety for the child/youth served.

3.F.   **3. The program demonstrates its proficiency to:**
   a. **Recognize abuse and neglect.**
   b. **Ensure that children/youths are protected throughout the investigation process.**
   c. **Ensure that families are supported throughout the investigation process.**
   d. **Develop a coordinated and collaborative approach for:**
      (1) **Investigating abuse and neglect.**
      (2) **Reporting abuse and neglect.**

Examples

3.a. Includes physical, emotional, and sexual abuse, neglect, and domestic violence.

3.F. 4. A full range of services are designed to address:

   a. Prevention of abuse and neglect through:

     (1) Education.

     (2) Support.

     (3) Structured programs.

   b. The timely and effective response to reports of maltreatment.

   c. Immediate safety of the child/youth served.

   d. Investigation of maltreatment reports.

   e. Case management.

   f. Support services for the child/youth and family designed to, when possible:

     (1) Maintain the child's/youth's connection to his or her family and community.

     (2) Maintain the family unit or reunify the child/youth with the family.

     (3) Meet the needs of the child/youth served in multiple domains.

   g. A range of options for out-of-home care or respite, emergency, or shelter care.

Intent Statements

The range of required services is often identified through legal mandates, legislation, and delegated responsibility.

Examples

4.f.(3) May include housing and education.

3.F. 5. The program's personnel:

   a. Determine whether the child/youth needs protective services.

   b. Contact law enforcement or other identified authority when required.

   c. Coordinate a response with other agencies when necessary.

   d. Coordinate a response with the community, when applicable.

3.F. 6. The program receives and responds to reports of alleged maltreatment on a 24-hour-a-day, 7-day-a-week basis.

Intent Statements

This may involve other after-hours emergency response phone systems, but the program must be able to respond at all hours.

3.F. 7. The program has a written procedure for access to qualified professionals 24 hours a day, 7 days a week.

3.F. 8. The program has on-call availability of supervisory personnel to respond to urgent situations 24 hours a day, 7 days a week.

3.F. 9. Initial reports of potential abuse or neglect include the following information:

   a. The reporting individual's:

     (1) Name (unless the reporter chooses to remain anonymous).

     (2) Contact information.

     (3) Relationship to the child/youth.

   b. Immediate concerns regarding the child's/youth's safety.

   c. The child's/youth's:

     (1) Name.

     (2) Address.

     (3) Age.

     (4) Current location.

   d. Name and address of the alleged perpetrator or other identifying information.

   e. When and where the alleged incident took place, if disclosed or observed.

   f. A description of indicators leading the reporter to believe the child/youth is in need of protective services.

   g. Any additional concerns about the child's/youth's safety.

3.F. 10. Information collected is used to develop an immediate response or safety plan.

3.F. 11. Any disclosure made by a child/youth to health professionals or personnel is recorded in the child's/youth's own words.

Examples

When possible, video recording may be used to reduce the need for the child/youth to appear in court.

3.F. 12. When applicable, the investigation report includes information on any identified special needs of the child/youth served.

Examples

Special needs of the child/youth may include medication regimes, allergies, or a fear of dogs.

3.F. 13. If the child/youth has a developmental delay, mental disability, speech impairment, or other communication need, a professional with expertise in the identified need is consulted or engaged to assist with the interview.

3.F. 14. Applicable authorities coordinate investigations to avoid subjecting the child/youth to repeated interviews.

3.F. 15. The program arranges for a medical examination when:
   a. Physical injuries are observed.
   b. Sexual abuse is suspected.
   c. It is otherwise believed that a medical examination is appropriate.

3.F. 16. When reports of parent/legal guardian or other caregiver abuse determine a child/youth is in need of protective services:
   a. Steps to protect the child/youth are identified as a priority.
   b. Other children/youths living in the home are interviewed to determine whether they are in need of protective services.

Intent Statements

The intent of this standard is to ensure that when children/youths living with a parent/legal guardian or other caregiver appear to be abused or neglected, immediate action is taken remove them from the home and place them in protective custody. Typically this is a legal process.

3.F. 17. To determine whether a child/youth is in need of protective services, other applicable resources are contacted.

Examples

Other applicable resources may include school staff, day care operators, extended family and friends, other social service agencies, physicians, counselors, public health officials, hospital staff, police officers, or corrections officers.

3.F. 18. Removal of a child/youth served from his or her home is not based solely on:
   a. Homelessness.
   b. Poverty.
   c. Minority status.

3.F. 19. When investigating a report on an indigenous child/youth, the child's/youth's identified community is contacted.

Intent Statements

Programs in the United States must meet the requirements of the Indian Child Welfare Act.

🍁 In Canada, in off-reserve situations, an indigenous designate is contacted with the parent's/legal guardian's consent.

3.F. 20. When possible, program personnel contact the person who filed the report to provide follow-up information.

Intent Statements

The program follows up with the person who made the report, as appropriate, to let them know that there has been a response to their concern and to gather any additional information.

3.F. 21. The program has procedures to respond to all instances of reported maltreatment:
a. Within an appropriate time period:
    (1) According to all applicable legal and regulatory requirements.
    (2) In consideration of safety issues.
b. Using standardized assessment.
c. Soliciting and considering the view of the child/youth.
d. Resulting in implementation of an immediate safety plan.

3.F. 22. Caseloads are maintained that allow for services to ensure:
a. Safety of the children/youths served.
b. Protection of the children/youths served.
c. A timely response.
d. That all legal requirements and regulations are met.
e. That, when not stipulated by legislation, regulations, or laws, type and frequency of contact is determined by the needs of the families and risk to the children/youths served.

3.F. 23. There is an adequate number of supervisory personnel to provide for:
a. Required decision making.
b. Support of direct service personnel.
c. Case and clinical supervision.

3.F. 24. The program implements policies and procedures for investigating reports of maltreatment that include assessments of:
a. The child/youth's:
    (1) Strengths.
    (2) Abilities.
    (3) Community connections.
    (4) Culture.
    (5) Spirituality.
b. The family's:
    (1) Strengths.
    (2) Abilities.
    (3) Community connections.
    (4) Culture.
    (5) Spirituality.

3.F. 25. The least intrusive measures that ensure the safety and well-being of the child/youth and family members served are considered.

3.F. 26. Case management includes:
a. Integrated case planning as characterized by:
    (1) Services that are:
        (a) Child/youth centered.
        (b) Family centered.
        (c) Collaborative.
        (d) Solution oriented.
        (e) Inclusive of all stakeholders involved.
    (2) Service providers who are in communication.
    (3) A plan that is developed and monitored.
    (4) Collaboration and education of any potential partners providing care to the child/youth and family.

b. **For the family served:**
   (1) **Voluntary collaborative relationships encouraged by service providers.**
   (2) **Open and active communication between the service provider and the family.**
c. **For the children/youths served:**
   (1) **Immediate planning for continuity of life-long relationships.**
   (2) **Involvement of:**
      (a) **Family members.**
      (b) **Community stakeholders.**

Examples

26.c.(1) Life-long relationship planning includes concurrent planning. Concurrent planning allows for the contingency that if the family reunification plan falters or takes a great deal of time, the child/youth has his or her life-long relationships maintained.

26.c.(2)(b) Community stakeholders could include indigenous elders or others identified by the child/youth.

3.F. **27. Policy and procedures govern case closure under each of these circumstances:**
   a. **The family remains intact.**
   b. **The family is reunited.**
   c. **Placement is made in family setting, such as kinship care.**
   d. **Adoption.**
   e. **Transition to adulthood.**

3.F. **28. A policy is implemented concerning parental rights, roles, and responsibilities that includes:**
   a. **Familiarizing parents of their rights.**
   b. **An opportunity for parents to plan for their child/youth, including planning for placement in out-of-home care.**
   c. **Opportunities to interact with their child/youth.**

3.F. **29. The program educates community members and other stakeholders concerning maltreatment issues and 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.

■ Policies that identify roles, responsibilities, legal requirements, and methods of communication
■ Written procedure for access to qualified professionals 24 hours a day, 7 days a week
■ Initial and investigation reports of alleged abuse or neglect
■ Safety plans, if applicable, in instances of reported abuse, neglect, or maltreatment
■ Documentation of any disclosure made by children/youths in their own words
■ Documentation of any special needs of the child/youth in the investigation report, if applicable
■ Policies and procedures for investigating reports of maltreatment which include assessing the child and family
■ A case management plan that is developed and monitored
■ Policies governing case closure
■ Policy concerning parental rights, roles, and responsibilities
■ Individual plans for the persons served
■ Records of persons served

G. Community Housing and Shelters

Description

Community housing or shelters address the desires, goals, strengths, abilities, needs, health, safety, and life span issues of the persons served, regardless of the type of housing 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 or shelters are provided in partnership with individuals and may include housing for family members as well as the child/youth served. These services are designed to assist the persons served to achieve success in and satisfaction with community living. These programs may provide reunification services with the child/youth served and his or her family. 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 or shelter programs may be referred to as runaway or youth shelters, domestic violence or homeless shelters, safe houses, youth intensive stabilization homes, intake shelters, supervised independent living, maternity homes, halfway houses, or recovery homes. These programs may be located in rural or urban settings and in houses, apartments, townhouses, congregate or other residential facilities. 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:

- Temporary shelters or emergency residences.
- Transitional living that provides interim supports and services for youth aging out of child welfare services, persons who are at risk of institutional placement, persons transitioning from institutional settings, or persons who are homeless.
- 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 and shelters program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.G. **1. The program provides the following community living components:**
   a. **Regular meetings between the person served and staff.**
   b. **Opportunities to participate in typical home activities.**
   c. **Appropriate linkage when the following healthcare needs of the person served are identified:**
      (1) **Physical health.**
      (2) **Mental/behavioral health.**
      (3) **Addictions.**
   d. **A personalized setting.**
   e. **Daily access to nutritious:**
      (1) **Meals.**
      (2) **Snacks.**

f. **The opportunity for expression of choice by the person served as to room and housemates.**

g. **Based on the needs and choices of the person served, opportunities to access:**
   (1) **Community activities.**
   (2) **Cultural activities.**
   (3) **Social activities.**
   (4) **Recreational activities.**
   (5) **Spiritual activities.**
   (6) **Employment/income generating activities.**
   (7) **Educational activities.**
   (8) **Necessary transportation.**
   (9) **Self-help groups.**
   (10) **Legal services.**
   (11) **Life skills development activities.**
   (12) **Other activities or resources, as appropriate.**

h. **Policies related to:**
   (1) **Visitors or guests.**
   (2) **Pets.**

Intent Statements

1.b. The program encourages each person served to take increasing responsibility for cooperative operation of the household.

1.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 person's well-being including consideration of his or her gender, gender identity, age, and developmental level. Whenever possible, each person has the choice of a private room or the opportunity to participate in the selection of roommates.

Examples

1.a. 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.
- Expectations and responsibilities.

1.b. Activities may include food preparation and performance of daily household duties.

1.c.(3) Addictions is an inclusive term that may include drugs, alcohol, nicotine, food, sex, gambling, internet, or other addictions.

1.e. Meals and snacks would consist of a variety that reflects the tastes, dietary concerns, and cultural preferences of the persons served.

1.g.(9) Activities could include meetings of 12-step and other self-help groups.

1.g.(11) May include activities to develop skills in areas such as money management, personal safety, or interpersonal relationships.

3.G. **2. When applicable, policies and written procedures address the special security procedures and confidentiality needs of the shelter and the persons served.**

Examples

Based on the type of program security and confidentiality, policies and written procedures may include:

- What information is made public, such as the location.
- Rules regarding:
  - Visitors.
  - Guests.
  - Pets.
  - Allowed personal items.
  - Contraband.

3.G. **3. Safety needs of the 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.**
   e. **Domestic violence.**
   f. **Self-care skills.**

Examples

3.e. Domestic violence may include a variety of relationships including spousal abuse, intimate partner abuse, and family violence. Domestic

violence is not limited to physical and emotional abuse.

3.G. **4. An individualized service plan is developed for each person served that:**

   a. Includes his or her input.

   b. Is based on the person's:

   (1) Strengths.

   (2) Needs.

   (3) Abilities.

   (4) Preferences.

   (5) Desired outcomes.

   (6) Cultural background.

   (7) Spiritual needs.

   (8) Other issues, as identified.

   c. Identifies:

   (1) Overall goals.

   (2) Methods/techniques to be used to achieve the goals.

   (3) Those responsible for implementation.

   d. When applicable, addresses:

   (1) Identified safety risks.

   (2) Identified health risks.

   e. Is reviewed at least quarterly with respect to:

   (1) Plan of services.

   (2) Goals.

   (3) Progress toward goals.

   f. 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.

   (4) Based on the changing preferences of the person served.

Intent Statements

The program includes the persons served as active participants giving direction in all aspects of the planning and revision processes. Plans are highly individualized, reflecting the diversity of the persons served.

Reasonable efforts and accommodations are made to obtain the active participation and understanding of the child/youth served, including the inclusion of an advocate or family member if the child/youth served prefers or if it is necessary to interpret the child's/youth's desires.

4.e. The program establishes a quarterly review schedule for the individualized service plan. The plan focuses on goals 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 personnel are hired.

The program may use self-assessments and/or person-centered planning to obtain this information. Individualized service 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-centered outcomes.

Examples

4.a. Staff notes and progress reviews may indicate involvement of the person served. A good practice is to write the individualized plans using "I" language and to quote the person in his or her plan.

3.G. **5. The following information is used in the development of the individualized service plan for each person served:**

   a. Relevant medical history.

   b. Relevant psychological information.

   c. Relevant school or academic records.

   d. Relevant social information.

   e. Information on current direct services and supports.

   f. Information on previous direct services and supports.

   g. Other issues, as necessary.

Intent Statements

This standard does not require that each person served have a physical or psychological evaluation. The program has a procedure in place to determine relevancy of the individualized plan

based on the person's situation and the services provided by the program. The individualized plans of the persons served demonstrate that this information has been considered in development of the plans.

3.G. **6. When possible, the person served has options to make changes in his or her living arrangements:**

  a. **At his or her request.**
  b. **At the request of his or her family, when applicable.**
  c. **In transitional living, on a periodic basis when initiated by the program.**
  d. **Based on informed choice.**

3.G. **7. 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.**

3.G. **8. Each person served is provided, as applicable:**

  a. **Skill development necessary to live as independently as possible.**
  b. **Educational and/or vocational programming.**
  c. **Ongoing support/services as he or she explores changes in his or her living arrangements.**
  d. **Skill development to ensure personal safety is maintained.**

Examples

8.d. The person served is aware of who to contact and what to do in situations where his or her safety may be compromised.

3.G. **9. Personnel coverage is based on the ages and needs of the persons served.**

3.G. **10. There is a system for the on-call availability of designated personnel 24 hours a day, 7 days a week.**

3.G. **11. Provisions are made to address needs for:**

  a. **Cultural activities.**
  b. **Spiritual activities.**
  c. **Quiet areas.**
  d. **Areas for visits.**
  e. **Other issues as identified by the person served.**

Intent Statements

When housing or sleeping areas are shared by two or more individuals, the program actively addresses the need to designate space for privacy and individual interests.

3.G. **12. The program assists the persons served to identify and utilize available modes of transportation, as appropriate.**

Intent Statements

When transportation cannot be accessed independently by the person served, the program coordinates transportation to other relevant services and activities.

3.G. **13. The program demonstrates efforts to maintain a person's residence as long as possible during temporary health, 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.

- Policies related to visitors or guests
- Policies related to pets
- Policies and written procedures that address the special security procedures and confidentiality needs of the shelter and the persons served, when applicable
- Individual plans for the persons served
- Records of persons served

H. Community Transition

Description

Community transition programs provide services that focus on the identified preferences, goals, and needs of youths transitioning from service systems designed for children and adolescents to adulthood. The program utilizes a collaborative approach to person-centered planning and decision making that includes the persons served and, in accordance with the preferences of the persons served, members of their families/support systems.

Recognizing that many of the persons served have experienced traumatic events that have impacted their relationships, the program emphasizes the importance of developing and maintaining healthy relationships of all types for successful transition to adulthood. The development of services and supports for each person is guided by an inventory of skills and interests and identification of the goals and priorities of and life skills needed by the person for successful transition to adulthood. Persons served are involved in the assessment of risks and consequences related to various behaviors in which they may choose to engage.

Community transition programs provide the persons served with opportunities to explore and understand how their lives will change as recognized adults in areas including, but not limited to, access to service systems and funding; living options; and educational, social, and vocational opportunities.

Community transition programs may be facility- or community-based and offered in outpatient or residential settings. The programs may be comprehensive in scope and provide a wide range of services or specialize in a single or multiple areas of services such as independent living and/or vocational skills.

Applicable Standards

An organization seeking accreditation for a community transition program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.H. **1. The program demonstrates on an ongoing basis meaningful youth involvement in:**
   a. **Program design.**
   b. **Identification of community resources.**
   c. **Development of community resources that expand:**
      (1) **The variety of community life experiences.**
      (2) **Opportunities for community access.**
      (3) **Opportunities for community inclusion.**

Intent Statements

The program is able to provide examples of how youth have influenced the development of services and/or changes that have been made based on youth input, e.g., modifications to community resources used or locations where services are provided.

3.H. **2. The program models healthy relationships:**
   a. **Between personnel and:**
      (1) **Persons served.**
      (2) **Families/support systems.**
      (3) **Other personnel.**
      (4) **Other stakeholders.**
   b. **Through all phases of a relationship including:**
      (1) **Developing a relationship.**
      (2) **Maintaining a relationship.**
      (3) **Ending a relationship.**
   c. **Of various types, including:**
      (1) **Acquaintances.**
      (2) **Families/support systems.**
      (3) **Peers.**
      (4) **Coworkers.**
      (5) **Service system personnel.**

Intent Statements

The youth who participate in community transition programs have often had limited or unhealthy relationship experiences. Program personnel set an example for the persons served through their modeling of healthy relationships of various types and through all phases of a relationship.

Examples

2.b. Healthy conflict and conflict resolution may be addressed throughout the phases of a relationship.

2.c. Various types of relationships have different boundaries and roles, and learning about these differences is essential to the ability of the youth to develop appropriate relationships of all types.

2.c.(3) There is recognition that some peer relationships may develop into intimate and/or sexual relationships.

3.H. **3. The program:**
   a. **Seeks the input of persons served on personnel training topics.**
   b. **Includes the following topics in its assessment of competency and competency-based training:**
      (1) **The effects of trauma on relationships, including:**
         (a) **Attachment.**
         (b) **Loss and grieving.**
         (c) **Trust.**
      (2) **Adolescent/young adult development, including typical and atypical:**
         (a) **Physiological development.**
         (b) **Brain development.**
         (c) **Emotional development.**
      (3) **Knowledge of current community resources.**

(4) **Best/promising practices focused on youth transitioning to adulthood.**

(5) **Substance use and abuse issues.**

(6) **Mental health issues.**

(7) **Advocacy.**

(8) **Young person culture.**

(9) **Relevant legal issues and court procedures.**

(10) **Life skills applicable to youth transitioning to adulthood.**

   c. **Provides opportunities, as appropriate, for persons served or program alumni to co-facilitate the training provided.**

Intent Statements

3.a. The program demonstrates how it seeks the input of persons served, understanding that each person chooses whether or not to contribute.

Examples

3.b.(1) Training on the effects of trauma on relationships may consider the importance of learning to develop long-term and lasting connections.

3.b.(2)(a) Physiological development addresses all aspects of physical development including sexual development and emerging and increasing sexual drive.

3.b.(2)(b) Training on brain development addresses the emerging research on how the adolescent brain develops and functions differently than the adult brain and therefore how interventions should be customized.

3.b.(3) Community resources could include resources for financial assistance, shelters, soup kitchens, spiritual centers, free health clinics, recreational programs, and vocational training.

3.b.(8) Training on young person culture might address use of social media and technology, including protection of privacy, and bullying.

3.b.(9) Relevant legal issues could include legal care and custody, probation, or legal charges.

3.c. The persons served are made aware of opportunities to participate in training of program personnel during orientation to the program.

Program personnel could encourage the participation of a person served should an opportunity arise in which the person identifies how services could be better or comments on how youth are misunderstood.

Resources

3.b.(4) Resources for best/promising practices include:

■ **www.childwelfare.gov/outofhome/ independent/practices.cfm**

■ **www.findyouthinfo.gov/youth-topics/ transition-age-youth**

■ **www.hunter.cuny.edu/socwork/nrcfpp/ pass/about-us/six_core_perspectives.htm**

■ **www.dshs.wa.gov/pdf/dbhr/mhtg/ Introduction.pdf**

■ **http://tipstars.org/Home.aspx**

3.H. **4.** **To be successful and valued in the community, persons served have opportunities to develop:**

   a. **Life skills.**

   b. **Knowledge.**

   c. **Experiences.**

   d. **A network of supports needed to sustain their well-being upon transition to the community, including:**

      (1) **Family.**

      (2) **Social.**

      (3) **Community.**

Intent Statements

There are opportunities for growth and development of the persons served.

Quality of life is specific to and defined by each person served. Skills and supports to enhance quality of life are determined and their effectiveness reported. When maintenance of skills is the primary goal, alternative service strategies may help to provide a variety of interesting experiences over time.

Examples

4.a. Opportunities to acquire life skills may include tangible skills such as job hunting, cooking, cleaning, and budgeting, as well as intangible skills such as decision making,

communication, and developing and maintaining relationships.

4.b. Knowledge acquisition could be both formal through educational settings, vocational training, or technical schools and nonformal through reading, listening, and participating in activities.

4.d. Support opportunities may include clean and sober social events; group events such as foster youth activities, peer mediator groups, church youth groups, Al-Anon, and YouthMove; and online support groups such as the National Alliance on Mental Illness Child and Adolescent Action Center (**www.nami.org/ Template.cfm?Section=Child_and_Teen_ Support&template=/Security/Login.cfm**).

3.H. **5.** **The program provides or arranges opportunities for the persons served to enhance their advocacy and leadership skills through:**
   a. **Training for:**
      (1) **Advocacy skills.**
      (2) **Leadership.**
   b. **Support for systems advocacy activities.**
   c. **Support for self-advocacy activities.**
   d. **Linkage with self-advocacy organizations.**
   e. **Other appropriate means, if applicable.**

Examples

The program may provide leadership and advocacy training activities to the person served or arrange for leadership and advocacy opportunities in the community such as participation in community councils or activities sponsored by advocacy groups.

3.H. **6.** **On an ongoing basis, the persons served are provided with understandable information about the service systems in which they participate that allows them to:**
   a. **Navigate those service systems.**
   b. **Make informed choices in accordance with their preferences and goals.**

Examples

Persons served who have a history of being charged with a crime are provided information they can understand about potential consequences should they be charged again, including the differences between the juvenile justice and adult court systems, what probation is and how this could affect their lives, how they could respond to persons or job applications that ask about their history, and who to contact for assistance should they be faced with these or similar circumstances.

3.H. **7.** **On an ongoing basis, the program:**
   a. **Assesses the potential risks to the person's health or safety in the community.**
   b. **Educates persons served regarding the consequences associated with choices to accept or reject such risks.**
   c. **Facilitates discussions for decision making.**
   d. **In partnership with the person served, identifies:**
      (1) **Actions to be taken to minimize risks.**
      (2) **Individuals responsible for those actions.**
   e. **Documents the discussions and decisions made by the person served.**

Intent Statements

In recognition of the changing lifestyles and choices of the person served and the wide variety of opportunities for community inclusion and access, the program encourages the person served and his or her family, as appropriate, to explore fully any risks inherent in their choices in terms of health, safety, lifestyle, sexuality, etc. Risks are considered to be exposure to a predictable event or environment that could result in serious physical or psychological injury to the individual.

While the program's risk assessment may reveal opportunities for education and discussion, it is recognized that the decision to modify behaviors or circumstances to reduce risk and improve health and safety is up to the person served

unless the individual is at imminent risk of harm. In this case the program is required to act accordingly, following its own policies and procedures.

Examples

Examples of potential risks to a person's health might include a person who is prescribed medication that includes precautions due to drowsiness continuing to ride his bike and/or drive his car instead of using alternate transportation.

Examples of potential risks to a person's safety might include a person who lives independently but does not know how to contact appropriate emergency personnel if needed or a person at a job that requires him or her to wait for public transportation in a high crime neighborhood after dark.

Other health and safety risks could include driving and texting, unprotected sex, or use of tobacco products.

3.H. **8.** **To facilitate person-centered planning that focuses on the mastery of life skills, the assessment of each person served includes an inventory of:**
   a. **Skills.**
   b. **Interests.**

Intent Statements

The program individualizes the planning for life skills services and training based on the assessment of each person's skills and interests rather than a uniform curriculum. Administering a skills and interests inventory allows the program to develop an individualized training curriculum so each person served can work toward mastering the life skills he or she is most interested in and can benefit from

3.H. **9.** **Individual service plans:**
   a. **Describe opportunities to participate in the community, as desired by the person served.**
   b. **Specify the manner in which the person served will participate in the community.**

Intent Statements

Identifying opportunities for community inclusion is a joint responsibility shared by the program and the persons served. Overcoming identified barriers may be beyond the program's service delivery capability but could be addressed by referrals to other community agencies, organizations, and resources.

Examples

9.b. Participating in the community could include attending community meetings; participating in neighborhood watch campaigns; and volunteering in community events such as relay for life, blood drives, heart walks and other health-related campaigns, and community clean-up activities.

3.H. **10.** **The persons served progress toward:**
   a. **Optimal use of:**
      (1) **Natural supports.**
      (2) **Self-help.**
   b. **Greater self-sufficiency.**
   c. **Greater control of their lives.**
   d. **Increased participation in the community.**

Examples

10.b. Self-sufficiency includes development of self-reliance but also recognizes the value of interdependent relationships and connections.

10.d. Participation in the community includes ways for youth to be actively engaged with others in the local environment. Youth identify how this occurs and what activities are meaningful to them. This may include volunteering in community projects such as clean-ups; voting; volunteering at community organizations such as a library, hospital, or pet shelter; and participating in organized or informal sports.

3.H. **11.** **When appropriate, current information on educational, vocational, or local employment opportunities is:**
   a. **Shared with the persons served.**
   b. **Used in developing services.**

Intent Statements

The program's focus on assisting young persons to transition to adulthood includes assisting them to identify options for furthering their education, learning specific technical skills for a career, or seeking employment.

3.H. 12. Based on the needs and desires of the person served, support is offered in the following areas:

   a. **Healthy lifestyles.**
   b. **Physical health and well-being.**
   c. **Mental health and well-being.**
   d. **Personal care.**
   e. **Education.**
   f. **Employment.**
   g. **Home maintenance.**
   h. **His or her role as a tenant, when applicable.**
   i. **Effective decision making.**
   j. **Family contact, if desired.**
   k. **Social life and friendships/ relationships.**
   l. **Community membership and social networks.**
   m. **Financial assistance and planning.**
   n. **Sexuality and reproductive health.**
   o. **Other identified needs.**

Examples

12.b. This may include assistance with daily needs such as personal hygiene, laundry, shopping, and meal preparation.

12.f. This may include assistance with job searches and job applications both online and in person.

12.g. Basic home upkeep and repair are addressed as well as when it may be necessary to call the landlord or seek professional assistance such as a plumber or electrician.

12.m. Financial assistance and planning are age appropriate and could include talking about banking, use of credit cards, and budgeting.

12.n. Birth control, prevention of sexually transmitted diseases, routine care, and symptoms that may require a visit to a healthcare provider are addressed.

12.o. Other identified needs could include transportation, including maintaining a vehicle or learning to navigate public transportation.

3.H. 13. Persons served are provided with 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. **Education and training activities.**
   h. **Volunteer and community service activities.**
   i. **Transportation, when necessary.**
   j. **Other activities as desired and appropriate.**

Examples

13.j. Other activities could include accessing substance use or mental health services or child care.

3.H. 14. A system is in place to provide access to on-call personnel 24 hours a day, 7 days a week.

Intent Statements

The extent of service support is determined by the needs of the person served and based on the program plans, local definitions, and regulations.

3.H. 15. Based on the needs and choices of the person served, assistance is offered in securing or maintaining housing that is:

   a. **Safe.**
   b. **Affordable.**
   c. **Accessible.**

Applicable Standards

Standards 16. and 17. apply when the program includes a residential component; e.g., transitional living apartments, supported living programs, group homes, residential centers, or shelters.

3.H. **16.** **In-home safety needs of the persons served are addressed with respect to:**

    a. **Environmental risks.**

    b. **Abuse or neglect inflicted by self or others.**

    c. **Personal safety skills.**

    d. **Medication management.**

Examples

16.a. Environmental risks might include health and safety issues related to food preparation and safe storage, the need to lock doors and windows, or the need to be cautious if there is snow or ice on the property.

3.H. **17.** **To the extent possible, persons served have input into:**

    a. **Where they live.**

    b. **With whom they live.**

3.H. **18.** **For all persons who leave services, a written discharge summary is prepared that includes:**

    a. **Date of admission.**

    b. **Reason for admission.**

    c. **Services provided.**

    d. **Extent to which established goals were achieved.**

    e. **Reasons for discharge.**

    f. **Status of the person at last contact.**

    g. **Recommendations for services or supports.**

    h. **Date of discharge from the 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.

- Records of the persons served
- Discharge summaries for the persons served
- Written information provided to persons served
- Personnel training curriculum

I. Community Youth Development

Description

Community youth development programs are designed to help persons served 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. The setting may be informal to reduce barriers between staff members and program participants and may include a drop-in center, an activity center, a day program, or a leisure or recreational setting.

Community youth development programs provide opportunities for persons served to participate in the community. The program 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, including:

- Leisure or recreational activities.
- Communication activities.
- Spiritual activities.
- Cultural activities.
- Sports.
- Vocational pursuits.
- Development of work attitudes.
- Employment activities.
- Volunteerism.
- Educational and training activities.
- Development of living skills.
- Health and wellness promotion.
- Socialization.
- Orientation, mobility, and destination training.
- Access and utilization of public transportation.
- Financial assistance and planning.

Applicable Standards

An organization seeking accreditation for a community youth development program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.I. **1. The program models healthy relationships:**

    a. **Between personnel and:**
        (1) **Persons served.**
        (2) **Families/support systems.**
        (3) **Other personnel.**
        (4) **Other stakeholders.**

    b. **Through all phases of a relationship including:**
        (1) **Developing a relationship.**
        (2) **Maintaining a relationship.**
        (3) **Ending a relationship.**

    c. **Of various types, including:**
        (1) **Acquaintances.**
        (2) **Families/support systems.**
        (3) **Peers.**
        (4) **Coworkers.**
        (5) **Service system personnel.**

Intent Statements

The youth who participate in community youth development programs have often had limited or unhealthy relationship experiences. Program personnel set an example for the persons served through their modeling of healthy relationships of various types and through all phases of a relationship.

Examples

1.b. Healthy conflict and conflict resolution may be addressed throughout the phases of a relationship.

1.c. Various types of relationships have different boundaries and roles, and learning about these differences is essential to the ability of the youth to develop appropriate relationships of all types.

1.c.(3) There is recognition that some peer relationships may develop into intimate and/or sexual relationships.

3.I. **2. On an ongoing basis, the program:**

a. **Assesses the potential risks to the person's health or safety in the community.**

b. **Educates persons served regarding the consequences associated with choices to accept or reject such risks.**

c. **Facilitates discussions for decision making.**

d. **In partnership with the person served, identifies:**

(1) **Actions to be taken to minimize risks.**

(2) **Individuals responsible for those actions.**

e. **Documents the discussions and decisions made by the person served.**

Intent Statements

In recognition of the changing lifestyles and choices of the person served and the wide variety of opportunities for community inclusion and access, the program encourages the person served and his or her family, as appropriate, to explore fully any risks inherent in their choices in terms of health, safety, lifestyle, sexuality, etc. Risks are considered to be exposure to a predictable event or environment that could result in serious physical or psychological injury to the individual.

While the program's risk assessment may reveal opportunities for education and discussion, it is recognized that the decision to modify behaviors or circumstances to reduce risk and improve health and safety is up to the person served unless the individual is at imminent risk of harm. In this case the program is required to act accordingly, following its own policies and procedures.

Examples

Examples of potential risks to a person's health might include a person who is prescribed medication that includes precautions due to drowsiness continuing to ride his bike and/or drive his car instead of using alternate transportation.

Examples of potential risks to a person's safety might include a person who lives independently but does not know how to contact appropriate emergency personnel if needed or a person at a job that requires him or her to wait for public transportation in a high crime neighborhood after dark.

Other health and safety risks could include driving and texting, unprotected sex, or use of tobacco products.

3.I. **3. Services and activities are organized around:**

a. **The identified preferences of the persons served.**

b. **The identified needs of the persons served.**

c. **Improving the ability of the persons served to understand their needs.**

d. **Assisting the persons served to achieve their stated goals in the following areas:**

(1) **Community living skills development.**

(2) **Self-worth.**

(3) **Interpersonal relations.**

(4) **Recreation or use of leisure time opportunities.**

(5) **Vocational development or employment.**

(6) **Educational development.**

(7) **Self-advocacy.**

(8) **Social resources.**

(9) **Health and wellness.**

3.I. **4. A written agreement for participation:**

a. **Is developed with the input of the person served.**

b. **Identifies:**

(1) **Expectations of the program.**

(2) **Goals for the person served.**

c. When applicable, addresses identified:
  (1) **Health risks.**
  (2) **Safety risks.**
d. Is communicated in a manner that is understandable to the:
  (1) **Person served.**
  (2) **Individuals responsible for implementing the agreement.**
e. 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.**

Intent Statements

The written agreement is similar to an individualized service plan in that the person served is actively involved and has a significant role in developing and determining the direction of the agreement.

3.I. **5. The persons served progress toward:**
  a. Optimal use of:
    (1) **Natural supports.**
    (2) **Self-help.**
  b. Greater self-sufficiency.
  c. Greater control of their lives.
  d. Increased participation in the community.

Examples

5.b. Self-sufficiency includes development of self-reliance but also recognizes the value of interdependent relationships and connections.

5.d. Participation in the community includes ways for youth to be actively engaged with others in the local environment. Youth identify how this occurs and what activities are meaningful to them. This may include volunteering in community projects such as clean-ups; voting; volunteering at community organizations such as a library, hospital, or pet shelter; and participating in organized or informal sports.

3.I. **6. If work is performed by the persons served, legal wage guidelines are followed.**

3.I. **7. The program provides information or referrals as needed to assist persons served in securing assistance to meet their basic needs.**

Intent Statements

The program strives to create linkages for the persons served with the community resources that will support them and meet their needs.

Examples

Information can be provided in multiple ways including written and oral. Assistance may include any of the following, based on the needs of the person served:

- Income maintenance.
- Benefits.
- Education and training opportunities.
- Food, clothing, and household goods.
- Short-term or emergency shelter.
- Housing subsidies, including long-term housing.
- Medical and dental care.
- Information on the impact of employment on securing and accessing future benefits.
- Transportation.
- Other community supports.

Other relevant services may include therapy, testing, medication management, crisis intervention, and psychiatric assessment.

3.I. **8. The program provides or arranges opportunities for the persons served to enhance their advocacy and leadership skills through:**
  a. Training for:
    (1) **Advocacy skills.**
    (2) **Leadership.**
  b. Support for systems advocacy activities.

c. Support for self-advocacy activities.

d. Linkage with self-advocacy organizations.

e. Other appropriate means, if applicable.

Examples

The program may provide leadership and advocacy training activities to the person served or arrange for leadership and advocacy opportunities in the community such as participation in community councils or activities sponsored by advocacy groups.

3.I. **9. For all persons who leave services, a written discharge summary is prepared that includes:**

a. Date of admission.

b. Reason for admission.

c. Services provided.

d. Extent to which established goals were achieved.

e. Reasons for discharge.

f. Status of the person at last contact.

g. Recommendations for services or supports.

h. Date of discharge from the 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.

■ Written agreements for participation

■ Progress notes

■ Discharge summaries for persons served

■ Records of persons served

J. Congregate Care

Description

Congregate care programs provide shelter, safety, and support outside of their natural homes or placements to children/youths for whom there are documented reports of maltreatment, abandonment, absence without leave, or other identified needs or who are unable to live with their parents or alternative family. Placement is usually made when smaller more typical home-like settings are unavailable. Although ideally the placement is time limited, longer term placements may be necessary or occur as a youth transitions to independent adulthood. In all situations, integration into the community to the greatest degree possible is achieved.

Applicable Standards

An organization seeking accreditation for a congregate care program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.J. **1. On-site staffing is adequate, based on the needs of the child/youth served.**

Intent Statements

Staffing sufficiency includes on-site, plans for backup in case of emergency and planned absences, and the variety of disciplines necessary to meet the needs of the children/youths served.

3.J. **2. Based on the needs of the child/youth served, services are provided by a coordinated team that:**

a. Includes, at a minimum, the following professionals:

(1) Assigned residential staff members or a plan coordinator.

(2) A qualified practitioner.

(3) Providers of appropriate medical support services.

b. Meets weekly.

Intent Statements

Because congregate care programs serve children/youths with varying needs, the specific qualifications and credentials of staff members are determined based on the specific needs of the child/youth served and the structure of the program.

2.a.(2) See the Glossary for the definition of *qualified practitioner*.

3.J.   **3.** **Personnel receive competency-based training to meet the identified needs of the child/youth served that covers:**

   a. **Attachment theory, including grief and loss.**
   b. **Child growth and development.**
   c. **Behavior management skills.**
   d. **Learning deficits.**
   e. **Social and emotional needs.**
   f. **Cultural competency.**
   g. **The effects of placement on children.**
   h. **Health and nutrition.**
   i. **Applicable legal issues.**
   j. **Methods of communication.**
   k. **Other specific needs.**

Examples

3.b. Including readiness to learn, brain development, and cognitive development.

3.c. Including management of violent or aggressive behavior and sexual behavior among residents.

3.i. Additional needs could include issues specific issues to the child served such as medical or physical needs or the use of assistive technology.

3.J.   **4.** **The program provides the following community living components:**

   a. **A written daily schedule of activities.**
   b. **Regular meetings between the child/youth 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. **Individual possessions and decorations.**
   h. **Daily access to nutritious meals and snacks.**
   i. **Opportunity for unstructured private time.**

Intent Statements

4.a. A written daily schedule would describe the activities offered.

4.c. The program encourages each child/youth served to take increasing responsibility for cooperative operation of the household.

4.f. This standard may not be possible, and therefore not applicable in correctional settings.

4.g. The program encourages and allows children/youths served to have and display their own personal possessions and decorations. These items are consistent with the personal choices and needs of the child/youth served, except for items contraindicated by their individual plans.

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 age-appropriate preparation of food and the performance of routine household duties.

3.J.   **5.** **Provisions are made to address the need for:**

   a. **Cultural and/or spiritual activities.**
   b. **Quiet areas.**
   c. **Areas for visits.**

3.J.   **6.** **The program provides or ensures the provision of:**

   a. **Medical services.**
   b. **Pharmaceutical services.**

3.J. **7.** **The program provides healthcare only:**

   a. **With written consent of the parent or legal representative, when applicable.**

   b. **If the healthcare to be provided is first aid.**

3.J. **8.** **In the case of an accident, illness, or injury involving a child/youth, the program:**

   a. **Connects the child/youth with needed medical attention in a timely manner.**

   b. **Notifies a parent and/or other legal representative.**

   c. **Notifies community care providers, as appropriate.**

Examples

8.c. Notifications may include a case manager, case worker, or therapist.

3.J. **9.** **When a child/youth served becomes ill and the condition may be infectious, until he or she can be safely removed from the program, he or she is:**

   a. **Kept as far away as practical from the other children/youths served.**

   b. **Monitored by a staff member for changes in status.**

3.J. **10.** **An individualized service plan is developed for each child/youth served that:**

   a. **Includes his or her input, when possible.**

   b. **Identifies:**

      (1) **Overall goals.**

      (2) **Methods/techniques to be used to achieve the goals.**

      (3) **Those responsible for implementation.**

   c. **When applicable, addresses:**

      (1) **Identified health risks.**

      (2) **Identified safety risks.**

   d. **Is reviewed at least quarterly with respect to:**

      (1) **Plan of services.**

      (2) **Goals.**

      (3) **Progress toward goals.**

   e. **Is revised, as appropriate:**

      (1) **Based on the satisfaction of the child/youth served.**

      (2) **To remain meaningful to the child/youth served.**

      (3) **Based on the changing needs of the child/youth served.**

Intent Statements

The program includes the child/youth 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 child/youth served, including the inclusion of an advocate or family member if the child/youth served prefers or if it is necessary to interpret the child's/youth's desires.

10.d. The program establishes a quarterly review schedule for the individualized service plan. The plan focuses on goals and results, and regular review is essential to ensure that goals are achievable and remain meaningful to the child/youth served. Plans are essential for all members of the team to perform their functions and to ensure continuity of services when new personnel are hired.

3.J. **11.** **The individualized service plan is based on the child's/youth's:**

   a. **Strengths.**

   b. **Needs.**

   c. **Abilities.**

   d. **Preferences.**

   e. **Desired outcomes.**

   f. **Cultural background.**

   g. **Spiritual needs.**

   h. **Other issues, as identified.**

Intent Statements

The program may use self-assessments and/or person-centered planning to obtain this information. Individualized service 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-centered outcomes.

Plans are highly individualized, reflecting the diversity of the child/youth served.

3.J. **12. The following information is used in the development of the individualized service 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 child/youth served 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 individualized plans demonstrate that this information has been considered in development of the plans.

3.J. **13. The child/youth served is:**

    a. **Enrolled in the local school system, whenever possible.**

    b. **Provided with alternative arrangements for continuity of education when local enrollment is not possible.**

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.

3.J. **14. The program's activities support the encouragement of:**

    a. **Motor skill development.**

    b. **Physical development.**

    c. **Physical fitness.**

    d. **Social development.**

    e. **Intellectual development.**

    f. **Speech and language development.**

    g. **Creativity.**

    h. **Emotional health.**

    i. **Cognitive skills.**

    j. **Personal safety.**

    k. **Self-care.**

    l. **Identity development.**

    m. **Development of skills for independence, when part of the youth's plan.**

3.J. **15. The program's learning environment recognizes the following identified needs of the child/youth:**

    a. **Cultural.**

    b. **Spiritual.**

    c. **Age.**

    d. **Gender.**

    e. **Developmental.**

    f. **Physical.**

    g. **Medical.**

3.J. **16. The program provides the child/youth access to activities, as applicable, including:**

    a. **Community activities.**

    b. **Cultural activities.**

    c. **Recreational activities.**

    d. **Spiritual activities.**

    e. **Employment.**

Intent Statements

When possible, activities are provided within the local community.

17. Consent for the transportation of a child/youth served to and from any activity away from the congregate care setting is:

　　a. Obtained at admission.

　　b. Approved in writing by a parent or 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.

- Written daily schedule of activities
- Written consent of the parents/legal representatives to provide healthcare or first aid, when applicable
- Individual plans for the persons served
- Written approvals from parents/legal representatives to transport children/youths to and from any activities away from the congregate setting, if applicable
- Records of persons served

K. Counseling/Outpatient

Description

Counseling/outpatient programs provide culturally and linguistically appropriate services that include, but are not limited to, individual, group, and family counseling and education on wellness, recovery, and resiliency. These programs offer comprehensive, coordinated, and defined services that may vary in level of intensity. Counseling/outpatient programs may address a variety of needs, including, but not limited to, situational stressors, family relations, interpersonal relationships, behavior management, mental health issues, life span issues, psychiatric illnesses, substance use disorders and other addictive behaviors, and the needs of victims of abuse, neglect, domestic violence, or other traumas.

Applicable Standards

An organization seeking accreditation for a counseling/outpatient program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.K.　**1. Counseling/outpatient programs provide or arrange for all of the following:**

　　a. Individual counseling/therapy.

　　b. Family counseling/therapy.

　　c. Group counseling/therapy.

Intent Statements

Based on the needs of the person served, the program offers or refers to service modalities that are designed to assist the person to achieve his or her goals in areas such as psychological or social functioning, self-esteem, and coping abilities or to external opportunities such as vocational, educational, or social.

The program must directly provide at least one of the listed services, and it must have the ability to provide referrals and arrangements for any of the listed services as needed by the persons served.

3.K. **2. The program offers education on:**
   a. **Wellness.**
   b. **Recovery.**
   c. **Resiliency.**

Intent Statements

These educational activities may be provided in individual, group, or other settings.

Examples

2.a. Wellness education is designed to assist the person served to achieve balance in physical and emotional health and wellbeing. For additional examples and ideas, see the SAMSHA website at **www.promoteaccteptance.samsha.gov/10by10/default.aspx**.

2.b. Recovery education includes activities designed to provide information about the person's disability/disorder with a focus on achieving the highest possible personal functioning and improvements in the person's social and occupational interactions.

2.c. Resiliency education is focused on improving the person's awareness of his or her strengths and building on those strengths.

3.K. **3. To maximize the opportunity of the persons served to participate in the program, services are provided:**
   a. **In locations that meet the needs of the persons served.**
   b. **At times that meet the needs of the persons served.**
   c. **On days that meet the needs of the persons served.**

Intent Statements

Services can be provided in traditional office settings, community settings, online or in virtual settings, or in personal homes. Programs seek to minimize interruptions of activities such as work and school as well as other daily responsibilities of persons served.

3.K. **4. To meet the needs of the persons served, the program demonstrates how it uses technology to:**
   a. **Increase access to services.**
   b. **Increase supports.**
   c. **Enhance services.**

Intent Statements

Program management and leadership seek to find and implement technologies that assist the persons served in meeting their goals. The program can describe what technologies it has implemented and what it is considering for the future.

Examples

4.a. The program may improve access to services through the use of websites, patient portals, tele-health services, social media, text messaging, and other methods to remind the persons served of appointments.

4.b. Increased supports could include use of technological supports between services, such as recovery-based applications or encouraging persons served to use online support communities and electronic communications with personnel, as appropriate.

4.c. The program may enhance services through technology such as patient portals for making appointments, requesting refills of medications, and accessing medical records; and/or through the use online tools such as outcome measures, cognitive behavioral therapy (CBT) tools, online assessments, and other services.

3.K. **5. The program addresses the emerging needs of the persons served through linkage to appropriate resources and supports.**

Examples

When a person served has emerging needs that are outside of the person-centered plan, such as being unable to pay utility bills, having a medical emergency in the family, or being unable to get to work due to a car breaking down, the program helps find support and assistance to address these needs through linkages to other services or providers.

3.K. **6. The program:**

   a. In collaboration with the person served, identifies the person's natural supports.

   b. Assists the person to develop and utilize his or her natural supports.

Examples

The program demonstrates its understanding of the need for persons served to develop and maintain a healthy support system. There is evidence that the program assists the person served to create long-term natural supports to reduce reliance on providers in their transition post-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.

- Individual program plans for the persons served
- Records of the persons served

L. Crisis Programs

Introduction

In this section two distinct programs are available for accreditation. An organization may seek accreditation in either or both of these programs based on the services provided.

- Crisis and Information Call Centers — Standards 1.–16. (page 202)
- Crisis Intervention —Standards 17.–27. (page 205)

NOTE: *An organization can choose to seek accreditation for any of the crisis programs that it provides, but it is not required to seek accreditation for all of the crisis programs provided.*

Crisis and Information Call Centers

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.

3.L. **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.h. Calls do not have to be recorded.

1.i. May address prank, abusive, or sexually inappropriate phone calls.

3.L. 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.L. 3. The program provides telephone intervention services.

3.L. 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.L. 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.L. 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.L. 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.L. 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.L. **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.L. **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.L. **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.L. **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.L. **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.L. **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.L. **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.L. **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 non-endorsement of specific referrals and fair and equitable referrals
- Records of the persons served

Crisis Intervention

Description

Crisis intervention programs offer services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, emotional distress, acts of domestic violence or abuse/neglect, and persons who are suicidal or identified as runaways.

Applicable Standards

An organization seeking accreditation for a crisis intervention program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.L. **17. An initial crisis intervention plan is developed upon contact for each person served.**

Intent Statements

Because crisis intervention programs consist of immediate and short-term response to the crises, the plan for care may be shorter than the individual plan described in Section 2.C. The plan may address only the immediate services needed to respond to the current crisis of the person served and the transition to other services, as appropriate.

3.L. **18. 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 and face-to-face at a treatment or service location, home, shelter, school, hospital, or other community site.

3.L. **19. 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. When mobile services are not provided by the program, the program has identified linkages with other community resources.

Examples

Mobile services may be provided by the program, or linkages for the provision of emergency or crisis intervention services may be established through such community organizations as visiting nurse groups that provide training, community mental health centers, and case management programs.

3.L. **20. Personnel providing mobile services are trained or certified in first aid and CPR.**

3.L. **21. 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:**
      (1) **The circumstances under which they can perform these procedures.**
      (2) **The degree of supervision required to perform these procedures.**
   e. **Handling standing orders.**

Intent Statements

Crisis intervention services often involve the provision of emergency medical care. The intent of this standard is to ensure that staff members, resources, and procedures are available to respond to these circumstances.

3.L. **22. 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.L. **23. The program has the capability to make appropriate clinical disposition decisions.**

Intent Statements

The basic components of any crisis intervention 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.L. **24. The program has the capability to access inpatient services or less restrictive alternatives.**

3.L. **25. The program has written procedures to guide access to inpatient services or less restrictive alternatives.**

3.L. **26. Qualified practitioners are available 24 hours a day, 7 days a week.**

Intent Statements

A *qualified practitioner or youth worker* is 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 human services. *Available* may include being on call.

3.L. **27. There are procedures for the involvement of significant others with the consent of the persons served.**

Intent Statements

These procedures should follow the legal requirements regarding the confidentiality rights 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.

- Initial crisis intervention plans
- Written emergency procedures
- Written procedures to guide access to inpatient services or less restrictive alternative
- Records of the persons served

M. Day Treatment

Description

Day treatment programs offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated, and structured treatment services and activities. 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 person-centered plans. Day treatment programs are offered four or more days per week, typically with support available in the evenings and on weekends. A day treatment program may prevent or minimize the need for a more intensive level of treatment. It may also function as a step-down from inpatient care or partial hospitalization or as transitional care following an inpatient or partial hospitalization stay to facilitate return to the community.

Applicable Standards

An organization seeking accreditation for a day treatment program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.M. **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.M. **2. The majority of program hours consist of scheduled treatment services that include at least three of the following:**

   a. Individual counseling/therapy.

   b. Family counseling/therapy.

   c. **Group counseling/therapy.**

   d. **Education, including at least one of the following topic areas:**

     (1) **Alcohol, tobacco, or other drugs.**

     (2) **Medication.**

     (3) **Psychoeducation.**

   e. **Occupational therapy.**

   f. **Other therapy services as appropriate.**

Intent Statements

The program ensures that the majority of services delivered are therapeutic activities designed to assist the persons served to achieve the goals outlined in their person-centered plans and may include services provided through technology. There may be some activities that are social or otherwise supportive in nature, but those services are secondary to the intention of providing therapeutic activities.

Examples

2.f. Could include activities such as art therapy, dance therapy, and animal-assisted therapy.

3.M. **3.** **Based on the needs of the persons served, the program offers additional activities that include, but are not limited to, the following areas:**

   a. **Emotional.**

   b. **Environmental.**

   c. **Financial.**

   d. **Intellectual.**

   e. **Occupational.**

   f. **Physical.**

   g. **Social.**

   h. **Spiritual.**

Intent Statements

These other activities provided by the program are designed to increase functioning of the persons served and serve as examples of additional nontherapeutic activities performed by the program. Additionally, these activities are focused on improving dimensions of wellness of persons served.

Resources

Additional information on dimensions of wellness can be found at **promoteacceptance.samhsa.gov/10by10/dimensions.aspx**.

3.M. **4.** **The program has consistently:**

   a. **Assigned personnel.**

   b. **Scheduled activities.**

Intent Statements

4.a. The program establishes a stable staffing pattern by assigning the same personnel to the program. Should the need arise, the organization may add personnel from a consistent pool to provide the needed intensity of interventions.

3.M. **5.** **The program's services are provided by an interdisciplinary team.**

Examples

Please see the Glossary for the definition of *interdisciplinary*.

3.M. **6.** **The program provides or arranges for psychiatric services to meet the needs of the persons served.**

Intent Statements

Psychiatric services are provided to persons served who need them by the program through its own psychiatrist, a contract psychiatrist, or other appropriate arrangement. Other appropriately trained and supervised psychiatric providers such as Advanced Practice Registered Nurses, Physician Assistants, or Prescribing Psychologists may be used.

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

N. Detoxification

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:

- *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.

- *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.

- *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 100 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.N.11.
- An inpatient detoxification program must also apply Standards 3.N.12.–13.

3.N. **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.a. When allowed by medical practice boards or other regulation, a physician's assistant or nurse practitioner may conduct the physical examination.

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. A face-to-face consultation could be done through telehealth services that allow the physician to see the person served.

When allowed by medical practice boards or other regulation, a physician's assistant or nurse practitioner may be used.

3.N. 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.N. 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.N. 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.N. 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.N. 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.N. 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.N. **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.N. **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.N. **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.N. **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.N. **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.N. **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

O. Diversion/Intervention

Description

Diversion/Intervention programs may include programs traditionally thought of as intervention that focus on changing outcomes for persons served and targeting antecedents of the problem. Diversion/Intervention programs utilize strategies designed to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Within the child welfare field, examples include alternative response, differential response, or multiple response systems. Diversion/Intervention 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 may include programs such as juvenile justice/court diversion, substance abuse diversion, truancy diversion, DUI/OWI classes, report centers, home monitoring, after-school tracking, anger management, and building healthy relationships.

Intervention programs target persons who are exhibiting early signs of identified problems and are at risk for continued or increased problems.

Applicable Standards

An organization seeking accreditation for a diversion/intervention program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.O. **1. Services are designed by personnel with demonstrated skill and knowledge in current evidence-informed/ evidence-based 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.O. **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 or public health activities, such as health fairs.
- Participation in community-wide health education activities.

3.O. **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/community issues.**
   h. **Internet safety.**
   i. **Acceptance of cultural diversity.**
   j. **Effective parenting.**

Examples

Information may be provided through:
- 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.O. **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.O. **5. The program includes two or more of the following strategies:**
   a. **Increasing knowledge and raising awareness.**
   b. **Building skills/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.O. **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.

3.O. **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/intervention 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.O. **8.** **The program utilizes a screening or assessment process:**

a. **To identify individuals for participation or enrollment in the program.**

b. **That includes a documented plan for individual outcomes.**

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.

- Plan or written logic model that details specific approaches to be used
- Plan for individual outcomes
- Program evaluation of services and training activities

P. Early Childhood Development

Description

An early childhood development program promotes healthy physical, mental, and emotional development of the child. Early childhood development programs provide services and resources that assist the parent(s)/legal guardian(s) to identify and accept responsibility for the management of their child's health and development. Services may be provided in congregate or community settings or in a home setting and include education, training, and hands-on support. Services are directed to identified families and children, and are designed to optimize development, functioning, and resilience; and prevent developmental delay. Such programs may also engage families, child care providers, and communities in planning for and providing inclusive child care in community settings that support the child's developmental goals.

These standards are aligned with the implementation of Quality Rating Improvement Systems (QRIS) utilized by many states in the U.S. to assess, improve, and communicate the quality of services in early childhood development programs.

Early childhood development programs seeking accreditation are encouraged to use the CARF standards and the identified state QRIS when developing and providing services.

Some examples of programs include:

- Families First
- Early Intervention (Canada)
- Supported child development programs
- Home visitation
- Family enhancement
- Looking After Children
- Building Blocks
- Healthy Families America
- Head Start
- Better Beginnings, Better Futures
- Child/youth development centers
- Infant development programs
- Birth to three (0–3) programs
- First Steps
- Early Start
- Early Years

Applicable Standards

An organization seeking accreditation for an early childhood development program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.P. **1. The program implements policies and procedures that address:**
   a. **Credentials of:**
      (1) **The director.**
      (2) **Any staff that work directly with children.**
   b. **Staffing ratios.**
   c. **Group size.**

Intent Statements

Personnel credentials, staffing ratios, and group size have been considered to be key indicators of quality early childhood development programs. Programs establish these policies and there is evidence they are implemented.

In states where QRIS is implemented, it is expected that the credentials of the director and staff working with children, staffing ratios, and group size requirements exceed the minimum state requirements.

3.P. **2. Program personnel receive competency-based training to meet the identified needs of the children served that covers:**
   a. **Attachment theory.**
   b. **Grief and loss.**
   c. **Child growth and development.**
   d. **Group dynamics.**
   e. **Health and nutrition.**
   f. **Behavior management skills.**
   g. **Learning theory and strategies.**
   h. **Cultural competency.**

i. The effects of separation on children.

j. Applicable legal issues.

k. Methods of communication.

l. Other specific needs.

Examples

2.c. Includes readiness to learn, brain development, and social, emotional, and cognitive development.

2.g. Includes age-specific curriculum and activities. Methods of communication may include teacher-child interactions, non-verbal communication, and communication with families including telephonic and electronic.

2.j. Includes mandatory reporting of child maltreatment.

2.l. Additional needs may include medical or physical needs or the use of assistive technology.

3.P. **3. The program promotes:**

a. **Positive parenting skills.**

b. **Positive caregiver skills, when applicable.**

c. **Positive interaction between:**
   (1) **Parent and child.**
   (2) **Caregiver and child, when applicable.**

d. **Education on child development.**

Examples

3.d. Includes information on age-appropriate expectations.

3.P. **4. The program encourages and optimizes:**

a. **Child and family resilience.**

b. **The permanence and stability of the family.**

c. **The connection of the family to its community.**

d. **The connection of the family to its culture.**

Examples

4.d. Resilience may refer to the child's and/or family's ability to respond to personal or environmental stressors.

3.P. **5. The program addresses the needs of each child served in the following areas:**

a. **Safety.**

b. **Education.**

c. **Emotional.**

d. **Growth and development.**

e. **Social and leisure activities.**

f. **Spiritual/cultural.**

g. **Identified medical needs, including allergies.**

h. **Others, as identified.**

Intent Statements

The program recognizes that many children have similar needs but additionally the needs of each child are addressed.

Examples

5.a. First aid responders are specially trained in child CPR.

5.b. Educational needs may include using a variety of instructional strategies, responding to curiosity, joint problem solving, and encouraging creativity and imaginative play.

5.b.–e. The program provides opportunities for the children served to have one-on-one time with personnel as well as time in group settings.

5.f. Recognition of the norms, customs, and holidays of various cultural groups. This may be evidenced in the available selection of reading materials, pictures, room décor and toys.

3.P. **6. The program provides the following services in collaboration with the families and communities served:**

a. **Assessment of needs in the following areas:**
   (1) **Child development.**
   (2) **Parental capacity, when possible.**
   (3) **Caregiver/setting capacity, when applicable.**
   (4) **Other needs.**

b. **Information on available community resources.**

c. Identification of services that are:
   (1) Culturally appropriate.
   (2) Age appropriate.
   (3) Developmentally appropriate.
d. Provision of, or linkage to, services needed by the child or family.

3.P. **7.** The program:
   a. Tracks children identified as possibly having a developmental delay.
   b. Follows through with appropriate interventions

3.P. **8.** The program addresses child development through:
   a. Parental education.
   b. Instrumental parental support.
   c. Caregiver support and education, if applicable.

Examples

Parental support may include parent resources or peer support. Services may be provided through demonstrating and modeling.

3.P. **9.** The program provides training to parents/guardians/caregivers to support the child's:
   a. Motor skills development.
   b. Physical development.
   c. Physical fitness.
   d. Social development.
   e. Intellectual or cognitive development.
   f. Speech and language development.
   g. Creativity.
   h. Emotional development.
   i. Communication skill development.
   j. Medical needs.
   k. Visual or hearing needs.
   l. Safety.
   m. Self care.

n. Identity development.
o. Ability to be included in a community setting.

3.P. **10.** The program's training/support curriculum recognizes the following identified needs of the child:
   a. Cultural.
   b. Spiritual.
   c. Age.
   d. Gender.
   e. Developmental.
   f. Physical.
   g. Medical.

3.P. **11.** The program's services reflect the following needs of the children served:
   a. Intensity of services.
   b. Locations where services are provided.
   c. Hours during which services are provided.
   d. Inclusive settings as chosen by the family, when applicable.

3.P. **12.** The program's daily activities are flexible enough to handle the following needs of the children served:
   a. Sleep or quiet time.
   b. Group and individual play.
   c. Variety.

Intent Statements

12.c. The program activities follow a schedule but also allows for variations that provide children with opportunities to experience and adapt to change.

Examples

Activities may include housekeeping, dress up, water and sand play, blocks, books, and puzzles.

3.P. **13.** **When services are provided without the parent(s)/legal guardian(s) present, the program provides healthcare only:**

    a. **With written consent of the parent(s) or legal guardian(s).**

    b. **If the healthcare to be provided is first aid.**

3.P. **14.** **At all times while children are present at or involved in activities arranged by the program, they are under adequate supervision to provide for their:**

    a. **Development.**

    b. **Safety.**

    c. **Well-being.**

    d. **Health.**

Intent Statements

Adequate supervision may be defined by licensure requirements, program policy, or state specific quality rating instruments (QRI's), however the program should consider this a minimum and should identify circumstances which would require higher levels of supervision.

Examples

14.b. Additional adult supervision is required for all age groups when activities are scheduled outside the facility.

3.P. **15.** **Nutritious meals and snacks are provided:**

    a. **By the program, unless the parents/ legal guardians or caregivers are required to furnish.**

    b. **At appropriate times and in sufficient quantities in accordance with the needs of the child.**

    c. **Consistent with any applicable requirements.**

3.P. **16.** **Prior to the initiation of services, parents/ legal guardians identify in writing the persons approved to:**

    a. **Have contact with the child while at the program.**

    b. **Pick up the child from the program.**

3.P. **17.** **Consent for the transportation of a child to and from any activity away from the day care setting is:**

    a. **Obtained at admission.**

    b. **Approved in writing by a parent or legal representative.**

3.P. **18.** **In the case of an accident, illness, or injury involving a child, the program:**

    a. **Connects the child with needed medical attention in a timely manner.**

    b. **Notifies a parent and/or other legal representative.**

3.P. **19.** **When a child becomes ill and the condition may be infectious, until he or she can be safely removed from the program, he or she is:**

    a. **Kept as far away as practical from the other children.**

    b. **Monitored by a staff member for changes in status.**

3.P. **20.** **Current contact information, including telephone numbers, of the following are kept readily available at the day care site:**

    a. **Parent/legal guardian and backup emergency contact.**

    b. **All personnel, including substitute personnel.**

    c. **The poison control contact.**

    d. **The fire department.**

    e. **Police department.**

f. **Ambulance.**

g. **Nearest health facility and/or identified physician.**

h. **Child abuse and neglect reporting agency.**

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 that address credentials of the director and staff who work directly with children, staffing ratios and group size

- Documentation of children identified as possibly having a developmental delay

- Evidence that the training/support curriculum recognizes the identified needs of the children

- Written identification of persons approved to have contact with the child while at the program and who can pick up the child from the program

- Written approvals from parents/legal representatives to transport a child to and from any activities away from the day care site, if applicable

- Current contact information for parents/ emergency contacts; all personnel; poison control; fire department; police department; ambulance; nearest health facility or identified physician; and child abuse/neglect reporting agency

- Individual program plans for the persons served

- Records of the persons served

Q. Foster Care

Introduction

In this section two distinct programs are available for accreditation. An organization may seek accreditation in any or all of these programs based on the services provided.

- Foster Care —Standards 1.–19. (page 220)
- Specialized or Treatment Foster Care — Standards 20.–36. (page 225)

Foster Family and Kinship Care

Description

Foster/kinship care is provided under a contract or agreement for the placement of a child/youth in a family setting outside the birth or adoptive family home. Foster/kinship care is provided to a family to establish and maintain a home for the child/youth. The courts may be involved in establishing this relationship.

Foster/kinship care is comprehensive and establishes a system of supports and services for the child/youth, the family of origin, and the foster/kinship family. Programs assist foster and/or kinship families to recognize their strengths and abilities to effect change for the child/youth and family in order to establish stability in the life of the child/youth. Foster/kinship care may include relative care, preadoption placements, or care in parent/counselor homes. In Canada this would include such programs as out of care options and general foster care homes.

Applicable Standards

An organization seeking accreditation for a foster family/kinship care program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.Q. **1. Services reflect the active participation of the:**

    a. **Child/youth served.**

    b. **Family of origin, if appropriate.**

    c. **Foster/kinship family.**

    d. **Others, as appropriate.**

Intent Statements

It is important that the program's services strive to allow as much participation of all parties as possible. This is to ensure that all the parties are working together with a common focus on the interests of the child/youth served.

3.Q. **2. The program advocates on behalf of:**

    a. **The child/youth served.**

    b. **The family of origin.**

    c. **The foster/kinship family.**

Intent Statements

The program should be able to demonstrate advocacy for all parties involved, as appropriate to the services provided.

Examples

This advocacy may relate to the outcomes of these services, including adoption. (See the following standard.)

3.Q. **3. Advocacy addresses the following areas, as appropriate:**

    a. **Assurance that basic needs are met.**

    b. **Basic rights protection.**

    c. **Legal representation.**

    d. **Permanency.**

    e. **Access to community resources and services.**

Intent Statements

3.d. Permanency may include reunification, adoption, or another planned permanent living arrangement.

3.Q. **4. The planning process addresses permanency and stability in the life of the child/youth served, including:**

    a. **Reunification with the family of origin, if appropriate.**

    b. **A range of possible living opportunities.**

    c. **Time lines of services.**

    d. **Activities to meet the time lines.**

Intent Statements

This planning is sometimes referred to as "concurrent" planning, in that several different possible outcomes may occur, and they may not all be evident at the start of the process. Flexibility and close monitoring of the situation are possible key indicators of conformance.

3.Q. **5. The program is responsible for or collaborates in the implementation of a reunification plan for each child/youth that includes:**

    a. **The involvement of:**

        (1) **The child/youth.**

        (2) **The guardian ad litem, when appropriate.**

        (3) **The family.**

        (4) **Significant others.**

        (5) **Other natural supports.**

    b. **A timetable.**

    c. **Identification of the service team.**

    d. **Justification for exclusion of the natural family, when applicable.**

Intent Statements

The reunification plan is designed to include the family from which the child/youth was removed. Their involvement in the planning process is critical when working on reunification. The reunification plan delineates what needs to occur for a child/youth to be placed back with his or her family. The Indian Child Welfare Act is followed, when applicable.

Examples

5.a.(3) This may include a birth family, kinship relationship, and/or an adoptive family.

3.Q. **6.** **Foster/kinship care services reflect planning in the following ways:**

a. **Children/youths served are afforded opportunities and supports so that whenever feasible they return to their families of origin.**

b. **When out-of-home placements are necessary, services are provided to the families of origin and foster families/kinship to support the opportunity for family reunification.**

c. **When reunification is not feasible, children/youths are identified for adoption.**

d. **When children/youths are identified for adoption, they receive the supports they need.**

e. **When family reunification or adoption is not feasible, child/youth have the opportunity for long-term inclusion in a typical family environment.**

f. **When children/youths cannot be maintained in a foster/kinship care environment, they experience the most culturally similar residential, educational, and social opportunities possible while efforts are made to secure a stable family environment.**

g. **When youth reach the age of discharge to independent adulthood without having achieved legal permanency, the program supports the youth in developing family ties and a network of social support.**

Intent Statements

A sense of permanency is established in the life of the child/youth served. Advocacy for each child/youth is critical in all instances, and particularly when reunification with the family of origin is not possible or is not in the best interest of the child/youth. It is understood that children who are removed from their home and placed into foster or kinship care may have been removed from their birth family, adoptive family, or other type of family unit.

3.Q. **7.** **Foster/kinship families are:**

a. **Recruited/accessed to meet the needs of the child/youth served.**

b. **Selected through a process that:**

(1) **Meets the following needs of the child/youth:**

(a) **Appropriate levels of care.**

(b) **An environment reflective of his or her current environment.**

(c) **Cultural identification.**

(2) **Provides for a broad selection of families to ensure that the needs of each child/youth will be met.**

c. **Monitored.**

d. **Supported with services.**

e. **Evaluated regularly.**

Intent Statements

CARF is not accrediting the foster/kinship family unit, but rather the services provided by the program that make foster/kinship care placement successful.

Examples

7.a. Specified needs could include:

■ Ability to take a sibling group.

■ Behavior management.

■ Conflict resolution.

■ Problem solving.

■ Anger management.

■ Decision making.

■ Crisis management.

■ Parenting.

■ Gender identity.

■ Sexuality.

■ Independent living.

3.Q. **8.** **If the program selects foster care providers, it has a comprehensive plan for recruitment, selection, and maintenance that:**

a. **Is reflective of the larger community that the program serves.**

b. **Includes a broad selection of families to ensure that the needs of the children/youths served are met.**

c. **Meets the expressed criteria set in all applicable jurisdictional guidelines.**

d. **Includes procedures for the monitoring of each home.**

Intent Statements

8.c. The program is able to provide examples of how their plan for recruitment, selection and maintenance of foster care providers meets all applicable jurisdictional guidelines.

Examples

8.c. Examples of jurisdictional guidelines include:

- A home study/assessment of the living environment completed prior to placement that includes interviews, current criminal record checks of all adults living in the home, and dwelling inspection.

- Foster parent applications only accepted from married couples in good health between the ages of 18 and 65.

- Initial training must occur within six months to having a child/youth placed in the home.

- Foster care providers selected based on the child's/youth's preferences (age dependent), the preferences of the care providers, and the recommendations from program staff base d the needs of the child/youth.

3.Q. **9. Recruitment of foster families and access to kinship care homes ensures the provision of a safe environment for the child/youth served, including security of:**

a. **Weapons.**

b. **Ammunition.**

c. **Pharmaceuticals.**

d. **Other items that could prove to be harmful to the child/youth.**

Examples

9.d. Other items could include:

- Sharp items or hazardous materials that may be harmful to a small child/youth with cognitive limitations.

- Items that may be used by a child/youth to harm self or others, such as knives, razors, or flammables.

3.Q. **10. The program utilizes written agreements that clearly define:**

a. **The expectations of the:**

(1) **Foster/kinship family.**

(2) **Program.**

b. **The following for each involved party:**

(1) **Role.**

(2) **Responsibilities.**

(3) **Interrelationship.**

(4) **Specific needs.**

(5) **Monitoring.**

c. **Payments, as applicable.**

d. **The process of termination, if necessary.**

e. **An appeal process, when applicable.**

Intent Statements

Written agreements are signed by program staff and other parties involved, as applicable.

Examples

10.a.(2) Included in program expectations could be available support, training requirements, and monitoring activities.

10.b.(2) Should there be damage to the foster home or property of the foster parents', it is helpful to have the responsible party defined in the agreement. Foster/kinship family responsibilities may include meeting and maintaining licensure requirements, emotional support, and a safe and comfortable environment which offers an opportunity to experience typical family life.

3.Q. **11.** **The program documents training provided to foster and kinship families, that:**

   a. **Covers:**

   (1) **Attachment theory.**

   (2) **Grief and loss.**

   (3) **Child/youth growth and development.**

   (4) **Behavior management skills.**

   (5) **Learning deficits.**

   (6) **Cultural competency.**

   (7) **The effects of placement on children/youths.**

   (8) **Applicable legal issues.**

   (9) **Methods of communication.**

   (10) **Required medications and/or medical services.**

   (11) **Trauma.**

   (12) **Specialized training, as needed.**

   b. **Includes:**

   (1) **Type of training or information provided.**

   (2) **Dates of training or information provided.**

   (3) **Length of training or information provided.**

3.Q. **12.** **Matching of the child/youth served with foster/kinship families:**

   a. **Is based on the child's/youth's identified:**

   (1) **Strengths.**

   (2) **Needs.**

   (3) **Preferences.**

   b. **Focuses on minimizing disruption of lifelong relationships.**

Intent Statements

The selection of a specific foster/kinship family setting should not be made based solely on availability. It is understood that kinship placement is preferable over foster care placement if safety is not in question, however placement among potential kinship families will be determined on the best match.

Examples

Preferences may include sexual orientation, gender identification, spirituality, culture, or placement with siblings.

3.Q. **13.** **The program advocates for the placement of children/youths with their siblings, as appropriate.**

3.Q. **14.** **When placement of children/youths with their siblings is not possible, the program advocates that the children/youths regularly visit with their siblings, if appropriate.**

3.Q. **15.** **Foster/kinship families have access to a system of support and relief, including a 24-hour emergency response system.**

3.Q. **16.** **The program provides open and full disclosure of the following information:**

   a. **Medical history.**

   b. **Current health status.**

   c. **Behavioral issues.**

   d. **Social functioning.**

   e. **Family relationships.**

   f. **Relevant historical events.**

Examples

May be provided through use of life books, pictures, medical or other records, or other personal items or stories.

3.Q. **17.** **Active communication exists between the program and the foster/kinship family.**

Intent Statements

The foster/kinship family should be actively connected to the program's service delivery and management. Case planning is inclusive of the foster/kinship family and shares significant events.

Examples

Communication may occur through service team meetings, family-based conferencing, or individual plan review.

3.Q. **18.** **Foster/kinship care services address the needs of each child/youth served in the following areas:**

  a. **Healthcare.**

  b. **Safety.**

  c. **Daily living.**

  d. **Education.**

  e. **Employment, when applicable.**

  f. **Emotional.**

  g. **Stages of development.**

  h. **Social and leisure activities.**

  i. **Religious/spiritual/cultural.**

  j. **Well-being.**

  k. **Others, as identified.**

Intent Statements

It is the responsibility of the program to ensure that these needs are being met by the foster/kinship family.

Examples

18.b. Safety needs may include privacy, close observation/supervision.

18.c. This includes items such as food, shelter, place to sleep, personal care, etc.

3.Q. **19.** **When a child/youth served moves to a different service or setting:**

  a. **Information is provided within a required time frame to the:**

  (1) **Family of origin, as appropriate.**

  (2) **Foster/kinship family, as appropriate.**

  (3) **Child/youth served.**

  (4) **New provider of service or new setting.**

  b. **The foster/kinship family from which the child/youth is departing is offered opportunity for an exit interview.**

Intent Statements

This standard extends active participation and communication to the movement of the child/youth served to a new or different setting or service. Required time frames are established by the program and/or any applicable legal/regulatory or other guidelines.

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.

- Reunification plans
- Plans related to foster/kinship care services
- Written agreements with foster/kinship families
- Documentation of training provided to foster and kinship families
- Individual program plans for the persons served
- Records of the persons served
- Comprehensive plan for recruitment and selection of foster care providers

Specialized or Treatment Foster Care

Description

Specialized or treatment foster care programs provide treatment services outside of their natural homes to children/youths for whom there are documented reports of maltreatment or identified needs requiring intensive interventions in a community-based setting. Treatment is provided in a safe and supportive setting and may be time limited. The program goal is to reunite the children/youths with their natural families or to provide what is identified as being in the best interest of each child/youth. The program may include treatment foster care, specialized foster care, therapeutic family services, or therapeutic foster care.

Applicable Standards

An organization seeking accreditation for a specialized or treatment foster care program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.Q. **20. The program implements a process for identifying, locating, and engaging family members, as appropriate, in services.**

Examples

The program demonstrates its efforts to engage family, including extended family, in services. This may include the use of internet-based search services to locate family members.

3.Q. **21. The program provides competency-based training to meet the identified needs of the children/youths served:**
   a. **To:**
      (1) **Personnel.**
      (2) **Specialized or treatment foster care providers.**
   b. **That covers:**
      (1) **Attachment theory.**
      (2) **Grief and loss.**
      (3) **Child/youth growth and development.**
      (4) **Behavior management skills.**
      (5) **Learning deficits.**
      (6) **Cultural competency.**
      (7) **The effects of placement on children/youths.**
      (8) **Applicable legal issues.**
      (9) **Methods of communication.**
      (10) **Required medications and/or medical services.**
      (11) **Trauma.**
      (12) **Specialized training as needed.**

Intent Statements

Training may be provided jointly involving program personnel and foster care providers.

Examples

21.b.(3) Training may include readiness to learn, brain development, and cognitive development.

21.b.(4) Training may include conflict resolution and management of violent, aggressive, or sexualized behaviors.

21.b.(12) Specialized training needs may include health and nutrition, the need for and use of assistive technology, substance abuse or mental health issues, or delinquency.

3.Q. **22. The program documents training provided to foster care providers, including the:**
   a. **Type of training.**
   b. **Length of training.**
   c. **Dates of training.**

3.Q. **23. The program provides access to professionals trained in child/youth and family care, based on the needs of each person served, including:**
   a. **A psychologist.**
   b. **A counselor.**
   c. **A family therapist.**
   d. **A social worker.**
   e. **A youth worker.**
   f. **A psychiatrist.**
   g. **Medical personnel.**
   h. **Other specialists, as appropriate.**

Examples

23.g. May include a nurse, physical therapist, or speech therapist, based on the needs of the child/youth served.

3.Q. **24. 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 children/youths served.**

Intent Statements

Contact information for current service providers, as well as providers of services that may potentially be needed, is maintained and readily available.

3.Q. **25.** **The children/youths served have opportunities to participate, as appropriate, in:**

a. **Community activities.**

b. **Cultural activities.**

c. **Recreational activities.**

d. **Spiritual activities.**

Intent Statements

Specialized or treatment foster care programs are designed to provide treatment within a community setting to foster the development and/or strengthen the child's/youth's skills to allow them to safely remain in the community and avoid a placement outside of the community. The program supports the foster family to provide opportunities for the child/youth to access various community activities.

3.Q. **26.** **If the program selects specialized or treatment foster care providers, it has a comprehensive plan for recruitment, selection, and maintenance that:**

a. **Is reflective of the larger community that the program serves.**

b. **Includes a broad selection of families to ensure that the needs of the children/youths served are met.**

c. **Meets the expressed criteria set in all applicable jurisdictional guidelines.**

d. **Includes procedures for the monitoring of each home.**

3.Q. **27.** **If the program is engaged in child placement activities, it has a comprehensive process for matching children/youths with available foster care providers that:**

a. **Considers the child's/youth's:**

(1) **Needs.**

(2) **Strengths.**

(3) **Preferences.**

b. **Considers the foster care providers' assessed:**

(1) **Skills.**

(2) **Competencies.**

c. **Includes an assessment of the appropriateness of the match, including:**

(1) **A familiar environment.**

(2) **Identification of any gaps and how the gaps will be addressed.**

Intent Statements

The program facilitates placements that match the child/youth served with an appropriate family to promote placement stability.

Examples

27.c.(1) A familiar environment could include the type of residence, such as a house or apartment; the type of neighborhood, such as rural or urban; and the size of the household.

3.Q. **28.** **The program utilizes written agreements that clearly define:**

a. **What the foster care providers can expect from the program, including:**

(1) **On-call support 24 hours a day, 7 days a week.**

(2) **Initial and ongoing training.**

(3) **Communication about appropriate and known information about the child/youth and his or her family.**

(4) **Available support for managing issues that arise in the placement.**

(5) **Supervision and monitoring.**

(6) **Payments, as applicable.**

b. **What is expected of the foster care providers, including:**
   (1) **Providing support to the child/youth in maintaining meaningful contact with his or her family, when appropriate.**
   (2) **Providing a high standard of daily care to the child/youth, including:**
       (a) **Nutritious meals and snacks.**
       (b) **A safe living environment.**
       (c) **A comfortable living environment.**
       (d) **Emotional support.**
       (e) **Boundaries consistent with the needs of the child/youth served.**
       (f) **Physical needs.**
   (3) **Encouraging the child/youth to personalize his or her living space with individual possessions.**
   (4) **Recognition and attention to any special needs of the child/youth, including:**
       (a) **Dietary needs.**
       (b) **Religious needs.**
       (c) **Other identified needs.**
   (5) **Providing a home that is safe and free from hazards.**
   (6) **Refraining from the use of corporal punishment and other inappropriate means of discipline.**
   (7) **Ensuring that the child's/youth's health-related needs are met.**
   (8) **Providing a supportive learning environment to build the skill levels of the child/youth.**
   (9) **Facilitating the child's/youth's engagement in developmentally appropriate peer and leisure activities.**
   (10) **Clearly communicating what is expected of the child/youth in terms of household rules.**

c. **The process of termination, if necessary.**
d. **An appeal process, when applicable.**

Examples

28.b.(7) Health-related needs include immunizations, routine well-care appointments, and dental care.

3.Q. **29. The program advocates for the placement of children/youths with their siblings, as appropriate.**

Intent Statements

It is understood that kinship placement is preferable over foster care placement if safety is not in question, however placement among potential kinship families will be determined on the best match.

3.Q. **30. When placement of children/youths with their siblings is not possible, the program advocates for and facilitates regular visit with their siblings, if appropriate.**

Intent Statements

The program facilitates ongoing connections with siblings. Safety is always a consideration, and visits are supervised as needed.

3.Q. **31. The program uses a plan to regularly monitor each foster home placement.**

3.Q. **32. The program assists birth/adoptive families to receive services that promote reunification, when appropriate.**

3.Q. **33. If the program is responsible for reunification, it provides or arranges for supervised visits based on identified permanency goals.**

3.Q. **34. The program has on-call availability of supervisory staff members to respond to urgent situations 24 hours a day, 7 days a week.**

3.Q. **35.** **The services of each child/youth served are supervised by a qualified practitioner who:**
   a. **Provides clinical oversight.**
   b. **Directs the treatment plan.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

3.Q. **36.** **The program has a plan for access to qualified practitioners 24 hours a day, 7 days a week.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

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 training provided to foster care providers
- Comprehensive plan for recruitment, selection, and maintenance of specialized or treatment foster care providers, if applicable
- Documentation of the foster care providers' assessed skills and competencies
- Assessments of the appropriateness of the match between children/youths and foster care providers
- Written agreements that clearly define what the foster care providers can expect from the program and what is expected of the foster care providers
- Plans for monitoring each foster home placement
- Plan for access to qualified practitioners 24 hours a day, 7 days a week
- Individual program plans for the persons served
- Records of the persons served

R. Group Home Care

Description

Group home programs provide placements to children/youths for whom there are documented reports of maltreatment, abandonment, absence without leave, or other identified needs, or treatment services to children/youths with identified behavioral needs. Services are provided in a safe and supportive setting and are time limited. The program goal is to reunite the child/youth with the natural family or other permanent placement when in the best interest of the child/youth. In all situations, integration into the community to the greatest degree possible is achieved.

Applicable Standards

An organization seeking accreditation for a group home care program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.R. **1. Based on the needs of the persons served, services are provided by a coordinated team that:**

   a. **Includes, at a minimum, the following professionals:**
      (1) **Assigned residential staff members or a plan coordinator.**
      (2) **A qualified practitioner.**
      (3) **Providers of appropriate healthcare support services.**
   b. **Meets weekly.**

Intent Statements

The specific qualifications and credentials of staff members are determined based on the specific needs of the persons served and the structure of the program.

1.a.(2) See the Glossary for the definition of *qualified practitioner*.

3.R. **2. The program provides access to professionals trained in child/youth and family care, based on the needs of each person served, including:**

   a. **A psychologist.**
   b. **A counselor.**
   c. **A family therapist.**
   d. **A social worker.**
   e. **A youth worker.**
   f. **A psychiatrist.**
   g. **Medical personnel.**
   h. **Other providers, as appropriate.**

Examples

2.g. Medical personnel may include a nurse, physical therapist, or speech therapist.

3.R. **3. Personnel receive competency-based training to meet the identified needs of the populations served that covers:**

   a. **Attachment theory.**
   b. **Grief and loss.**
   c. **Child growth and development.**
   d. **Behavior management skills.**
   e. **Life skills.**
   f. **Learning deficits.**
   g. **Social and emotional needs.**
   h. **Cultural competency.**
   i. **The effects of placement on children.**
   j. **Health and nutrition.**
   k. **Applicable legal issues.**
   l. **Methods of communication.**
   m. **Trauma.**
   n. **Other specific needs.**

Examples

3.c. Including readiness to learn, brain development, and cognitive development.

3.d. Including management of violent or aggressive behavior and sexual behavior among residents.

3.j. Including recognition of the need for special diets.

3.n. Other needs could include population-specific trainings such as sign language, or

training related to substance abuse, bullying, or delinquency.

3.R. 4. The program assists birth/adoptive families to receive services that promote reunification, when appropriate.

3.R. 5. The program uses a process for identifying, locating, and engaging family members, as appropriate, in services.

Examples

The program demonstrates its efforts to engage family, including extended family, in services. This may include the use of internet-based search services to locate family members.

3.R. 6. The program advocates for the placement of children/youths with their siblings, as appropriate.

3.R. 7. When placement of individuals with their siblings is not possible, the program advocates that the persons served regularly visit with their siblings, if appropriate.

Intent Statements

The program facilitates ongoing connections with siblings. Safety is always a consideration, and visits are supervised as needed.

3.R. 8. If the program is responsible for reunification, it provides or arranges for supervised visits based on identified permanency goals.

3.R. 9. When applicable, if the permanency plan is not feasible and the child/youth is identified for adoption, the process:
   a. Conforms to all applicable laws and regulations.
   b. Includes ongoing monitoring and providing supports until the adoption or other placement is finalized.

3.R. 10. The program provides the following community living components, in accordance with all applicable regulations:
   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. Individual possessions and decorations.
   h. Daily access to nutritious:
      (1) Meals.
      (2) Snacks.
   i. Opportunities for unstructured private time.

Intent Statements

The program provides opportunities for the child/youth to experience and build the necessary skills to live within a community setting.

10.a. A written daily schedule would describe the activities offered.

10.c. The program encourages each child/youth served to take increasing responsibility for cooperative operation of the household.

10.g. The program encourages and allows children/youths served to have and display their own personal possessions and decorations. These items are consistent with the choices and needs of the children/youths, except for items contraindicated by their individualized plans.

Examples

10.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.

10.c. These activities may include age-appropriate food preparation and performance of routine household duties.

3.R. 11. Provisions are made to address the need for:
  - a. Quiet areas.
  - b. Areas for visits.

3.R. 12. The program provides or ensures the provision of:
  - a. Healthcare services.
  - b. Pharmaceutical services.

3.R. 13. In the case of an accident, illness, or injury involving a child/youth, the program:
  - a. Connects the child/youth with needed medical attention in a timely manner.
  - b. Notifies a parent and/or other legal representative.
  - c. Notifies community care providers, as appropriate.

Examples

13.c. Notifications may include a case manager, case worker, or therapist.

3.R. 14. When a child/youth served becomes ill and the condition may be infectious, until he or she can be safely removed from the program, he or she is:
  - a. Kept as far away as practical from the other persons served.
  - b. Monitored by a staff member for changes in status.

3.R. 15. The child/youth served is:
  - a. Enrolled in the local school system, whenever possible.
  - b. Provided with alternative arrangements for continuity of education when local enrollment is not possible.

Examples

15.b. 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.
  - Coordination with home school services.
  - Coordination and monitoring of assignments.
  - Coordination with the community school to facilitate reintegration.

3.R. 16. The program's activities support the encouragement of:
  - a. Motor skills development.
  - b. Physical development.
  - c. Physical fitness.
  - d. Social development.
  - e. Intellectual development.
  - f. Speech and language development.
  - g. Creative expression.
  - h. Emotional health.
  - i. Cognitive skills.
  - j. Personal safety.
  - k. Self-care.
  - l. Identity development.
  - m. Development of skills for independence, when part of the youth's plan.

3.R. 17. The program facilitates access to activities as applicable, including:
  - a. Community activities.
  - b. Cultural activities.
  - c. Recreational activities.
  - d. Spiritual activities.
  - e. Employment, when applicable.

Intent Statements

When possible, activities are provided within the local community.

Examples

17.c. Activities may include participation in sports teams, youth groups, or scouts.

3.R. 18. **Consent for the transportation of a child/youth served to and from any activity away from the group home care setting is:**

    a. **Obtained at admission.**

    b. **Approved in writing by a parent or legal representative.**

3.R. 19. **The program has on-call availability of supervisory staff members to respond to urgent situations 24 hours a day, 7 days a week.**

3.R. 20. **The services of each child/youth served are supervised by a qualified practitioner who:**

    a. **Provides clinical oversight.**

    b. **Directs the treatment plan.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

3.R. 21. **There is at least a quarterly review of the following for each child/youth served:**

    a. **Plan of services.**

    b. **Goals.**

    c. **Progress toward goals.**

Intent Statements

The intent of this standard is to ensure that the individualized plan is reviewed frequently enough to track progress toward identified goals and to note any new needs or interests.

3.R. 22. **The program has a plan for access to qualified practitioners 24 hours a day, 7 days a week.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

🍁 Programs in Canada must meet the requirements of their provincial/territorial 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.

- Written daily schedule of activities
- Written approvals from parents/legal representatives to transport children/youths to and from any activities away from the group home setting, if applicable
- Plan for access to qualified practitioners 24 hours a day, 7 days a week
- Documentation of quarterly reviews of service plans, goals, and progress toward goals
- Individual program plans for the persons served
- Records of the persons served

S. Health Home

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.

3.S. **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.S. **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.S. **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.S. **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.S. **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.S. **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.S. **7.** **The health home team ensures that the following services are provided, as needed, to all persons served:**
   a. **Health promotion, including education.**
   b. **Comprehensive care management, including:**
      (1) **Outreach.**
      (2) **Engagement.**
      (3) **Triage based on acuity.**
      (4) **Assessment of service needs.**
      (5) **Identification of gaps in treatment.**
      (6) **Development of an integrated person-centered plan.**
   c. **Care coordination, including, but not limited to:**
      (1) **Implementation of the person-centered plan.**
      (2) **Assignment of health team roles and responsibilities.**
      (3) **Arranging for and ensuring access to primary care and other needed healthcare services.**
      (4) **Appointment scheduling.**
      (5) **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.S. **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.S. **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.S. **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.S. **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.S. **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.S. **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.S. **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.S. **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.S. 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.S. 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.S. 18. Written procedures guide ongoing:

a. Communication among interdisciplinary 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 healthcare 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.S. 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.S. **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**) or those recommended by the Centers for Medicare and Medicaid Services (**www.cms.gov**) which include:

- Adult Body Mass (BMI) assessment.
- Ambulatory care —sensitive condition admission.
- Care transition — record transmitted to health care professional.
- Follow-up after hospitalization for mental illness.
- Plan — all cause readmission.
- Screening for clinical depression and follow-up plan.
- Initiation and engagement of alcohol and other drug dependence treatment.
- Controlling high blood pressure.

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

T. Home and Community Services

Description

Home and community services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The home and community services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and community services must include at least one of the following service delivery areas:

- Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.

- Services for persons who need assistance to access and connect with family, friends, or coworkers within their homes and communities.

■ Services for persons who need or want help with activities in their homes or other community settings.

■ Services for caregivers that may include support, counseling, education, respite, or hospice.

NOTE: *A service provider seeking accreditation for home and community services is not required to provide all four of the service delivery areas identified in the service description. However, it must include in the site survey all of the service delivery areas it provides that meet the service description.*

Applicable Standards

An organization seeking accreditation for a home and community services program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

Applicable Standards

All organizations seeking accreditation for home and community services must meet Standards 1.–15.

3.T. **1. To facilitate the appropriate level of services/supports for the person served, the home and community services demonstrate knowledge of and the ability to identify appropriate service options/settings.**

Intent Statements

Services are individualized to the persons served. The home and community services may provide a full spectrum of services or only one type of service but demonstrate an awareness and use of community resources that may be used to support or enhance services to the person served.

3.T. **2. The home and community services identify and address gaps in service delivery.**

Intent Statements

The HCS may address gaps in service at both the level of the person served and the level of the program/service.

Examples

Gaps in service delivery for a person served may be addressed by referring the person to another program/service in the local community or contracting with an external provider to engage with the team of the person served. For example a qualified professional working with a family observes that the parent is no longer able to do household chores because of physical limitations and as a result, there are now concerns about the cleanliness of the home and the safety of the child/youth. The qualified professional could refer the parent for medical evaluation and a potential referral for homemaker services.

At the level of the program/service, the HCS may explore developing a new service, partnering with another provider in the community to provide or develop additional services, or advocating with a payer to cover services that are not currently covered.

3.T. **3. To verify the backgrounds of all personnel, written procedures identify actions to occur:**

    a. Prior to the delivery of services to the persons served or to the organization.

    b. At stated intervals throughout employment.

    c. In response to the information received.

Intent Statements

This standard relates to standard I.2. in Section 1. To reduce risk and ensure the safety of the persons served, the organization defines its process to verify backgrounds of all personnel and take action when appropriate. The organization has procedures in place in the event that backgrounds or credentials cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

Examples

Personnel may attend orientation but not provide direct service to the persons served until background verification is complete.

3.T. **4.** **Personnel demonstrate competencies in the delivery of home and community services, including, but not limited to:**

a. **Addressing the unique needs of persons served.**

b. **Communication with persons served and their families/support systems.**

c. **Communication with other providers serving the persons served.**

d. **Facilitating active involvement of the persons served and families/support systems in the service delivery process.**

e. **Facilitating behavioral supports.**

f. **Facilitating cognitive interventions.**

g. **Handling developmental/life transitions.**

h. **Knowledge of community resources.**

i. **Recognition and reporting of suspected abuse and neglect.**

j. **Setting and maintaining professional boundaries.**

Intent Statements

In Section 1.I. Human Resources standards, organizations are asked to identify skill sets that would assist with the achievement of the outcomes for the person served as well as organizational mission and goals. This standard identifies areas that would be included in orientation as well as ongoing training as appropriate for the HCS. These are not the only skill sets that an HCS program may include but these should be evident.

3.T. **5.** **Policies and written procedures are implemented that address, at a minimum, the following service delivery issues:**

a. **Availability of appropriate equipment, supplies, etc., at the service delivery site from initial service delivery through exit/transition.**

b. **Confidentiality and privacy of information concerning the persons served in the home and community environments.**

c. **Clarification of the roles and responsibilities of:**

(1) **Families/support systems.**

(2) **Service providers.**

(3) **Others, as appropriate.**

d. **Contingency plans if either the family/support system or the service provider is unable to deliver care.**

e. **Unsuccessful delivery of services.**

f. **Referral/transition to other services.**

g. **Assignment of personnel in accordance with the needs and choices of the persons served.**

h. **Safety of personnel, including:**

(1) **Personal safety while providing services.**

(2) **Communication systems.**

(3) **Weather conditions and other natural environmental events.**

(4) **The physical environment at the service delivery site.**

i. **Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.**

j. **Within the scope of services, the availability of home and community services to respond to:**

(1) **Persons served.**

(2) **Families/support systems.**

(3) **Service providers.**

(4) **Other stakeholders.**

Intent Statements

Home and community services are offered to persons served in a variety of settings. Policies and procedures address the uniqueness of the settings and types of situations staff members may encounter when decisions need to be made, potentially on an immediate basis, without the "on-site" support of supervisors or others who are typically available in a facility-based program.

Examples

5.e. Unsuccessful delivery of services may be the result of an issue on the part of the provider or the person served.

5.j.(1) The scope of the services may be focused only on therapeutic interventions and not include social reintegration activities.

5.j.(2) The scope of the services may include the availability of respite services for family/support systems.

3.T. **6.** **A risk assessment of each person served addresses the following areas:**
   a. **Behavioral.**
   b. **Cognitive.**
   c. **Communication.**
   d. **Developmental.**
   e. **Emotional.**
   f. **Environmental.**
   g. **Physical.**
   h. **Capability of the family/support system.**
   i. **Other, as appropriate.**

Intent Statements

To decrease the potential of harm to the person served, risk assessments are an integral part of home and community services. The analysis of this information may result in changes to the person-centered plans as well as improvement at the level of the services.

Examples

6.c. Risks in communication may be the inability to communicate emergent needs, inability to understand verbal or written communication, or different languages being spoken by the persons served and staff.

6.d. Developmental delays may produce risk in social or work situations. Age of an individual may not match their developmental level and increase their risk in daily activities.

6.g. Physical risks may include the potential for falls or impulsivity on the part of the person served when moving around his or her home.

6.h. Risk assessment related to the family/support system might include the availability of the family/support system, its understanding of the health status of and safety precautions required for the persons served, and family/support system dynamics.

3.T. **7.** **Service delivery is scheduled at an agreed-upon time that supports the person-centered plan.**

Intent Statements

There is a system in place to determine the most appropriate schedule for service delivery based on the lifestyle and preferences of the persons served and the scope of the home and community services.

3.T. **8.** **In accordance with the choice of the person served, the home and community services assist the person served to develop a disaster preparedness and emergency plan that considers the following:**
   a. **Assessment of the current knowledge of:**
      (1) **The person served.**
      (2) **The family/support system.**
   b. **Assessment of the physical environment where services are delivered, including accessibility of the environment.**
   c. **Identification of modifications necessary to ensure safety in the event of an emergency.**

d. Community resources, including:

(1) Identification of resources for:

(a) Evacuation.

(b) Shelter.

(c) Recovery.

(2) Accessibility of resources for:

(a) Evacuation.

(b) Shelter.

(c) Recovery.

e. Basic needs in the event of an emergency.

f. Identification of circumstances in which service delivery can be postponed or omitted.

g. Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

h. Contingency plans for:

(1) The person served.

(2) The family/support system.

(3) Personnel.

Intent Statements

Persons served by HCS are at risk in emergent situations because of a variety of issues including age, developmental, cognitive, and physical levels of functioning. To address these risks persons served can seek, if they desire, to receive more information from the HCS on how to address emergent situations.

8.d.(1)(c) and **8.d.(2)(c)** Recovery after a disaster means the return of the person served to his or her home or community setting.

Examples

8.d.(1)(c) and **8.d.(2)(c)** Recovery might include physical home repairs, utility recovery, water damage, or public health assessment for safe/healthy living conditions.

8.e. Basic needs may include food, water, utilities, etc. Utility needs might include back-up power for a person who uses a power wheelchair or ventilator, or telephone service to be able to call 911 or reach family members who are away from home.

Resources

Resources for emergency preparedness include:

- **dhs.gov/disabilitypreparedness**
- **osha.gov/SLTC/emergencypreparedness/ index.htm**
- Office of Disability Employment Policy at the Department of Labor: **dol.gov/odep/ programs/emergency.htm**
- U.S. Department of Transportation: **dotcr.ost.dot.gov/asp/emergencyprep.asp**
- Emergency Evacuation Preparedness: Taking Responsibility For Your Safety-A Guide For People with Disabilities and Other Activity Limitations: **cdihp.org/products.html**
- Disaster Resources for People with Disabilities and Emergency Managers: **jik.com/ disaster.html**
- Emergency Preparedness Initiative (EPI) National Organization on Disability: **nod.org**
- Amputee Coalition of America resources for emergency preparedness: **amputee-coalition.org/nllic_easyread.asp**
- Special supplement to ACA InMotion When Disaster Strikes-a Pocket Survival Guide: **amputee-coalition.org/inmotion/ jan_feb_08/pocket_survival_guide.html**
- National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities: **diversitypreparedness.org**
- The Disaster Recovery Information Exchange (DRIE) has chapters throughout Canada: **drie.org**
- Public Safety and Emergency Preparedness Canada: **publicsafety.gc.ca** Provincial or territorial emergency measures organizations can also be used as resources.
- Disaster Preparedness for People with Disabilities: **disability911.com**
- The Canadian Centre for Emergency Preparedness: **ccep.ca**

3.T. 9. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the home and community services, on an ongoing basis:

 a. Determine that the technology and/or equipment:

 (1) Functions properly.

 (2) Achieves the intended purpose.

 b. Notify the appropriate designee, as needed.

 c. In accordance with the person-centered plan, incorporate the technology and/or equipment into service delivery.

Intent Statements

Technology has an ever-increasing presence in home and community services. It is important that service providers are attuned to the role and impact of technology on the lives of the persons served. The extent to which the service provider interacts in the environment in which technology is used by the person served guides the involvement of the service provider in the activities of this standard.

Examples

A driver who transports persons served to appointments in the community is unlikely to come into contact with environmental controls and adaptive equipment used by the person served in his or her home. However, because the person served may use a power mobility device (PMD), the driver would inquire about and observe whether the person is able to use the PMD safely and effectively. If the driver were to discover that the person served is not able to use the PMD as intended or was having some mechanical difficulty with it, it would be his responsibility to notify the appropriate person who could assist the person served.

"Smart homes" utilize information and communication technology that assist with daily living activities, safety, falls, health monitoring, and environmental control. Smart homes allow and provide a way to record the activities or inactivity of an individual in a home and report the event to a caregiver or family member in accordance with the preference of the person served. Examples of smart home systems include emergency call systems, control of heating and air systems, health monitoring, safety devices, medication monitoring, video cameras, and keyless entry. A person served might communicate to the home health aide that a video camera is not working. The aide notifies the appropriate personnel in the HCS, who then follow up with the appropriate family member or vendor.

3.T. 10. In accordance with the choice of the person served, the home and community services partner with the family/support system throughout the service delivery process, including ongoing consideration of:

 a. The family/support system's:

 (1) Ability and willingness to support and participate in the plan.

 (2) Composition.

 (3) Interpersonal dynamics.

 (4) Different methods of:

 (a) Engagement.

 (b) Communication.

 (c) Coping.

 (d) Problem solving.

 (5) Strengths and limitations.

 (6) Knowledge base.

 (7) Expectations of the home and community services.

 (8) Educational needs.

 (9) Responsibilities, including legal responsibilities.

 (10) Geographic proximity to the person served.

 b. Unique financial, social, or cultural factors that might influence the home and community services.

 c. Health status of the primary caregiver.

Intent Statements

When the person served agrees to having members of the family/support system involved in the

delivery of services, the home and community services assess the family/support system to include it effectively and optimally in the service delivery process. This assessment process can provide information that impact the opportunity for the person to remain in his or her home or community setting.

Examples

Factors that might impact participation in service delivery or support include that members of the family/support system live at a distance, work during typical service delivery times, have limited resources to assist, etc.

10.a.(3) Interpersonal dynamics refers to the interactions between the person served and his or her spouse/significant other, friends, peers, coworkers, employer, and community.

10.a.(4) Engagement may include the ability of the family/support system to participate in training sessions, learn new skills, call or email questions or concerns to personnel when they live at a distance, and willingness to participate in the person-centered plan, as appropriate.

10.a.(9) Responsibilities may include work and family-related responsibilities such as being the caregiver for young children or elderly parents.

10.b. Financial, social, or cultural factors may influence service delivery in areas such as setting goals for the person served, the provision of information and services, and exit/transition options.

3.T. 11. In accordance with the choice of the person served, policies and written procedures facilitate collaboration with the family/support system in decision making through the following:
   a. Accessible information.
   b. Time lines for exchange of information.
   c. Understanding of the information provided.

Intent Statements

To facilitate the decision-making roles of the person served and family/support system, they are given information in a way that is understandable and in sufficient time to make informed decisions.

Examples

11.c. The level of understanding of information may be determined though the assessment processes, asking the person served or members of the family/support system to summarize the discussion and decisions made, or verification by the person responsible for coordinating services.

3.T. 12. The home and community services provide education:
   a. To:
      (1) Persons served.
      (2) Families/support systems.
      (3) Other relevant stakeholders.
   b. In accordance with identified needs, that addresses, but is not limited to:
      (1) Accessing emergency care if necessary.
      (2) Communication with other service providers.
      (3) Developing a system to record personal health information.
      (4) Disease management.
      (5) Information about community resources and how to access them.
      (6) Preventive care.
      (7) Procedures unique to the provision of home and community services.
      (8) Safety issues related to the service delivery site.
      (9) Specific healthcare procedures and techniques, as appropriate.

Intent Statements

12.b.(3) Having a system or tool to record personal health information helps the persons served and their families/support systems ensure that they receive ongoing quality healthcare.

Such information empowers persons served to be responsible for an important step in their care, lessens the fragmentation of care among healthcare settings, and will likely decrease the risk of medical errors.

3.T. 13. **The home and community services have a mechanism to ensure that both the person served and the service provider can understand and communicate with each other.**

Examples

Accents and other language issues may pose barriers to communication between the persons served and the service provider. Mechanisms for nonverbal communication such as the use of a communication board or device may be necessary.

3.T. 14. **Based on the scope of services, to enhance the involvement of the persons served in the community, the home and community services:**
   a. **Are knowledgeable about the options available for:**
      (1) **Housing.**
      (2) **Transportation.**
      (3) **Technology.**
   b. **In accordance with the choice of the person served, advocate for the development of options for:**
      (1) **Housing.**
      (2) **Transportation.**
      (3) **Technology.**

Intent Statements

Whether the home and community services address housing, transportation, and technology would be guided by the scope of services provided. Many times persons served may lack knowledge of options in their area. There may be the need for the home and community services provider to assist the person served to become aware of options and resources that they will need to tap into to develop their plan for housing, transportation and /or technology. This may be needed to allow the person served to remain in his or her home and/or community, to get to and from work, and/or to participate in social activities.

Examples

14.a.(1) Housing options may include supported housing, public housing, or general community housing that is accessible for persons who use a wheelchair.

14.a.(2) Public transportation options may address transportation that is convenient for a person served who has limited endurance, mobility, or cognition and para-transit systems for persons served who use assistive mobility equipment.

14.a.(3) Technology options may include off-the-shelf technology as well as resources for customized technology to be used by the person served in the home and other community settings.

3.T. 15. **In accordance with the choice of the person served, the home and community services provide or arrange for financial assistance and planning that addresses:**
   a. **Benefits planning.**
   b. **Sustainability of services.**
   c. **Contingency planning.**
   d. **Education related to financial literacy.**
   e. **Short- and long-term planning for future services, including:**
      (1) **Funding and supports available.**
      (2) **Eligibility criteria.**
      (3) **Range of services available.**
      (4) **Amount of services available.**
      (5) **Impact on continuing benefits.**

Intent Statements

An in-depth financial analysis of the short and long-term costs of living independently will take into consideration both the present ability and future service needs of the person served.

In assisting an individual to live independently in the community, it is important to evaluate present and future costs associated with the living situation.

Examples

Factors to be considered include how benefits of the person served might be impacted and the potential of funding for services changing. It is important that the person served consider

being responsible for his or her own finances if appropriate.

Training in financial literacy may be provided directly by the home and community services or referred to an appropriate resource in the community.

Applicable Standards

Home and community services that provide specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need must also meet Standards 16.–18.

3.T. **16. The home and community services address the impact of the following areas on the service delivery process for each person served:**
   a. **Allergies.**
   b. **Current medications, including:**
      (1) **Medication sensitivities and adverse reactions.**
      (2) **Why each medication is prescribed.**
      (3) **Side effects.**
      (4) **Drug interactions.**
      (5) **Implications of abrupt discontinuation of medications.**
      (6) **Compliance.**
      (7) **Schedule for taking medications.**
   c. **The etiology and anticipated course of the illness, injury, impairment, disability, or a specific age or developmental need.**
   d. **The results of relevant diagnostic interventions.**
   e. **The results of relevant therapeutic interventions.**
   f. **Communication ability.**
   g. **Fatigue.**
   h. **Nutrition.**
   i. **Pain.**
   j. **Risk factors.**

   k. **Signs and symptoms of emergent medical or psychological conditions.**
   l. **Sleep.**

Intent Statements

To ensure the safety of the persons served and determine the most appropriate and beneficial interventions, knowledge of each person's health and medical status and history are important. This knowledge will allow the home and community services to minimize unnecessary interventions, establish an accurate baseline of health and functional status, set realistic goals, and optimize results. Whether services are provided by credentialed personnel or non-credentialed personnel, the impact of these areas on the service delivery for each person served is observed, considered, reported as applicable, and, as needed, addressed in the person-centered plan, including the involvement of additional team members as necessary.

16.b. The home and community services are aware of the effects of medications currently taken by the person served on his or her ability to participate in the services and tolerate therapeutic activity.

Examples

16.a. Allergies include medication allergies, food allergies, latex allergies, and any other allergies the services need to be aware of to ensure the safety of the person served.

16.h. Nutrition includes a person's diet as well as the consistency of his or her diet.

16.j. Risk factors may include that a child/youth has a history of runaway behaviors and involvement with the juvenile justice system, parental substance abuse.

3.T. **17. Depending on individual needs, the home and community services provide ongoing education and training to each person served that addresses:**
   a. **Disease management.**
   b. **Health advocacy, including prompt communication about health issues.**

c. Prevention related to:

(1) Recurrence of the illness, injury, impairment, disability, or a specific age or developmental need.

(2) Potential risks and complications due to the illness, injury, impairment, disability, or a specific age or developmental need.

d. Primary health care.

e. Utilization of health care resources.

f. Wellness.

Intent Statements

The ability for an individual to become engaged with wellness and management of their health issues is key to maintaining the ability to remain in home and community settings. Appropriate education and training is provided to persons based on their needs.

Examples

Persons served may take advantage of technology (computer, DVD, CDs) to become better educated or engaged with exercise programs, etc. They may need education about areas such as how to be an advocate for their needs.

17.b. It is important for persons served to be able to identify signs and symptoms and when it would be appropriate to contact a home and community services provider or other professional health care provider. Signs and symptoms might include changes in eating or sleeping patterns, rapid increase or decrease in weight, bizarre behaviors, night terrors, isolation, and suicidal ideation. The sudden onset, abruptness, or increased intensity or frequency of these symptoms signal the person served to advocate for care, medications, additional services, etc.

17.e. Education on utilization of health care resources might include decision making related to which health care provider is the most appropriate to seek advice for specific health issues or how to use insurance funding most effectively to meet individual needs.

3.T. **18.** The home and community services provide education on medication, as appropriate:

a. To:

(1) Persons served.

(2) Families/support systems.

b. That addresses:

(1) Actions to take in an emergency.

(2) Administration.

(3) Dispensing.

(4) Disposal.

(5) Errors.

(6) Expiration dates.

(7) Identification, including purpose of each medication prescribed.

(8) Implications for management of multiple medications.

(9) Implications of abrupt discontinuation.

(10) Indications and contraindications.

(11) Obtaining medication.

(12) Sharing medication.

(13) Side effects.

(14) Storage.

Intent Statements

Medication management in home and community settings differs from facility-based settings in which medications are controlled by pharmacists, nurses, and physicians. The ability to assess the understanding and competency of a person served and his or her family/support system to manage medications is critical to the person's safety, health, and well being.

Applicable Standards

Home and community services that provide respite services must also meet Standard 19.

3.T. **19.** **When respite services are provided somewhere other than the person's own home, the person served brings the following with him or her, if applicable:**

    a. **Adaptive equipment.**

    b. **Assistive technology.**

    c. **Emergency contact information.**

    d. **Information on everyday routines.**

    e. **Information/instructions regarding any special needs.**

    f. **Instructions for specific healthcare procedures.**

    g. **Medications.**

    h. **Pertinent health/medical history.**

Intent Statements

The ability for the respite services to create an environment that will meet the needs of the person while in that setting is critical.

19.d. In order to maintain a person-centered approach, respite services are knowledgeable about the normal routine of the person served.

Examples

19.a.–b. Depending upon the types of persons served, respite providers may need to be able to use a variety of equipment and assistive technology and may need additional training to develop those competencies. Training might be provided by the family, vendors, or other resources.

19.c.–h. A portable profile may be used to provide information.

19.e. Special needs may include nutritional/dietary needs.

Additional Resources

Associations are frequently used resources for information on regulations, accessibility, quality, development, evidence-based practices, accepted practices in the field, and regulatory. Additional resources for information include:

- World Homecare and Hospice Association
  http://www.whho.org
- National Association of Home Care and Hospice
  http://www.nahc.org
- Canadian Home Care Association
  http://www.cdnhomecare.ca

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 concerning verification of background information
- Policies and written procedures that address the service delivery issues
- Contingency plans if either the family/support system or service provider is unable to deliver care
- Disaster preparedness and emergency plans for the persons served
- Policies and written procedures concerning telecommunication, if applicable
- Policies and written procedures to facilitate collaboration with the family/support system in decision making
- Financial plans for the persons served that include benefits planning and contingency planning, in accordance with the choice of the persons served
- Individual program plans for the persons served
- Records of the persons served

U. Intensive Family-Based Services

Description

Intensive family-based services are provided in a supportive and interactive manner and directed toward maintaining or restoring a healthy family relationship and building and strengthening the capacity of families to care for their children. The services are time limited and are initially intensive, based on the needs of the family. The services demonstrate a multisystemic approach and have a goal of keeping families together or supporting reunification. The services may include wraparound and family preservation type programs.

Applicable Standards

An organization seeking accreditation for an intensive family-based services program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.U.   **1.   A full range of services are designed to:**

   a.   **Prevent out-of-home placement.**

   b.   **Maintain intact families.**

   c.   **Promote reunification.**

3.U.   **2.   Flexible services based on identified needs include, as appropriate:**

   a.   **Individual counseling services.**

   b.   **Skills 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.**

      (8)   **Parenting skills.**

   c.   **Family therapy.**

   d.   **School-based services.**

   e.   **Crisis management/stabilization services.**

   f.   **Positive youth development services.**

   g.   **Substance abuse services.**

   h.   **Nutritional services.**

   i.   **Health services.**

   j.   **Services coordination.**

   k.   **Medication management/monitoring services.**

   l.   **Culturally based services.**

   m.   **Housing services and prevention of homelessness.**

   n.   **Economic assistance referrals.**

   o.   **Child support enforcement referrals.**

   p.   **Employment services.**

   q.   **Domestic violence response services.**

Intent Statements

The program provides services designed to meet needs in any area of a family's functioning that may impact family stability. Services may be provided directly by the program or they may be provided under contract or through referrals.

Examples

2.q. Domestic violence may include interpersonal, family, and intimate partner violence and is not limited to physical or emotional abuse.

3.U.   **3.   Flexible resources are available to meet the family's tangible needs.**

Intent Statements

The program provides or facilitates access to available resources to meet the family's needs.

Examples

Available resources might include contingency funds or petty cash that can be used for essentials for the family, such as fixing a car to allow family to have transportation for work or other necessary appointments, purchasing needed clothing, or paying utility bills.

3.U. 4. **The program implements a process for identifying, locating, and engaging family members, as appropriate, in services.**

Examples

The program demonstrates its efforts to engage family, including extended family, in services. This may include the use of internet-based search services to locate family members.

3.U. 5. **The program has a plan for families to have access to a consistent team 24 hours a day, 7 days a week.**

Examples

The plan may be a crisis plan, an on-call roster, a section of the individualized plan of the persons served, or part of the program's description.

3.U. 6. **The program facilitates access to professionals trained in child/youth and family care, including:**
   a. **A psychologist.**
   b. **A counselor.**
   c. **A family therapist.**
   d. **A social worker.**
   e. **A youth worker.**
   f. **A psychiatrist.**
   g. **Medical personnel.**
   h. **Other providers, as appropriate.**

Intent Statements

It is understood that in some geographic locations, not all of the listed professionals may be available locally. It is important for the program to assist the persons served to connect with appropriate professionals for identified needed services that are beyond the scope of the program.

Examples

6.g. Medical personnel include a nurse, a physical therapist, or a speech therapist, based on the needs of the child/youth and family served.

3.U. 7. **Information on current community resources is:**
   a. **Maintained.**
   b. **Used for appropriate referrals of the persons served.**

3.U. 8. **The program collaborates appropriately with other programs in planning service delivery.**

3.U. 9. **The program provides access to respite care, including 24-hour crisis response services.**

Intent Statements

The program has a strategy to handle urgent situations that includes normative responses and actions as well as the most restrictive responses and actions that may be necessary to ensure the safety of the child/youth and maintain family stability.

3.U. 10. **Services are supervised by a qualified practitioner who:**
   a. **Provides clinical oversight.**
   b. **Directs the individualized plan for the persons served.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

🍁 Programs in Canada must meet the requirements of their provincial/territorial 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.

■ Plan to ensure access to consistent team 24 hours a day, 7 days a week

■ Information on current community resources

■ Information on resources to meet the family's tangible needs

■ Individual program plans for the persons served

■ Records of the persons served

V. Intensive Outpatient Treatment

Description

Intensive outpatient treatment programs are clearly identified as separate and distinct programs that provide culturally and linguistically appropriate services. 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 and/or interventions delivered by a variety of service providers in the community. The program may 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 level of treatment; and is considered to be more intensive than traditional outpatient services.

Applicable Standards

An organization seeking accreditation for an intensive outpatient treatment program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.V. **1. An intensive outpatient treatment program offers:**

    a. At least nine direct contact hours per week to adult persons served.

    b. At least six direct contact hours per week to children/adolescents served.

3.V. **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 intensive outpatient program offers a variety of service modalities that are designed to assist the person served to achieve his or her goals related to psychological or social functioning, self-esteem, and coping abilities or to external opportunities such as vocational, educational, or social.

3.V.   **3. The program offers education on:**

    a. **Wellness.**

    b. **Recovery.**

    c. **Resiliency.**

Intent Statements

These educational activities may be provided in individual, group, or other settings.

Examples

3.a. Wellness education is designed to assist the person served to achieve balance in physical and emotional health and wellbeing. For additional examples and ideas, see the SAMSHA website at **www.promoteaccteptance.samsha.gov/10by10/default.aspx**.

3.b. Recovery education includes activities designed to provide information about the person's disability/disorder with a focus on achieving the highest possible personal functioning and improvements in the person's social and occupational interactions.

3.c. Resiliency education is focused on improving the person's awareness of his or her strengths and building on those strengths.

3.V.   **4. To maximize the opportunity of the persons served to participate in the program, services are provided:**

    a. **In locations that meet the needs of the persons served.**

    b. **At times that meet the needs of the persons served.**

    c. **On days that meet the needs of the persons served.**

Intent Statements

Services can be provided in traditional office settings, community settings, online or in virtual settings, or in personal homes. Programs seek to minimize interruptions of activities such as work and school as well as other daily responsibilities of persons served.

3.V.   **5. To meet the needs of the persons served, the program demonstrates how it uses technology to:**

    a. **Increase access to services.**

    b. **Increase supports.**

    c. **Enhance services.**

Intent Statements

Program management and leadership seek to find and implement technologies that assist the persons served in meeting their goals. The program can describe what technologies it has implemented and what it is considering for the future.

Examples

5.a. The program may improve access to services through the use of websites, patient portals, tele-health services, social media, text messaging, and other methods to remind the persons served of appointments.

5.b. Increased supports could include use of technological supports between services, such as recovery-based applications or encouraging persons served to use online support communities and electronic communications with personnel, as appropriate.

5.c. The program may enhance services through technology such as patient portals for making appointments, requesting refills of medications, and accessing medical records; and/or through the use online tools such as outcome measures, cognitive behavioral therapy (CBT) tools, online assessments, and other services.

3.V. **6. When appropriate, and with the consent of the person served, the program integrates treatment with other services.**

Intent Statements

Often persons receiving outpatient treatment are also involved with healthcare and/or social services. The intent of this standard is to ensure that the program actively seeks information from and communicates with other healthcare providers, social service entities, schools, legal entities, child welfare agencies, and other services that are likely to improve the quality of its services to persons served and the outcomes achieved.

3.V. **7. The program addresses the emerging needs of the persons served through linkage to appropriate resources and supports.**

Examples

When a person served has emerging needs that are outside of the person-centered plan, such as being unable to pay utility bills, having a medical emergency in the family, or being unable to get to work due to a car breaking down, the program helps find support and assistance to address these needs through linkages to other services or providers.

3.V. **8. The program:**

    a. In collaboration with the person served, identifies the person's natural supports.

    b. Assists the person to develop and utilize his or her natural supports.

Examples

The program demonstrates its understanding of the need for persons served to develop and maintain a healthy support system. There is evidence that the program assists the person served to create long-term natural supports to reduce reliance on providers in their transition post-discharge.

3.V. **9. A review of the person-centered plan for each person served in an intensive outpatient treatment program occurs at least once per month.**

Examples

The review may be documented with updates or changes to the plan, with a plan update document, or through progress notes. The program demonstrates that it is adjusting to ongoing assessments and emerging issues 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 sub-section. See Appendix A for more information on required documentation.

- Individual person-centered plans of persons served
- Documentation of monthly reviews of person-centered plans
- Records of persons served

W. Promotion/Prevention

Description

Promotion/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. Promotion/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/neglect, exposure to and experience of violence in the home and community, and to inform the general public of problems associated with those issues, thereby raising awareness; or to intervene with at-risk or identified individuals to reduce or eliminate identified concerns. Programs may be provided in the community, school, home, workplace, or other settings. Programs that offer training to current or future child/youth personnel are also included.

Organizations may provide one or more of the following types of promotion/prevention programs, categorized according to the population for which they are designed:

■ Universal (Promotion) 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. Promotes positive behavior and includes social marketing and other public information efforts.

■ Selected (Prevention) 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 child and youth service 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 promotion/prevention program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.W. **1.** **The program is designed by personnel with demonstrated skill and knowledge in current evidence-informed/evidence-based prevention theory and practice.**

Intent Statements

Programs that provide training only will be designed by personnel with demonstrated skill and knowledge in professional development.

Examples

The program can demonstrate conformance to this standard through staff member interviews and documentation of skills and training in personnel files.

3.W. **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 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 inter-personal, family, and intimate partner relationships; bullying, gangs, and school-based violence.
- **2.f.** Safe sex, sexually transmitted diseases, HIV/AIDS, communicable diseases, teen pregnancy.
- **2.g.** Spirituality-based programs; dating issues.

3.W. **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.W. **4. Universal (promotion) and selected (prevention) programs include two or more, and training programs include a.–g., of the following strategies:**

a. **Increasing knowledge and raising awareness.**

b. **Building skills/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.W. **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.W. **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.W. **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.W. **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.

- Plan or written logic model detailing the approaches to be used in the program
- Documentation of evaluations of the program/services and training activities
- Written comprehensive curriculum for each course offered by trainings programs

X. Residential Treatment

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 disorders; who are victims or perpetrators of domestic violence or other abuse; for persons needing treatment because of eating or sexual disorders; or drug, gambling, or internet addictions. 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 behavioral health disabilities or 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, or in a natural setting such as a wilderness program. Residential treatment programs may include child caring institutions, domestic violence treatment homes, specialized educational programs, nonhospital addiction treatment centers, psychiatric treatment centers, or other nonmedical settings. Residential treatment programs may serve persons on a voluntary or involuntary basis and may be in a secure setting.

Applicable Standards

An organization seeking accreditation for a residential treatment program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.X. **1. The program provides treatment with integrated therapies, activities, and experiences throughout the day, seven days per week, which consists of three or more of the following:**

  a. **Therapeutic activities such as individual, family, 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. **Development of social skills.**

j. **Development of a social support network.**

k. **Development of vocational skills.**

l. **Assistance in securing housing that is safe, decent, affordable, and accessible.**

m. **Medical care and/or therapies.**

n. **Development of recreational and leisure skills.**

o. **Education on wellness and recovery.**

Examples

1.c. Training may address:

- Community integration goals and activities.
- Identification of target symptoms.
- Behavior management.
- Interview practices.
- Factors impacting the person 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.
- Parenting.
- Peer relationships, such as creating and maintaining healthy relationships.
- Incident reporting.

- Menu planning and meal preparation.
- Cultural competency and relevance.
- Sanitation and infection control.
- Safety procedures.
- Anger management.
- Conflict resolution.
- Scheduling of:
  - Menu planning and meal preparation.
  - Cleaning and maintenance of appliances.
  - Daily routines.
- Maintenance of adaptive equipment.
- Special dietary requirements.
- Recreation.
- Wellness.

3.X. 2. The services of each person served are supervised by a qualified practitioner who:

a. **Provides clinical oversight.**

b. **Directs the treatment plan.**

Intent Statements

See the Glossary for the definition of *qualified practitioner*.

3.X. 3. Based on the needs of the person served, services are provided by a coordinated team that:

a. **Includes, at a minimum, the following professionals:**

(1) **Assigned residential staff members or a plan coordinator.**

(2) **A qualified practitioner.**

(3) **Providers of appropriate health-care support services.**

b. **Meets weekly.**

Intent Statements

Because residential treatment programs serve individuals 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 program.

3.a.(2) See the Glossary for the definition of *qualified practitioner*.

3.X. 4. The program provides the following community living components, in accordance with all applicable regulations:

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. Individual possessions and decorations.

h. Daily access to nutritious:

(1) Meals.

(2) Snacks.

i. Opportunities for unstructured private time.

Intent Statements

The program provides opportunities for the persons served to experience and build the necessary skills to live within a community setting.

4.a. A written daily schedule would describe the activities offered.

4.c. The program encourages each person served to take increasing responsibility for cooperative operation of the household.

4.g. The program encourages and allows the persons served to have and display their own personal possessions and decorations. These items are consistent with the choices and needs of the persons served, except for items contraindicated due to safety reasons or by their individualized plans.

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 age-appropriate food preparation and performance of routine household duties.

3.X. 5. The program provides or ensures the provision of:

a. Healthcare services.

b. Pharmaceutical services.

Examples

❦ In Canadian programs providing Secure Services, any child/youth who has not had a medical examination within the last year should be seen by an appropriate healthcare professional within 10 days.

3.X. 6. The program has at least one staff member immediately available at all times who is trained in:

a. First aid.

b. Cardiopulmonary resuscitation (CPR).

c. The use of emergency equipment.

3.X. 7. Provisions are made to address the need for:

a. Cultural activities.

b. Spiritual activities.

c. Quiet areas.

d. Areas for visits.

3.X. 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 individualized plan is reviewed frequently enough to track progress toward identified goals and to note any new needs or interests.

3.X. **9.** **Persons served are given opportunities to participate in:**
   a. **Community activities.**
   b. **Cultural activities.**
   c. **Recreational activities.**
   d. **Spiritual activities.**

Intent Statements

9.a. It is understood that in a locked residential program, access to community activities may be restricted.

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.X. **10.** **Consent for the transportation of a child/youth served to and from any activity away from the residential setting is:**
   a. **Obtained at admission.**
   b. **Approved in writing by a parent or 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.

- Written daily schedule of activities
- Individual program plans for the persons served
- Quarterly reviews of the individual program plans
- Written approvals from parents/legal representatives to transport children/youths to and from any activities away from the group home setting, if applicable
- Records of persons served

Y. Respite

Description

Respite services facilitate access to time-limited, temporary relief from the ongoing responsibility of providing for the needs of the person served, families, and/or organizations. Respite services may be provided in the home, in the community, or at other sites, as appropriate.

Respite services may be planned or unplanned and may provide services of a short duration, such as respite for medical appointments, or longer duration, such as vacation or emergency coverage. Respite programs are not an alternative for placement.

Applicable Standards

An organization seeking accreditation for a respite program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

3.Y. **1.** **Respite services received by the family are based on their:**
   a. **Specific needs.**
   b. **Preferences.**

Intent Statements

Family needs and preferences make respite services unique to the families receiving them.

3.Y. **2.** **Respite services are:**
   a. **Accessible.**
   b. **Respectful of:**
      (1) **Each family's living routine.**
      (2) **The needs of the person served.**

Intent Statements

This standard reinforces the partnership between the persons served and the service provider.

Examples

Respite programs may consider the family's spiritual/religious beliefs, observance of holidays, school and work schedules, and curfews.

3.Y. **3.** **Family members are identified as resources for respite providers.**

Intent Statements

Generally, families know best what the person served needs and can be helpful in training others.

3.Y. **4.** **When applicable, the following accompany the person served:**

   a. Necessary medications.

   b. Needed medical equipment.

   c. Instructions for:

      (1) Medical care.

      (2) Specific needs of the person served.

   d. Personal belongings.

Examples

4.c.(2) This may include information about the person's safety needs, habits, fears, and functional status.

4.d. This may include items which have sentimental value or are comforting to the person served.

3.Y. **5.** **The respite site is matched to the identified needs of each person served.**

Intent Statements

The service delivery location is an important part of the family's service needs and could include a home or facility-based setting. Proximity is considered.

3.Y. **6.** **Recommendations for additional services are communicated to the family as needs are identified.**

Intent Statements

As a basis of the partnership between the program and the family, the program has a responsibility to convey its observations regarding the services needed to the family and the person served for their consideration.

3.Y. **7.** **The program implements written procedures that address health and safety concerns for each person entering respite services.**

Intent Statements

Written procedures address health and safety issues of the person served as well as others in the respite setting.

Examples

Respite services are offered in a variety of settings. Persons who receive respite services may use a single type of setting or may use a variety of settings with different respite providers. Some respite services may be offered in family homes where other children and youth are present, therefore written procedures address health and safety issues of the person served as well as others in the respite setting.

3.Y. **8.** **The individual record includes:**

   a. The date and time of entry into the program.

   b. Information about the person's personal representative, conservator, guardian, and/or representative payee, if any of these have been appointed, including his or her:

      (1) Name.

      (2) Address.

      (3) Telephone number.

   c. Information about the person to contact in the event of an emergency, including his or her:

      (1) Name.

      (2) Address.

      (3) 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 person's primary care physician, including, when available, his or her:

   (1) Name.

   (2) Address.

   (3) Telephone number.

g. Healthcare reimbursement information, if applicable.

h. As applicable, the person's:

   (1) Safety plan.

   (2) Court orders or other legal documents.

   (3) Health history and current status.

   (4) Current medications.

   (5) Preadmission screening, when conducted.

   (6) Documentation of orientation.

   (7) Consents.

   (8) Authorizations for release of information.

i. The date and time of discharge from the program.

j. The disposition of the person served at discharge.

Examples

8.j. May include whether the person served was discharged to the same person or family and to the same location where they were living prior to receiving respite services and any changes that have occurred.

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 instructions for medical care and specific needs of the persons served

■ Records of persons served

■ Written procedures that address health and safety

Z. Support and Facilitation

Description

Support and facilitation services are designed to provide instrumental assistance to children/youths and their families. They may also support or facilitate the interventions of other programs (for example, child/youth protection or support programs for foster or adoptive parents). These strength-based services are provided to enhance and support the child's/youth's and family's well-being. Services can include transporting children/youths served, supervising visitation between family members, individual support, child minding, safe exchange, homemaking services, parent aides, curfew monitoring, peer and youth support and family-to-family support, and translation services. The services are primarily delivered in the home or community. A variety of persons other than a program's staff, such as volunteers and subcontractors, may provide these services.

Applicable Standards

An organization seeking accreditation for a support and facilitation program must apply the standards in Section 1. In addition, standards in Section 2 must be applied according to the table at the beginning of Section 2, along with the standards in this subsection.

If the service is a foster care support program, Standards 1.–4. in this subsection must be met.

If the service is an adoption support program, Standards 1.–3. and 5.–13. in this subsection must be met.

If the service is a specialized recruitment program, Standards 1.–3. and 14.–19. in this subsection must be met.

3.Z. **1.** **The support and facilitation program demonstrates knowledge of and ability to provide appropriate services.**

Intent Statements

Services are individualized to the persons served and may provide a full spectrum of support and facilitation or only one type of service. The program demonstrates an awareness and use of community resources

Examples

A driver transporting a child/youth with physical challenges has the knowledge and skills necessary for safe transportation.

Visitation support programs are aware of what types of interactions observed require intervention.

Family-to-family support programs rely on relatives with relatable experiences to provide support to family member parents to enhance their roles as caregivers.

3.Z. **2.** **To maximize the opportunity of the persons served to participate in the program, services are provided:**
   a. **In locations that meet the needs of the persons served.**
   b. **At times that meet the needs of the persons served.**
   c. **On days that meet the needs of the persons served.**

Intent Statements

Services can be provided in traditional office settings, community settings, online or in virtual settings, or in personal homes. Programs seek to minimize interruptions of activities such as work and school as well as other daily responsibilities of persons served.

3.Z. **3.** **As applicable, there is coordination to facilitate continuity of care.**

Intent Statements

Support and facilitation personnel collect and provide information as appropriate to others involved in the life of the person served.

Foster Care Support Services

Applicable Standards

In addition to Standards. 1.–3., foster care support services must also meet Standard 4.

3.Z. **4.** **Training is provided through a standardized process, as appropriate:**
   a. **To:**
      (1) **Personnel.**
      (2) **Foster/kinship families.**
   b. **That includes, when applicable:**
      (1) **Attachment theory, including grief and loss.**
      (2) **Child/youth growth and development.**
      (3) **Behavior management skills.**
      (4) **Learning styles.**
      (5) **Cultural competency.**
      (6) **The effects of placement on children.**
      (7) **Health and nutrition.**
      (8) **Applicable legal issues.**
      (9) **Methods of communication.**
      (10) **Available services and supports.**
      (11) **Other specific needs.**

Intent Statements

The training subject areas should consider the relevant material for each of the trainee groups. Training may include a variety of methods including the use of films, classes, written materials, and online module.

Examples

4.b.(3) Behavior management may include appropriate methods of discipline.

4.b.(4) Learning styles includes how the person served best acquires new knowledge as well as any challenges or deficits the person served is faced with.

4.b.(9) Includes parent/child communication skills.

4.b.(11) Additional needs could include issues specific to the child/youth served, such as medical or physical needs or the use of assistive technology.

Adoption Support Services

Applicable Standards

In addition to Standards 1.–3., adoption support services must meet Standards 5.–13.

3.Z. 5. The program implements policies and written procedures related to:
  a. Supports for special needs adoptions.
  b. Supports for open adoptions.
  c. Supports for closed adoptions.
  d. Best practices.
  e. How cultural issues relevant to the persons served will be addressed.
  f. Adoptee relationships with:
    (1) Siblings.
    (2) Extended families.
    (3) Birth parent(s).
    (4) Previous foster families or other caregivers.
    (5) Significant others.

Examples

1.e. This may include how the adoptee maintains relationships with persons of their native culture.

3.Z. 6. Information on current community resources is:
  a. Maintained.
  b. Used for appropriate referral and placement of each child/youth served.

Intent Statements

Adoption support programs seek and maintain information on local community resources as well as have a collection of web-based or other reference material for dissemination to persons served.

3.Z. 7. 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 persons served.

Intent Statements

Contact information for current service providers as well as services potentially needed is maintained and readily available.

Examples

Referral networks may include behavioral health services, tutoring services, and community youth programs.

3.Z. 8. The program provides access to professionals trained in child/youth and family care, based on the needs of each child/youth, including:
  a. A psychologist.
  b. A counselor.
  c. A social worker.
  d. A youth worker.
  e. A psychiatrist.
  f. Medical care.
  g. Other providers as appropriate.

Examples

8.f. May include a nurse, physical therapist, or speech therapist, based on the needs of the child/youth served.

3.Z. 9. Training is provided through a standardized process, as appropriate:
  a. To:
    (1) Personnel.
    (2) Birth parents.
    (3) Adoptive parents.
    (4) Prospective adoptive parents.
    (5) Adoptees.
    (6) Applicable family members.

b. **That includes, when applicable:**
   (1) **Attachment theory.**
   (2) **Grief and loss.**
   (3) **Trauma stress.**
   (4) **Adoption issues.**
   (5) **The possibility of mental health issues and potential resources.**
   (6) **The impact of child abuse and neglect.**
   (7) **Child/youth growth and development.**
   (8) **Brain development.**
   (9) **Behavior management skills.**
   (10) **Learning styles.**
   (11) **Cultural sensitivity and responsiveness.**
   (12) **The effects of placement on children.**
   (13) **Applicable legal issues and court procedures.**
   (14) **Methods of communication.**
   (15) **Available services and supports.**
   (16) **Other specific needs.**

Intent Statements

The training subject areas should consider the relevant material for each of the trainee groups. Training topics may be specific to a particular phase of the adoption process. Training may include a variety of methods including the use of triad members to facilitate trainings, films, classes, and panel discussions.

Examples

10.b.(4) This may include stages of adoption; why adoption may be chosen; post-adoption depression; building a new family, taking into consideration such challenges as developing new family culture, integrating a new family member with her/his culture, values, beliefs, etc.; and lifelong adoption issues.

9.b.(7) This may include developmental milestones and health and nutrition requirements.

10.b.(16) In international adoptions, training may include information to facilitate settlement into a new geographical location.

3.Z. **10.** **The program confirms that the child/youth is legally available for permanent placement.**

Examples

Confirmation of legal availability for adoption is often evidenced by court documents, which would also clarify status of parental rights and visitation restrictions as applicable.

3.Z. **11.** **In the event of an adoption disruption or dissolution, the program provides counseling support or referrals to appropriate agencies to:**
   a. **The child/youth.**
   b. **The adoptive family where the child/youth had been placed.**

3.Z. **12.** **When permissible, the program provides services to adult adoptees that address:**
   a. **Efforts to gather information about their birth family and adoption circumstances.**
   b. **Need for assistance and support.**

Intent Statements

It is important to address issues of loss, cultural identity, medical history, and other significant information and events, when open adoption or other legal status allows.

3.Z. **13.** **The program provides services to birth parents, as needed, including:**
   a. **Education.**
   b. **Counseling.**
   c. **Support.**

Specialized Recruitment

Applicable Standards

In addition to Standards. 1.–3. specialized recruitment services must also meet Standards 14.–19.

3.Z. 14. When applicable, families are:

    a. Recruited to reflect the needs of the child/youth served.

    b. Selected through a process that:

        (1) Reflects the following needs of the child/youth:

            (a) Appropriate levels of care.

            (b) An environment reflective of his or her current environment.

            (c) Cultural identification.

        (2) Provides for a broad selection of families to ensure that the needs of each child/youth will be met.

    c. Monitored.

    d. Supported with services.

    e. Evaluated regularly.

Intent Statements

CARF is not accrediting the family unit, but rather the services provided by the program that make placement successful.

Examples

14.a. Specified needs could include:

- Behavior management.
- Conflict resolution.
- Problem solving.
- Anger management.
- Decision making.
- Crisis management.
- Parenting.
- Gender identity.
- Sexuality.
- Independent living.

3.Z. 15. Recruitment of families ensures the provision of a safe environment for the child/youth served, including security of:

    a. Weapons.

    b. Ammunition.

    c. Pharmaceuticals.

    d. Other items that could be harmful to the child/youth.

Examples

15.d. Other items could include:

- Sharp items or hazardous materials harmful to a small child or a youth with cognitive limitations.
- Items that may be used by a child/youth to harm self or others, such as knives, razors, or flammables.

3.Z. 16. The program utilizes written agreements that clearly define:

    a. The expectations of the:

        (1) Adoptee, when applicable.

        (2) Birth parent(s), when applicable.

        (3) Adoptive family.

        (4) Foster family, when applicable.

        (5) Program.

    b. The legal rights of all involved.

    c. All applicable fees.

Intent Statements

Written agreements are signed by program staff and other parties involved, as applicable.

Examples

2.a.(5) Items often included in written agreements include training requirements, support availability during preplacement visits, and post-adoptive finalization.

3.Z. 17. Training is provided through a standardized process, as appropriate:

    a. To:

        (1) Personnel.

        (2) Birth parents.

        (3) Adoptive or foster parents.

(4) **Prospective adoptive or foster parents.**

(5) **Adoptees.**

(6) **Applicable family members.**

b. **That includes, when applicable:**

(1) **Attachment theory.**

(2) **Grief and loss.**

(3) **Trauma stress.**

(4) **Adoption issues.**

(5) **The possibility of mental health issues and potential resources.**

(6) **The impact of child abuse and neglect.**

(7) **Child/youth growth and development.**

(8) **Brain development.**

(9) **Behavior management skills.**

(10) **Learning styles.**

(11) **Cultural sensitivity and responsiveness.**

(12) **The effects of placement on children.**

(13) **Applicable legal issues and court procedures.**

(14) **Methods of communication.**

(15) **Available services and supports.**

(16) **Other specific needs.**

Intent Statements

The training subject areas should consider the relevant material for each of the trainee groups. Training topics may be specific to a particular phase of the adoption process. Training may include a variety of methods including the use of triad members to facilitate trainings, films, classes, and panel discussions.

Examples

17.b.(4) This may include stages of adoption; why adoption may be chosen; post-adoption depression; building a new family, taking into consideration such challenges as developing new family culture, integrating a new family member with her/his culture, values, beliefs, etc.; and life-long adoption issues.

17.b.(7) This may include developmental milestones and health and nutrition requirements.

17.b.(16) In international adoptions, training may include information to facilitate settlement into a new geographical location.

3.Z. **18. Matching of the child/youth served with families:**

a. **Is based on the child's/youth's identified:**

(1) **Strengths.**

(2) **Needs.**

(3) **Preferences.**

b. **Focuses on minimizing disruption of lifelong relationships.**

Intent Statements

The selection of a specific family setting should not be made based solely on availability.

Examples

Preferences may include considerations related to sexual orientation, gender identification, spirituality, culture, or placement with siblings.

3.Z. **19. Based on the needs of the child/youth, the program:**

a. **Advocates for the placement of children/youths with their siblings.**

b. **When placement with siblings is not possible, advocates for and facilitates the planning of ongoing visits and contacts with siblings, as appropriate.**

Intent Statements

Maintaining sibling relationships is vital when preserving family; however, consideration regarding the safety of the child/youth served as well as siblings is a priority in placement decisions

Examples

19.b. Strategies for facilitating ongoing visits include adoptive families and children/youths planning for sleep-overs and joint vacations, meals, and other activities. Telephone calls, letters, and social networking are methods of ongoing communication.

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 that describe the requirements of providers' involvement in the individual planning process, if applicable

- Documentation of regular evaluations of foster families

- Written agreements that define the expectations of the program, the responsibilities of the foster families, the process of termination, and the appeal process

- Policies and written procedures related to adoption support services, if applicable

- Information on current community resources

- Documentation of the status of parental rights

- Written agreements for specialized recruitment services that define the expectations of the program, the responsibilities of the families, the process of termination, and the appeal process

SECTION 4

Child and Youth Services Specific Population Designations

A. Juvenile Justice

Description

Juvenile justice programs serve a specific population of adjudicated juveniles referred by the court or from within the juvenile justice system. 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 youth's ability to function effectively in the family, school, and community. The juvenile justice mandates include community safety needs in all judicial decisions and require that child and youth services 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, training, or employment 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 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, 2 (according to the table at the beginning of Section 2), and one or more of the service-specific core programs in Section 3, along with the standards in this subsection. For example, a juvenile justice program providing treatment through a residential model would apply the standards in Sections 1 and 2 as well as Sections 3.X. Residential Treatment and 4.A. Juvenile Justice.

4.A. **1.** **Services are delivered by a team with specialized knowledge of the various theories of, and approaches to, juvenile justice services.**

Intent Statements

In addition to Standard 2.A.18. 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 child/youth served in meeting his or her goals.

4.A. **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, provincial, or territorial confidentiality laws.**

Intent Statements

2.a. Access to clinical records can include access to information such as:

- Individual plans.
- Custody records.

4.A. **3.** **The child/youth 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 services 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 child/youth served work cooperatively and collaboratively as a team.

The child/youth 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.A. **4.** **When the program is responsible for the oversight of restitution or community service work required of the child/youth served, it:**

   a. **Ensures that all wage and hours laws are followed.**

   b. **Identifies a process for accurately accounting for funds/hours.**

4.A. **5.** **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:**

      (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

5.a. 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.

5.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.A. **6.** **The juvenile justice program conducts a timely assessment for each child/youth served that includes:**

   a. **A detailed history of the child's/youth'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 child's/youth's participation in organizations or groups that encourage criminal behavior.**

c. **The relationship between the child's/youth's behavioral health and his or her criminal activity.**

d. **Risk to self, other child/youth 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.A. **7.** **When applicable and/or permitted, family members and/or significant others are:**

a. **Identified.**

b. **Located.**

c. **Engaged in services.**

4.A. **8.** **When a juvenile justice program provides child and youth services in a correctional setting, it provides or advocates for access to a full range of services based on the child's/youth'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 child/youth served.

Examples

The services could include:

■ Screening and assessment.

■ Crisis intervention.

■ Case management, including referral to other services needed.

■ Crisis stabilization.

■ Counseling.

■ Medication management.

■ Inpatient and/or residential treatment.

■ Aftercare.

4.A. **9.** **When the program provides child and youth services in a correctional setting, the transition plan refers the child/youth 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.A. **10.** **Predischarge transition plans are:**

a. **Developed:**

(1) **With the active involvement of the child/youth 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, except when placement is less than 30 days.**

4.A. **11.** **The curriculum-based education program component for each child/youth 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, territorial, and state requirements.**

Intent Statements

11.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 child/youth served. This standard includes ensuring that reasonable accommodations are available for children/youths with special educational needs.

11.c. Because many of the juvenile justice educational services are provided as part of or within a treatment program, this standard encourages the program to ensure that the educational plan for each child/youth served is consistent with the philosophy of the treatment program.

Examples

The program 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.

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 conducted by the juvenile justice program
- Transition plans for the persons served
- Documentation of a curriculum-based education program component for each person served
- Individual plans for the persons served, as applicable
- Records of the persons served

B. Medically Complex

Description

Medically complex standards are applied to programs that serve a specific population of children/youths 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 child/youth 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 child/youth served in addition to medical consultation related to policies and procedures.

Services to children/youths 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 children/youths 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 child/youth'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 child/youth, 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 children/youths 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, 2 (according to the table at the beginning of Section 2), and one or more of the service-specific core programs in Section 3.

Organizations that serve children/youths who meet the definition of medically complex in a program that has not been specifically designed for this population may opt to apply

these standards in addition to the standards in Sections 1, 2 (according to the table at the beginning of Section 2), and one or more of the service-specific core programs in Section 3.

4.B. **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 child/youth served at a given point in time.

4.B. **2. The program collaborates with:**

　　a. **Healthcare providers who provide specialized medical, psychological/behavioral, and other therapeutic care to the child/youth served.**

　　b. **Other providers who provide specialized care to the child/youth served.**

Examples

2.b. Other providers may include child care, recreation, and education.

4.B. **3. Services are managed by an individual who has:**

　　a. **The education, training, and experience needed to meet the needs of children/youths 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.B. **4. The program informs the primary care physician(s) of the progress of each child/youth 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 children/youths 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 child/youth served and/or by a residential facility.

Examples

4.b. Examples of significant changes in the status of the child/youth served include an acute illness

that precipitates transfer to another level of care, a fall that results in significant injury, or death.

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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 children/youths 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.B. **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.B. **7.** **The program promotes a positive, therapeutic approach to behavior management, as applicable, that addresses:**
   a. **Instruction and guidance to the child/youth regarding desired behaviors that:**
      (1) **Build on current strengths.**
      (2) **Promote resiliency.**
   b. **Environmental factors to enhance the desired behaviors of the child/youth.**
   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 children/youths served; reducing noxious stimuli such as bright sunlight or odors; and limiting exposure to equipment, appliances, substances, etc. that may pose risk to children/youths served.

4.B. **8.** **As appropriate to the scope of the program, end-of-life planning:**
   a. **Is directed by the wishes/desires of the child/youth 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 child/youth served and/or legal guardian.**
   d. **Includes the guidance of a medical professional, if desired by the child/youth served and/or legal guardian.**
   e. **Is communicated to applicable service providers in the required format, if applicable.**

Intent Statements

Children/youths 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 child/youth 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 child/youth 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 child/youth served.

4.B. 9. The program has a written philosophy of health and wellness for the children/youths 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 children/youths 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 children/youths 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 children/youths served.

4.B. 10. The primary assessment for each child/youth served in the program includes the identification of:
  a. Presenting health risks.
  b. Health goals.
  c. Expected health benefits.

4.B. 11. Based on the initial and ongoing assessments, the individual plan of care addresses needs in the following areas, as appropriate:
  a. Adjustment of the child/youth to activity limitations.
  b. Adjustment of the family to activity limitations.
  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.B. 12. The individual plan of care:
  a. Specifically addresses how services will be provided in a manner that ensures the safety of the child/youth served.
  b. Identifies the services provided by skilled healthcare providers.

4.B. 13. Wellness for the child/youth 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 individual plan for each child/youth served.

4.B. **14.** The environment where services are provided addresses the behavioral and cognitive needs of the child/youth 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.B. **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 children/youths served are included or removed from those activities.

4.B. **16.** When applicable, the living environment provided for the child/youth served is:

a. Developed based on input from the child/youth served and family/guardian.

b. Modified as needed based on input from the child/youth served and family/guardian.

c. Inclusive.

d. Integrated into the community.

e. Physically supportive to meet the needs of the children/youths living in the residence.

f. Psychologically supportive to meet the:

(1) Emotional needs of the child/youth served.

(2) Social needs of the child/youth served.

4.B. **17.** When applicable, individual possessions and decorations reflecting the choices by the child/youth served are evident in his or her living environment.

4.B. **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 individual plan or medical condition.

4.B. **19.** **The education and training program for the child/youth 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.B. **20.** **When a child/youth served dies, opportunities are provided to other children/youths 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 available

- Written philosophy of health and wellness

- Initial and ongoing assessments of the persons served

- Individual plans for the persons served, including end-of-life planning, when applicable

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.	Cultural competency and diversity 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.a.	For U.S. organizations receiving federal funds, policy on corporate compliance, including an authorizing document, and designation of a primary contact
1.A.7.b.	Written designation of a staff member to serve as the organization's compliance officer
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 conflict of interest and 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

Implement the Plan (Continued)

Standard(s)	Requirements
F. Financial Planning and Management	
1.F.2.	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
1.H.5.	Written emergency procedures
1.H.7.d.	Written evidence of unannounced tests of all emergency procedures
1.H.9.	Written procedures regarding critical incidents
1.H.10.	Written analysis of critical incidents
1.H.12.h.	Written emergency procedures related to transportation services
1.H.13.b.	External inspections reports
1.H.14.b.	Self-inspection reports
1.H.15.	Written procedures concerning hazardous materials

Implement the Plan (Continued)

Standard(s)	Requirements
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
1.J.2.	Written procedures for services delivered via information and communication technologies, if applicable
K. Rights of Persons Served	
1.K.2.	Policies on the rights of persons served
1.K.3.a.	Policy(ies) and written procedure by which persons served may make a formal complaint
1.K.3.c.	Documentation of formal complaints
1.K.4.	Annual written analysis of all formal complaints
L. Accessibility	
1.L.2.	Accessibility plan
1.L.3.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
1.M.3.d.	Written business and service delivery objectives, performance indicators, and performance targets.

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.9.	Written procedures for the provision of mobile services
2.A.10.	Written program description that guides service delivery
2.A.11.	Policies and written procedures for collaboration in decision making
2.A.16.	Written procedures for the provision of crisis intervention services
2.A.18.e.	Documentation of attendance of participants at team meetings and results of team meetings
2.A.20.	Written procedures for the supervision of direct service personnel
2.A.21.	Documented ongoing supervision of direct service personnel
2.A.22.	Policies and supporting written procedures on behavioral interventions
2.A.23.a.	Policies addressing the use of crisis intervention procedures and written procedures governing the use of special treatment interventions and restrictions of rights
2.A.25.	Policies that address the handling of items brought into the program including drugs, weapons, and tobacco products
2.A.30.	Policy on obtaining criminal background checks on all persons providing direct services to children or youths
2.A.37.	Policies and procedures are that inclusive of a peer workforce
2.A.40.	Documented competency-based training for peer supporters
2.A.41.	Ethical codes of conduct that specifically address boundaries related to peer support services

Section 2. General Program Standards (Continued)

Standard(s)	Requirements
2.B. Screening and Access to Services	
2.B.1.	Policies and written procedures that define access to services
2.B.5.b.	Documentation of the immediate and urgent needs of the person served
2.B.6.a.	Documentation of actions when a child/youth is found ineligible for services
2.B.7.	Waiting list procedures and other required documentation
2.B.8.c.	Documentation of orientation provided to persons admitted to services
2.B.8.e.(4)	Copy of the program rules, provided to person served at orientation
2.B.8.e.(5)	Program policies, provided to child/youth served at orientation
2.B.12.	Primary assessment that includes the specified information
2.B.13.b.	Interpretive summary from primary assessment
2.C. Individualized Plan	
2.C.1.–2.	Individual plan for each person served
2.C.3.	Personal safety plans, when applicable
2.C.10.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.11.b.	If services are provided to persons who have intensive medical needs, the person-centered plan addresses how services will be provided
2.C.12.	Progress notes
2.D. Transition/Discharge	
2.D.1.	Written procedures for referrals, transition, and discharge
2.D.4.	Written transition plan
2.D.5.	Documents provided to external programs/services to support transition plans
2.D.6.	Reunification plan
2.D.11.	Written discharge summary for each child/youth that documents service episodes and results of services

Section 2. General Program Standards (Continued)

Standard(s)	Requirements
2.E. Medication Use	
2.E.1.	Policy that identifies whether medications are used in the program and the process for children/youths served to obtain medications needed to promote recovery and/or desired treatment/service outcomes
2.E.2.	Documented ongoing training and education regarding medications for persons served and personnel
2.E.3.	Written procedures for medications physically controlled by the program
2.E.4.a.	Up-to-date individual record of all medications used by persons served
2.E.4.b.	Telephone number of a poison control center, provided to personnel and persons served
2.E.4.c.	Written procedures regarding medications prescribed for or provided to a person served
2.E.5.	Written procedures for prescribing, dispensing, or administering of medications
2.E.6.	Written procedures for prescribing of medications
2.E.7.a.	Treatment guidelines and protocols related to prescribing of medications
2.E.7.b.	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.7.	Personal safety plan
2.F.8.	Policies on the use of seclusion or restraint
2.F.9. and 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 Person Served	
2.G.1.	Individual records of children/youths served
2.G.2.	All documents that require signatures include original or electronic signatures
2.G.3.	Individual records of children/youths served that include the identified elements
2.G.4.	Policy that specifies time frames for entries to the records of the person served
2.G.6.	Policies regarding information to be transmitted to other individuals or agencies
2.H. Quality Records Review	
2.H.1.	Quarterly records review

Section 3. Program Specific Standards

Standard(s)	Requirements
3.A. Adoption	
3.A.1.	Policies and written procedures
3.A.2.	Written agreements that define expectations, legal rights, and applicable fees

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.A.3.	Confirmations that the child/youth is legally available for permanent placement
3.A.5.e.	Comprehensive plan for selection of adoptive families
3.A.6.a.(2)–(5)	A home study; determination of readiness to adopt; criminal background checks; and formal approval conducted by a team
3.A.7.	Assessments that include the identified information
3.A.8.	Information collected from the birth parents
3.A.19.c.–d.	Tracking and analysis of adoption disruptions and dissolutions
3.A.22.	Individual record for each child/youth served that includes the identified elements
3.B. Assessment and Referral	
3.B.1.	Policies for assessment and referral
3.B.2.a.	Assessments of the needs of the person served
3.B.3.	Written summary assessment and referral(s)
3.C. Behavioral Consultation	
3.C.7.	Behavioral assessments
3.C.8.	Functional assessments when dealing with problem behaviors
3.C.11.	Written behavioral strategies
3.C.13.a.	Collected and summarized empirical data on implemented strategies
3.C.14.	Policies and written procedures addressing the use of behavioral treatments
3.C.15.a.	Curriculum, if consultation in Early Intensive Behavior Intervention (EIBI) is provided
3.D. Case Management/Services Coordination	
3.D.5.	Individualized plans with identified needs
3.D.6.	Ongoing coordination among multiple service providers
3.E. Child/Youth Day Care	
3.E.4.f.–g.	Policies regarding acceptance and late pickup
3.E.5.	Parents identify in writing the persons approved to have contact with the child/youth while at the program and to pick up the child/youth from the program

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.E.10.a.	Written consent of the parent or legal representative to provide healthcare
3.E.12.	Approval in writing by parent or legal representative of arrangements for transportation of a child/youth to and from any activity away from the day care site
3.E.15.	Current contact information, including telephone numbers, kept readily available at the day care site
3.E.16.	Documentation of the child's/youth's attendance, including arrival and departure times, arrival and departure times of personnel, and issues that arise during the child's/youth's stay
3.F. Child/Youth Protection	
3.F.1.	Program policies
3.F.7.	Plan for access to qualified professionals 24 hours a day, 7 days a week
3.F.9.	Information collected for initial reports of potential abuse or neglect
3.F.10.	Immediate response or safety plan
3.F.11.	Disclosures made by a child/youth are recorded in the child's/youth's own words
3.F.12.	Investigation report that includes information on any special needs of the child/youth served
3.F.21.d.	Immediate safety plan
3.F.24.	Policies on investigations of reports of maltreatment
3.F.26.a.(3)	Case management plan
3.F.27.	Policy on case closure for child/youth and family
3.F.28.	Policy on parental rights, roles, and responsibilities
3.G. Community Housing and Shelters	
3.G.1.h.	Policies on visitors, guests, and pets
3.G.2.	Policies and written procedures for special security procedures and confidentiality needs
3.G.4.	Individual service plan for each child/youth served
3.G.5.	Individual service plan for each child/youth served

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.H. Community Transition	
3.H.7.e.	Discussions and decisions made by the person served
3.H.9.	Opportunities to participate in the community and manner in which the person served will participate are documented in the individual plan
3.I. Community Youth Development	
3.I.2.e.	Discussions and decisions made by the person served
3.I.4.	Written agreement for program participation
3.I.9.	Discharge summary
3.J. Congregate Care	
3.J.4.a.	Written daily schedule of activities
3.J.7.a.	Written consent of parent or legal representative for healthcare services
3.J.10.	Individual service plan for each child/youth served
3.J.11.	Individual service plan for each child/youth served
3.J.17.	Written approval by parent or legal representative of arrangements for transportation
3.L. Crisis Programs	
Crisis and Information Call Centers	
3.L.1.	Program policies and written procedures
3.L.2.a.–c.	Written training plan and detailed curriculum
3.L.4.	Written procedures to ensure access during identified hours of operation
3.L.6.	Written procedures
3.L.9.b.	Written statement describing crisis resolution
3.L.11.b.	Written agreements with secondary providers
3.L.14.	Written procedures for information and referral programs
3.L.15.	Policy for information and referral programs

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
Crisis Intervention	
3.L.17.	Initial crisis intervention plan, developed upon contact for each child/youth served
3.L.21.	Written emergency procedures
3.L.25.	Written procedures that guide access to inpatient services or less restrictive alternatives
3.N. Detoxification	
3.N.1.	Medical evaluation, obtained prior to or within 24 hours of admission
3.N.2.e.	Health screening completed for each person admitted
3.N6.	Documentation maintained by qualified personnel regarding each person's condition
3.N.9.	Written procedures addressing transfer to emergency medical services
3.O. Diversion/Intervention	
3.O.6.	Plan or written logic model that details the specific theoretical and methodological approaches to be used, and how they will be applied within the community
3.O.7.c.	Evaluation of programs/services and training activities
3.O8.b.	Screenings or assessments have a documented plan for individual outcomes
3.P. Early Childhood Development	
3.P.1.	Policies and procedures to address staff credentials, staffing ratios and group size
3.P.7.a.	Tracking of children identified as possibly having a developmental delay
3.P.10.	Training/support curriculum
3.P.13.a.	Written consent of parent or legal representative for program to provide healthcare
3.P.16.	Written identification of persons approved to have contact with child/youth
3.P.17.	Written approval by parent or legal representative of arrangements for transportation

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.P.20.	Current contact information
3.Q. Foster Care	
Foster Family and Kinship Care	
3.Q.5.	Reunification plan for each child/youth
3.Q.8.	Comprehensive plan for recruitment, selection, and maintenance of foster care providers
3.Q.10.	Written agreement for foster/kinship families
3.Q.11.	Documentation of training provided to foster and kinship families
Specialized or Treatment Foster Care	
3.Q.22.	Documentation of provider training, including the type, length, and date of training
3.Q.26.	Comprehensive plan for the selection of providers
3.Q.27.c.	Assessment of the appropriateness of the match for children/youths with available foster care providers
3.Q.28.	Written agreement that defines the expectations of the organization and the foster care provider
3.Q.31.	Plan to regularly monitor each foster home placement
3.Q.36.	Plan for access to qualified practitioners 24 hours a day, 7 days a week
3.R. Group Home Care	
3.R.10.a.	Written daily schedule of activities
3.R.18.	Approval in writing by parent or legal representative of arrangements for transportation of a child/youth to and from any activity away from the congregate setting
3.R.21.	At least a quarterly review of each child's/youth's plans of services, goals and progress
3.R.22.	Plan for access to qualified practitioners 24 hours a day, 7 days a week
3.S. Health Home	
3.S.1.	Written program description covering all areas listed
3.S.3.b.	Written procedures for access to primary care or other medical services, sharing of information, and coordination of care

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.S.7.b.(4)	Assessment of service needs
3.S.7.b.(6)	Integrated person-centered plans for persons served
3.S.13.	Policies regarding initial consent for treatment
3.S.14.	Written screening procedures
3.S.15.	Health assessment screening
3.S.16.	Person-centered plan for each person served
3.S.17.	Written procedures for follow-through in response to the initial assessment
3.S.18.	Written procedures for all areas listed
3.T. Home and Community Services	
3.T.3.	Written procedures for actions to occur to verify backgrounds of personnel
3.T.5.	Policies and written procedures addressing all listed service delivery issues
3.T.6.	Risk assessment of each child/youth served
3.T.8.	Emergency plans that include assessment of current knowledge, physical environment, modifications necessary, community resources, utility needs, program continuation, provisions for communication, contingency plans, emergency preparedness
3.T.11.	Policies and written procedures to facilitate collaboration with family/support system
3.U. Intensive Family-Based Services	
3.U.5.	Policy that demonstrates commitment to having an identified person/team working consistently with the family
3.U.7.	File of current community resources for appropriate referrals
3.V. Intensive Outpatient Treatment	
3.V.9.	Review of person-centered plan occurs at least once per month
3.W. Promotion/Prevention	
3.W.5.	Written program plan
3.W.6.c.	Evaluation of programs, services, and training activities
3.W.7.	Written comprehensive curriculum for each course offered

Section 3. Program Specific Standards (Continued)

Standard(s)	Requirements
3.X. Residential Treatment	
3.X.4.a.	Written daily schedule of activities
3.X.8.	At least a quarterly review of each child's/youth's plans of services, goals and progress
3.X.10.	Approval in writing by parent or legal representative of arrangements for transportation of a child/youth to and from any activity away from the group home setting
3.Y. Respite	
3.Y.4.c.	Instructions that accompany the person served for medical care and other specific needs of person
3.Y.7.	Written procedures that address health and safety concerns for each person entering respite services
3.Y.8.	Individual records for each person served that include all listed information
3.Z. Support and Facilitation	
3.Z.5.	Policies and written procedures related to all listed areas
3.Z.14.e.	Regular evaluations of provider families
3.Z.16.	Written agreements with provider families that include all listed areas

Section 4. Child and Youth Services Specific Population Designations

Standard(s)	Requirements
4.A. Juvenile Justice	
4.A.6.	Timely assessment for each child/youth served that includes the identified elements
4.A.9.	When the program provides services in a correctional setting, a transition plan that includes the identified elements
4.A.10.	Predischarge transition plans that address the identified elements
4.A.11.	Curriculum for education program component for each child/youth served

Section 4. Child and Youth Services Specific Population Designations

Standard(s)	Requirements
4.B. Medically Complex	
4.B.1.	Program description of services that includes the identified elements
4.B.9.	Written philosophy of health and wellness for the children/youths served
4.B.10.	Primary assessment for each child/youth served that includes identification of presenting health risks, health goals, and expected health benefits
4.B.11.	Person-centered plan of care for each child/youth served that addresses identified needs
4.B.12.	Individual plans of care that address how services will be provided to ensure the safety of the child/youth served and that identify the services provided by skilled healthcare providers
4.B.13.g.	Activities to promote wellness evident in the individual plan for each child/youth served

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. During an original survey the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey.

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. Standards that require activities be conducted on an *ongoing* or *as needed* basis are also not included here.

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. 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.F.12.	If the organization is a CCRC, an independent audit of the financial statements is completed within 120 days of fiscal year end
1.G.1.b.(1)	Risk management plan reviewed for relevance
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.7.	Unannounced tests of all emergency procedures, including complete actual or simulated physical evacuation drills, tested on each shift at all locations
1.H.10.	Critical incidents are reviewed, resulting in a written analysis provided to or conducted by leadership
1.H.12.l.	If transportation services are contracted, the contract is reviewed against Standards 1.H.12.a.–k.
1.H.13.	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

Activities to be Conducted Annually (Continued)

Related Standard	Activity
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.J.1.c.	Review of technology and system plan
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.4.	Written analysis of all formal complaints that determines trends, areas needing performance improvement, and actions to be taken
1.L.2.b.	Accessibility plan annual review
1.N.1.	Performance analysis
2.A. Program/Service Structure	
2.A.1.c.	Review and update scope of services
2.E. Medication Use	
2.E.8.a.	Documented peer review on prescribing of medications
2.F. Nonviolent Practices	
2.F.5.a.	Written status report on plan for minimization or elimination of use of seclusion and/or restraint
2.F.15.b.(1)	Review of use of seclusion and restraint
3.S. Health Home	
3.S.15.c.(2)	Health assessment screening

Activities to be Conducted Semiannually

Related Standard	Activity
2.E. Medication Use	
2.E.5.l.	Assessment of abnormal involuntary movements 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. Quality Records Review	
2.H.1.	Quarterly professional review of service quality, appropriateness, and utilization
3.G. Community Housing and Shelters	
3.G.4.e.	Review of plan of services, goals, and progress toward goals for child/youth served
3.J. Congregate Care	
3.J.10.d.	Review of plan of services, goals, and progress toward goals for child/youth served
3.R. Group Home Care	
3.R.21.	Review of plan of services, goals, and progress toward goals for child/youth served
3.X. Residential Treatment	
3.X.8.	Review of plan of services, goals, and progress toward goals for child/youth served

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

Activities to be Conducted Monthly

Related Standard	Activity
3.C. Behavioral Consultation	
3.C.4.	In Behavioral Consultation, monthly team meetings occur between individual plan participants
3.V. Intensive Outpatient Treatment	
3.V.9.	Review of person-centered plan

Activities to be Conducted Weekly

Related Standard	Activity
3.J. Congregate Care	
3.J.2.b.	Weekly team meetings
3.R. Group Home Care	
3.R.1.b.	Weekly team meetings
3.X. Residential Treatment	
3.X.3.b.	Weekly team meetings

Activities to be Conducted Daily

Related Standard	Activity
3.J. Congregate Care	
3.J.4.a.	Daily schedule of activities provided
3.R. Group Home Care	
3.R.10.a.	Daily schedule of activities provided
3.X. Residential Treatment	
3.X.4.a.	Daily schedule of activities provided
4.B. Medically Complex	
4.B.13.b.	Daily structured and unstructured activities
4.B.13.d.	Daily group interaction
4.B.18.	Daily access to nutritious meals and snacks

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.12.b.	Regular review of driving records of all drivers
1.H.12.k.	Maintenance of vehicles owned or operated by the organization
1.I.2.b.(2)	Verification of backgrounds and credentials of personnel throughout employment
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.A. Program/Service Structure	
2.A.18.d.	Meet as often as necessary to carry out decision-making responsibilities
2.A.23.c.	Regular evaluation of any restrictions placed on the rights or privileges of the persons served

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity
2.B. Screening and Access to Services	
2.B.9.	Continuously conducts assessments
2.B.14.	Time frames for conducting reassessments, when appropriate
2.E. Medication Use	
2.E.5.n.	Review of medication use activities as part of quality monitoring and improvement system
2.F. Nonviolent Practices	
2.F.14.	Sign off on all use of seclusion and restraint within designated time frame
3.C. Behavioral Consultation	
3.C.13.	Ongoing formal monitoring
3.C.15.f.	Reassessments of children/youths at regular intervals
3.G. Community Housing and Shelters	
3.G.1.a.	Regular meetings between the child/youth served and staff
3.J. Congregate Care	
3.J.4.b.	Regular meetings between the child/youth served and program personnel
3.L. Crisis and Information Call Centers	
3.L.14.b.	Regularly updating database
3.Q. Foster Care	
3.Q.7.e.	Regular evaluations of foster/kinship families
3.Q.31.	Regular monitoring of each foster home placement
3.R. Group Home Care	
3.R.10.b.	Regular meetings between the child/youth served and program personnel
3.X. Residential Treatment	
3.X.4.b.	Regular meetings between the child/youth served and program personnel
3.Z. Support and Facilitation	
3.Z.14.e.	Regular evaluations of families in a specialized recruitment program

Activities to be Conducted at a Frequency
Determined by the Organization

Related Standard	Activity
4.A. Juvenile Justice	
4.A.5.b.	Regular interdisciplinary cross training related to clinical and juvenile justice issues

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. Additionally, standards that address provision of information only, instruction, skill development, notifications, feedback, and other communications have not been 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.7.c.(1)–(2)	Training on corporate compliance	Personnel	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

Implement the Plan (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
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
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 appropriate	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.7.c.(4)	Necessary education and training of personnel regarding emergency procedures	Personnel	No	As needed
1.H.10.b.(5)	Necessary education and training of personnel regarding critical incidents	Personnel	No	As needed
1.H.11.b.(1)(a)	Training regarding infections	Personnel, persons served, and other stakeholders	No	None specified
1.H.11.b.(1)(b)	Training regarding communicable diseases	Personnel, persons served, and other stakeholders	No	None specified
1.H.12.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

Implement the Plan (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
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
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)(a)	Training that addresses reporting of suspected abuse	Personnel	No	At orientation and regular intervals
1.I.5.b.(8)(b)	Training that addresses reporting of suspected neglect	Personnel	No	At orientation and regular intervals
1.I.5.b.(9)	Training that addresses rights of the persons served	Personnel	No	At orientation and regular intervals
1.I.5.b.(10)	Training that addresses rights of personnel	Personnel	No	At orientation and regular intervals
1.I.5.b.(11)	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

Implement the Plan (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
J. Technology				
1.J.3.	Training in equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting	Personnel who deliver services via information and communication technologies	Yes	None specified
1.J.4.	Instruction and training in equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting	Persons served, families/support systems, and others, as appropriate	No	None specified

Section 2. General Program Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.A. Program/Service Structure				
2.A.15.	Family education	Persons Served	No	None specified
2.A.19.b.(1)	Training that includes areas that reflect the specific needs of the persons served	Personnel providing direct services	Yes	None specified
2.A.19.b.(2)	Training that includes clinical skills that are appropriate for the position	Personnel providing direct services	Yes	None specified
2.A.19.b.(3)	Training that includes person-centered plan development	Personnel providing direct services	Yes	None specified
2.A.19.b.(4)	Training that includes interviewing skills	Personnel providing direct services	Yes	None specified
2.A.19.b.(5)	Training that includes program-related research-based treatment approaches	Personnel providing direct services	Yes	None specified
2.A.27.	Training in the use of adaptive devices, toys, and equipment, when applicable	Personnel, persons served, caregivers, others	No	None specified
2.A.39.b.	Training on the role of peer support specialists	Personnel	No	None specified
2.A.40.	Documented competency-based training	Peer support specialists	Yes	None specified
2.B. Screening and Access to Services				
2.B.3.e.(2)	Personnel are trained on use of screening instruments	Personnel	No	None specified
2.B.9.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

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
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
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

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
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.1.a.	The organization has a policy on how personnel will be trained on prevention of workplace violence	Personnel	No	None specified
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

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.F.3.d.	Training on first aid and CPR	Same as above	Yes	Initial and ongoing
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
2.H. Quality Records Review				
2.H.2.a.	Personnel are trained to perform a quarterly review of records of the persons served	Personnel	No	None specified

Section 3. Child and Youth Services Core Program Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.A. Adoption				
3.A.9.b.	Education on adoption	Birth parents	No	None specified
3.A.10.	Training that covers all areas listed in the standard	Personnel, birth parents, adoptive parents, prospective adoptive parents, adoptees, and applicable family members	No	None specified
3.C. Behavioral Consultation				
3.C.1.	Training on behavioral strategies and techniques	Support system of the person served	No	None specified
3.C.2.	Training on specific behavior management techniques	Personnel	no	None specified
3.C.10.	Training on behavioral strategies	Child/youth served, family, other support persons	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.C.15.b.(1)–(3)	Training on Early Intensive Behavioral Intervention (EIBI)	Family, intervention workers, other individuals	No	None specified
3.C.15.g.	Training of intervention workers in behavioral management theory and practical skills	Intervention workers	No	Ongoing
3.E. Child/Youth Day Care				
3.E.3.	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.F. Child/Youth Protection				
3.F.2.	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.F.29.	Education on maltreatment issues and services	Community members	No	None specified
3.G. Community Housing and Shelters				
3.G.8.b.	Educational and/or vocational programming	Persons served	No	None specified
3.H. Community Transition				
3.H.3.b(.1)–(10)	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.H.7.b.	Education about health and safety risks and consequences associated with choices	Persons served	No	Ongoing
3.I. Community Youth Development				
3.I.8.a.–b.	Training to enhance advocacy and leadership skills	Persons served	No	None specified
3.J. Congregate Care				
3.J.3.	Training that covers all areas listed in the standard	Personnel	Yes	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.K. Counseling/Outpatient Programs				
3.K.2.	Education on wellness and resiliency	Personnel, persons served, other stakeholders	No	None specified
3.L. Crisis Programs				
Crisis and Information Call Centers				
3.L2.a.–c.	Training that is guided by written training plan, a detailed curriculum, and a post-training assessment of competency	Persons providing services	Yes	Initial and ongoing
3.L.11.	Training for roll-over calls	Secondary providers	No	None specified
Crisis Intervention				
3.L.20.	Persons providing mobile services are trained and certified in the use of first aid and CPR	Personnel	No	None specified
3.M. Day Treatment				
3.M.4.a., g., and h.	Education regarding alcohol, drugs, medications, and psychoeducation as part of treatment activities	Persons served	No	None specified
3.O. Diversion/Intervention				
3.O.1.	Training on diversion alternatives	Personnel	No	None specified
3.P. Early Childhood Development				
3.P.3.	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.P.8.	Education on child development	Parents and caregivers	No	None specified
3.P.10.	Training that covers all areas listed in the standard	Parents and caregivers	No	None specified
3.Q. Foster Care				
Foster Family and Kinship Care				
3.Q. 11.a.(1)–(12)	Training that covers all areas listed in the standard	Foster and kinship families	No	None specified
Specialized or Treatment Foster Care				

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.Q.22.	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.R. Group Home Care				
3.R.3.a.–n.	Training that covers all areas listed in the standard	Personnel	Yes	None specified
3.T. Home and Community Services				
3.T.12.	Education that covers all areas listed in the standard	Persons served, families/support systems, other stakeholders	No	None specified
3.T.15.d.	Education on financial literacy	Persons served	No	None specified
3.T.17.	Education and training that covers all areas listed in the standard	Persons served	No	Ongoing
3.T.18.	Education that covers all areas listed in the standard	Persons served, other stakeholders	No	None specified
3.V. Intensive Outpatient Treatment				
3.V.3.	Education on wellness and recovers	Persons served, other stakeholders	No	None specified
3.W. Promotion/Prevention				
3.W.3.	Education on wellness and recovery	Persons served, other stakeholders	No	None specified
3.X. Residential Treatment				
3.X.1.o.	Education on wellness and recovery	Persons served, other stakeholders	No	None specified
3.X5.	Training in first aid, CPR, and the use of emergency equipment	Personnel	No	None specified
3.Z. Support and Facilitation				
3.Z.4.	Training that covers all areas listed in the standard	Personnel, foster/kinship families	No	None specified
3.Z.9.	Training that covers all areas listed in the standard	Personnel, birth parents, adoptive parents, prospective adoptive parents, adoptees, and applicable family members	No	None specified

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.Z.17.	Training that covers all areas listed in the standard	Personnel, birth parents, adoptive parents, prospective adoptive parents, adoptees, and applicable family members	No	None specified

Section 4. Child and Youth Services Specific Population Designations

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.A. Juvenile Justice				
4.A.5.b.	Training that covers all areas listed in the standard	Personnel	No	Prior to service delivery
4.A.11.	Education program that covers all areas listed in the standard	Child/youth served	No	None specified
4.B. Medically Complex				
4.B.19.	Education and training program that covers all areas listed in the standard	Child/youth served	No	None specified

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 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, Child and Youth Services) 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.

Administrative location: Sites where the organization carries out administrative operations for the programs or services seeking accreditation and/or personnel who provide the programs or services seeking accreditation are located.

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 strengths, needs, abilities, and preferences 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, Child and Youth Services) Being part of the mainstream of family and local community life, engaging in typical 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: Services and/or assistance programs that are available to the members of a community. They commonly offer persons help to become more self-reliant, increase their social connectedness, and maintain their human rights and well being.

Community settings: Locations in the community that are owned or leased and under the control of another entity, organization, or agency, and where organization personnel go for the purpose of providing services to persons in those locations. Examples include: community job sites that are owned or leased by the employer(s) where the organization may provide employment supports such as job coaching, vocational evaluation, or work adjustment; school settings where services such as early intervention or prevention services may be provided during the school's regular school, pre-school, or after-school program hours; or public or private sites such as libraries, recreational facilities, shopping malls, or museums where services such as community integration, case management, or community support may be provided.

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 more than one physician.

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.

Controlled/operated: The right or responsibility to exercise influence over the physical conditions of a facility where service delivery/administrative operations occur. An organization is considered in control of all facilities where it delivers services to persons who are present at the time of service delivery for the sole purpose of receiving services from the organization (e.g., services provided to students at a school outside of the school's regular school, pre-school, or after-school program hours). An organization is not considered in control of facilities where it delivers services to persons who are present at the time of service delivery for purposes other than receiving services from the organization (e.g., services provided at a school to students who are present at the school to participate in the school's regular school, pre-school, or after-school programs).

Core values: The essential and enduring tenets of an organization. They are a small set of time-less 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, contribut-ing, 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, pro-duce, 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 behav-ior 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) A document that 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, language, religion, economic status, gender, age, or sexual orientation.

Donated location/space: Physical space not owned or leased by the organization but made available to the organization without charge for the purposes of delivering services or for administrative operations on an ongoing basis and which the organization controls or operates during the time of service delivery/administrative operations. The location and availability of the space does not vary at the discretion of the donating entity.

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, Child and Youth Services, Employment and Community Services, Vision Rehabilitation Services) A person's parents, spouse, children, 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, 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. 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, Child and Youth Services) 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 Retirement Communities, Employment and Community Services, Medical Rehabilitation, 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 non-conformance 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 other opioid agonists or partial agonists.

Medication-assisted treatment: (Opioid Treatment Program) Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care. (Definition from SAMHSA)

Medication control: (Aging Services, Behavioral Health, Child and Youth Services, 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 use disorder 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, Child and Youth Services) 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 may be initiated or planned, facilitated in partnership with such a provider.

Natural supports: (Employment and Community Services, 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 opioid use disorder.

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 transition/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 might 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, Child and Youth Services, 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 or leased by a person served.

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. 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.

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, Opioid Treatment Program) 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 lifestyle, 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, 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, changing from child/adolescent service systems to adult systems, or leaving care or services/supports.

Transition plan: (Aging Services, Behavioral Health, Child and Youth Services, Opioid Treatment Program) A document developed with the full participation of the person served that (a) focuses on a successful transfer/transition between program or service phases/levels/steps or (b) focuses on a successful transition to a community living situation. The plan could be part of the individual plan and details 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: The time a person is young—generally referring to the time between childhood and adulthood.

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