2026

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Continuing Care Retirement Community

Standards Manual

carf INTERNATIONAL

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CARF International is a group of private, nonprofit companies (including CARF, CARF Canada, and CARF Europe) that accredit health and human services. For more information, please visit www.carf.org.

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INTRODUCTION

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

The CARF International 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, **https://carf.org/about/#IAC**

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 providing access to services and improving the quality of life for 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.** They are the principal decision makers throughout the course of a program/service. Persons served have the right to choose whether members of the family, support system, or advocates may participate in that decision-making process. In circumstances when the person served is unable to exercise self-representation at any point in the decision-making process, *person served* is interpreted to also encompass those persons legally authorized to make decisions on behalf of the person served.

Values

CARF believes in the following core values:

- All people have the right to be treated equitably with dignity, respect, and inclusion.
- 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 over 60 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 survey findings and, ultimately, allow CARF to determine the accreditation decision. On subsequent surveys, the organization is expected to demonstrate continuous conformance from any previous period of CARF accreditation.

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 the instructions in those sections.

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 standards. 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 applying for accreditation, 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 seeks accreditation for a program or service that is not listed in this manual, the organization should also contact CARF for more information.*

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 with any questions regarding which manual to use, which standards apply, interpretation of the standards, and clarification of the accreditation process. It is important to access CARF resources throughout the preparation process. Following is a list of CARF's customer service units (CSUs) and other publications related to each.

Customer Service Unit	Standards Manuals and Related Publications
Aging Services	■ Aging Services Standards Manual ■ Aging Services Survey Preparation Workbook* ■ Continuing Care Retirement Community Standards Manual ■ Continuing Care Retirement Community Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Behavioral Health	■ Behavioral Health Standards Manual ■ Behavioral Health Survey Preparation Workbook* ■ Certified Community Behavioral Health Clinic Standards Manual with Survey Preparation Questions ■ Opioid Treatment Program Standards Manual ■ Opioid Treatment Program Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Child and Youth Services	■ Child and Youth Services Standards Manual ■ Child and Youth Services Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Employment and Community Services	■ Employment and Community Services Standards Manual ■ Employment and Community Services Survey Preparation Workbook* ■ Standards Manual Supplement for Employment Service Centres in Canada** ■ Standards Manual Supplement for Networks**
Medical Rehabilitation	■ Medical Rehabilitation Standards Manual ■ Medical Rehabilitation Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Vision Rehabilitation Services	■ Vision Rehabilitation Services Standards Manual with Survey Preparation Questions ■ Standards Manual Supplement for Networks**
*CARF recommends using the companion survey preparation workbook for your standards manual. The workbook assists in conducting a self-evaluation in preparation for the accreditation survey. **Supplements for the standards manuals are available for download in the Resources section of the Customer Connect portal **(customerconnect.carf.org).**	

NOTE: *Standards manuals become effective on July 1, 2026, to allow organizations sufficient time to incorporate changes into their operations.*

Accreditation Policies and Procedures

These 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 or supplemented between standards manual publication dates. Notification of changes, additional information, and clarification can be obtained at the CARF website or by contacting CARF.

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. **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.**
   c. **The requirements of 1.a. and 1.b. for a minimum of:**
      (1) **Six months, if the organization does not maintain current CARF Five-Year Accreditation for at least one program/service.**
      (2) **Three months, if the organization maintains current CARF Five-Year Accreditation for at least one program/service.**

Intent Statements

This timeframe 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 timeframe 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 (or three, if applicable) months prior to the site survey. This condition applies to organizations that have newly initiated program(s)/service(s) and to those that have ongoing program(s)/service(s) that are provided sporadically. Therefore, in the applicable period

prior to the survey, the organization should have served at least one person in each service seeking accreditation.

In a network, direct services are provided by its participants.

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 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 recommendations 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.

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

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 with the annual maintenance fee.

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

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:

Five-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.

Organizations must achieve accreditation as a CCRC to attain a Five-Year Accreditation.

There is fulfillment of ongoing and annual reporting requirements.

Nonaccreditation

The organization has major areas for improvement 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.

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 term 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/service information. ■ The resource specialist provides the organization access to Customer Connect (**customerconnect.carf.org**), CARF's secure website for managing the accreditation relationship, including transmitting documents and maintaining ongoing communication. As documents are posted to Customer Connect, 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 organizational changes, including the name or email address of the key contact person. ■ The organization orders the standards manual in which its program(s)/service(s) best fit. Visit **www.carf.org/catalog**. ■ 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, program(s)/service(s) 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 (for original surveys only) at least three full calendar months before the two-month timeframe 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, the organization must notify CARF immediately.
STEP 4 **CARF invoices for the survey fee.**	After reviewing all information in the survey application, CARF invoices the organization for the survey fee. The survey fee invoice is posted to Customer Connect and an email notification is sent to the organization's Survey Key Contact. 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 expertise, field experience, and other relevant factors with the organization's unique characteristics. ■ CARF makes best efforts to notify 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 assesses the organization's conformance to all applicable standards through the observation of services, interviews with persons served and other stakeholders, and review of documentation. ■ Surveyors also provide consultation to the organization. ■ The organization is informed of the survey team's findings related to the standards at an exit conference before the team concludes the survey. The survey team submits its findings to CARF, but the team does not determine the accreditation decision. ■ The organization pays expenses of surveyors.

STEP 7 **CARF issues the accreditation decision.**	CARF reviews the survey findings and issues the appropriate accreditation decision. Approximately six to eight weeks after the survey, the organization is notified of the accreditation decision and receives a written report. Within 60 days of the decision, the organization receives a certificate of accreditation that lists the program(s)/service(s) included in the accreditation.
STEP 8 **Submit a Quality Improvement Plan.**	Within 90 days after notification of accreditation, 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 all recommendations identified in the report.
STEP 9 **Submit all annual reporting materials.**	An organization that achieves a Five-Year Accreditation submits a signed Annual Conformance to Quality Report (ACQR) to CARF on the accreditation anniversary date each year during the term of accreditation. This is a condition of accreditation. ■ CARF notifies the organization approximately ten weeks before it is due that the report is available for submission via Customer Connect. ■ The ACQR reaffirms the organization's ongoing conformance to the CARF standards. ■ A nonrefundable annual maintenance fee is submitted with the ACQR. **Annual Financial Report with Ratio Pro** *Due 150 days after fiscal year-end date.* A CCRC that achieves a Five-Year Accreditation submits an Annual Financial Report, Ratio Pro spreadsheet, and audit to CARF within 150 days of the organization's fiscal year end date in each of the years following the issuance of accreditation. ■ CARF sends the organization the form for this report approximately ten weeks before it is due. ■ The Financial Report, Ratio Pro spreadsheet, and audit is reviewed to confirm 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 term of accreditation. Organizations should also contact CARF as needed to help maintain conformance to the standards and keep CARF informed of administrative or other items. ■ CARF offers publications to help organizations provide quality program(s)/service(s). ■ 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 Education and Training

CARF has educational opportunities that focus on the standards and survey preparation, enhancing quality in health and human service provision, outcomes management, and innovative practices, and are provided in multiple formats to promote ease of access and participation. Go to **www.carf.org/what-we-offer** for a calendar of upcoming options 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, program(s)/service(s) 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.

Step 2. Conduct a self-evaluation

To be issued 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 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 submission of the survey application.

Note: *The application fee is submitted only for original surveys.*

Survey Timeframe At a Glance

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

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

*Expiration Month	**Survey application due to CARF no later than	Preferred Timeframe
Aug	Feb 28/29	*Jul/Aug
Sept	Feb 28/29	*Jul/Aug
Oct	Apr 30	Aug/Sept
Nov	May 31	Sept/Oct
Dec	Jun 30	Oct/Nov
Jan	Jul 31	Nov/Dec
Feb	Aug 31	Dec/Jan
Mar	Sept 30	Jan/Feb
Apr	Oct 31	Feb/Mar
May	Nov 30	Mar/Apr
Jun	Dec 31	Apr/May May/Jun

*CARF does not issue July expirations as the standards manuals become effective on July 1 of each year.
**CARF may request organizations with large surveys to submit their applications early.

Note: *Actual survey timeframes 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 timeframe. 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 must be notified in writing immediately. CARF will not process any application or schedule any survey prior to payment of the nonrefundable application fee. Failure by CARF to receive payment in full of the nonrefundable application fee within 10 calendar days of application submission may result in a delay of survey timeframe and/or be treated as the organization's voluntary withdrawal of the application, at CARF's discretion.

Selection of Program(s)/Service(s) to be Surveyed

In the survey application, the organization identifies the program(s)/service(s) it desires to have surveyed by CARF, the site(s) where they are provided (including administrative locations), and any program(s)/service(s) delivered via information and communication technologies. 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 submitted with the survey application.

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

Note: *Organizations using this manual must include the CCRC program when completing the application. If the organization only seeks accreditation for other programs in this manual, it should use the Aging Services Standards Manual.*

CARF does not consider the funding or referral entities as differentiating a program/service 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 determines and may change the size and/or scope of any accreditation survey or decision as it deems appropriate.

Organizations with Multiple Program(s)/ Service(s)

If one survey includes multiple program(s)/ service(s) or sites for accreditation, and any one program/service or site is operating at a lower level of conformance to the standards than the others, the level of accreditation issued for that survey will be the level of the lowest-conforming program, service, or site.

An organization may submit more than one survey application if it wants to have separate surveys for different program(s)/service(s) 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 program(s)/service(s) or sites that are part of that survey. In this case, different decisions may be issued as appropriate.

Step 4. CARF invoices for the survey fee

After reviewing the survey application, CARF invoices the organization for the survey fee. Organizations seeking accreditation as a Continuing Care Retirement Community also pay surveyor travel expenses related to the site survey. Surveyors will submit their expenses directly to CARF within seven days of the survey end date.

Payment of the survey fee must be received 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, at least 30 days prior to the survey, a binding purchase order for the full amount of the survey fee. The survey fee becomes non-refundable, in whole or in part, five days prior to the survey.

Please contact CARF for current fees.

Outstanding Debt

Payment of the entire survey and other fees referenced in this manual must be received when due. CARF will not accept a survey application from any organization that has an outstanding past due debt to CARF until payment of that debt has been received in full. In the event of any outstanding past due debt, CARF may: delay or terminate the processing of an application, the scheduling of a survey (including change of timeframe), or the issuance of an accreditation decision; treat the nonpayment as the organization's voluntary withdrawal of its application and cancellation of any scheduled survey; issue a Nonaccreditation decision; and/or modify an organization's existing accreditation, up to and including termination of accreditation.

Step 5. CARF selects the survey team

Surveyors are assigned to surveys based on a number of factors, including but not limited to, the surveyors' experience with the types of program(s)/service(s) being surveyed, experience with characteristics of the persons served, availability, 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.

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 timeframe of no fewer than four weeks within a specific period of two consecutive months is required for scheduling. CARF must be advised in the survey application if there are days during the designated timeframe 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 stated in the application. The use of weekends as survey days is limited to organizations that provide services on those days and only with prior approval from the organization.

Cancellation and Rescheduling

Reasonable best efforts are made to notify the organization of the specific survey dates at least 30 calendar days prior to the survey. An organization is considered scheduled for a survey on the date the scheduling notification is sent. The dates established by CARF are final. A cancellation/rescheduling fee, plus all related nonrefundable travel 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/rescheduled by CARF due to untimely payment of fees, suspension or termination of accreditation, or other unresolved matters as may be determined by CARF.

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 timeframe, the organization's current accreditation will not lapse but will be extended until notification of the next accreditation 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. The surveyors may 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 the interviews individually or in a group, in person, or via technology. After the survey, the persons served are encouraged to continue to provide CARF with feedback about the services provided at any organization with accredited program(s)/service(s).

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. Surveyors maintain the confidentiality of all interviews.

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. CARF is also available to provide organizations seeking accreditation with complimentary technical assistance, by email and telephone, about the accreditation process and standards interpretation.

During an original or inaugural follow-up survey, the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least 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 since its last survey.

If an organization is a unit or department within a larger entity that develops and/or controls any policies, procedures, plans, or practices relevant to the survey, the organization should be prepared to demonstrate to the survey team how it and its program(s)/service(s) seeking accreditation implement such policies, procedures, plans, and practices.

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 font, color, and size adjustments to ensure the poster is accessible for all persons served. This poster must remain conspicuously posted and readily available to all persons served 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. Information received by CARF may be sent to the surveyors.

Pre-survey contact

Approximately three weeks before the survey, one or more survey team members will contact the organization to discuss logistics and answer questions the organization may have regarding scheduling interviews and other items.

Assemble or arrange access to records

To facilitate an efficient and consultative survey, CARF requests that the organization upload to CARF's secure electronic platform those nonconfidential documents that demonstrate conformance to standards, so that such documents are accessible to the survey team the day prior to the start of the survey. Such documents should include the organization's written policies, plans, procedures and performance analyses. Other 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.

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 other means, to be interviewed by the survey team. 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

The following is a sample survey schedule, which will vary for each organization.

Note: *One or more surveyor roles may be digitally enabled, as determined by CARF. In such event, CARF will provide notice and instructions to the organization.*

First Day

Opening of business

The survey team 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 program(s)/service(s) 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 program(s)/service(s) 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 start directly with community sites that are a part of the survey rather than participate in the tour.

Mid-morning to late afternoon

The survey team meets to coordinate efforts and proceed with survey activities. The organization is asked to schedule interviews with any persons identified, 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.

With a short lunch break, the team spends the rest of the day observing the program(s)/service(s) 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, financial reports, administrative records, and other materials. Records for review shall be selected by the survey team. A responsible person from the organization should be available 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 its findings for conformance to the standards. If the organization offers residential programs, community housing, or supported living services, evening hours may also be used to tour sites.

Except as may be requested by the survey team to assess conformance to standards, the organization should not schedule any evening activities for the 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.

Opening of business

The survey team obtains additional information, continues its interviews, reviews documents, and performs 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 organization to summarize the findings and/or discuss any areas still to be resolved.

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 program(s)/service(s) 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 conclude the survey. Once the survey team concludes the survey, the organization may not contribute any further information to demonstrate conformance to the standards. The survey typically concludes no later than 3:00 p.m.

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 prior to completion of the survey.*

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 issues the accreditation decision

The survey team reports its findings to CARF for review and determination of the accreditation decision. After the accreditation decision has been made, a written accreditation report is issued 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 identifies recommendations for standards that were not fully met. The report may also contain other suggestions and consultation. When the organization is resurveyed, it is held accountable for follow up on the recommendations in the previous report and for evidence of conformance to standards throughout the term 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 recommendations identified in the accreditation 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 recommendations require further explanation or if the organization needs assistance in determining whether its planned action may 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 or appeal of a Nonaccreditation decision and the outcome of that review or appeal is a One-Year, or Five-Year Accreditation, the QIP must be submitted to CARF within 45 days of notice of the outcome of that review or appeal.

Step 9. Submit all annual reporting materials

As part of the commitment to ongoing performance excellence that all CARF-accredited organizations are expected to demonstrate, each organization that achieves a Five-Year Accreditation must submit an Annual Conformance to Quality Report (ACQR) to CARF via Customer Connect for each year of its accreditation. The report is due to CARF on each anniversary date, along with the nonrefundable annual maintenance fee. 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.

The Annual Financial Report and Ratio Pro

CARF monitors an organization's financial strength and conformance to the CARF standards through the review of the Financial Report, *Ratio Pro* spreadsheet, and audit. Please contact CARF if your organization needs assistance with the *Ratio Pro* tool.

Step 10. CARF maintains contact with the organization

Ongoing Communication of Administrative Items and Significant Events

During the term of accreditation, the organization must provide timely information to CARF about certain events that occur within or affect the organization or its accredited program(s)/service(s). Some situations may require further actions to be taken. (e.g., see the "Supplemental Surveys" and "Allegations, Suspensions, and Stipulations" sections.) Information about the events listed below must be communicated to CARF within 30 days of their occurrence:

- Change in leadership.
- Change in ownership (e.g., asset transfer, statutory merger, consolidation, or stock or membership transfer).
- Change in organization name.
- Change in mail and/or email address.
- Relocation, expansion, or elimination of an accredited program or location.
- Financial distress.
- Investigation.
- Material litigation.
- Catastrophe.
- Sentinel event.
- Bans on admission, fines, penalties, or other governmental sanctions.

Changes in ownership and/or leadership, the addition of a site to an existing accreditation, mergers, consolidations, joint ventures, and acquisitions involving accredited program(s)/

service(s) may require the payment of an administrative fee or a supplemental survey.

Forms for reporting administrative items and significant events

Forms for reporting administrative items and significant events are available in 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 Nonaccreditation or modification of existing accreditation up to and including termination.

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 governmental agencies.

Public Information

Identification of Accreditation by the Organization

CARF accreditation is issued to an organization for identified program(s)/service(s). An organization that has achieved accreditation should identify this achievement publicly, and use of the CARF logo by an accredited organization for this purpose is encouraged. The CARF logo is available on Customer Connect (**customerconnect.carf.org**). All references to CARF accreditation by the organization must clearly identify the accredited program(s)/service(s), unless all program(s)/service(s) 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 accreditation report.

Certificate of Accreditation

Within 60 days of issuance of accreditation, the organization is provided with one complimentary certificate of accreditation, which is suitable for framing. Additional certificates are available for purchase on Customer Connect. This certificate identifies the organization that submitted the survey application, the accreditation decision, the program(s)/service(s) for which the organization is accredited, and the month and year in which the accreditation expires. For each year that an organization meets the annual requirements for continuing conformance, CARF will provide a seal to affix to the certificate indicating continued accreditation.

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 program(s)/service(s) 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 program(s)/service(s), and the certificate is regarded as providing information and guidance for the public at large and for persons considering services.

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

Upon dissolution of the organization or loss of accreditation for any reason, each unexpired certificate must be returned to CARF and the organization must refrain from representing itself or its program(s)/service(s) 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 program(s)/service(s) 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 program(s)/service(s).
6. An organization's accreditation decision and status.
7. Whether an organization has requested review or appeal of an accreditation decision.
8. As required by law or contract.

For convenient access to information, CARF includes on its website a searchable list of organizations with accredited program(s)/service(s), including identifying information such as name, address, and telephone number. This posting allows the public to review 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 program(s)/service(s) 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 program(s)/service(s) are being added or the mission and focus of the organization or its program(s)/service(s) or locations 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 program(s)/service(s). 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 program(s)/service(s).

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

An organization with currently accredited program(s)/service(s) 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, the organization must submit a completed survey application to CARF and pay the associated survey fee.

The maximum term of the accreditation of the new program, service, or location added will be the remaining term 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 current accreditation decision, the result will be a change of accreditation decision and term of the accreditation.

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 conduct announced or unannounced monitoring visits of organizations with accredited programs/services. 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 may be modified as a result of a monitoring visit, and submission of a new Quality Improvement Plan may be required. A monitoring visit may consist of a partial or full survey team depending on the nature of the information received. CARF may assess a survey fee for the monitoring visit, in which case the fee is due to CARF within (7) calendar days of the invoice date. If CARF does not receive payment in full of any such fee by the due date, the accreditation will be revoked.

Extension of Accreditation

Extensions of accreditation may be granted at CARF's sole discretion. Any organization seeking an extension should submit its written request prior to timely submission of its resurvey application. While no request for extension will be approved prior to submission of the application, organizations are advised to contact CARF in advance for guidance regarding the likelihood that an extension will be granted under the circumstances. Extensions are generally not granted for more than three months.

Every extension request must include a sufficiently detailed explanation of the supporting rationale for CARF to give it reasonable consideration. Unless otherwise instructed by CARF, any request for an extension greater than three months must also include:

- Copies of the most recent performance analyses, as specified in Standards 1.M.1. and 1.M.2. in this manual.
- An update of the Quality Improvement Plan.
- Communication regarding any unreported administrative items or significant events

required by these accreditation policies and procedures, if applicable.

- Letter from a funding agency or referral entity that supports the extension request, if appropriate.

If an extension is granted, only those program(s)/service(s) that are currently accredited and listed in the submitted resurvey application will be included in the extension. The resurvey following an extension will be conducted using the standards manual in effect on the date of the survey, and the extension will be disregarded when issuing the new expiration date.

Organizations that submit a resurvey application or request for extension after the application due date risk a lapse in accreditation.

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 attach stipulations and/or modify the organization's accreditation status up to and including revocation of accreditation. During suspension or following any revocation, the organization and its program(s)/service(s) are not accredited and may not communicate to third parties that they are CARF accredited. CARF may request an immediate response from the organization, the submission of documents and other information, and/or information from external organizations and individuals. CARF may also perform a monitoring visit. Failure to timely respond or unsatisfactory response to any CARF inquiry 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 accreditation report and accreditation decision are released, CARF may withhold the release of the report and decision until such time as CARF may determine.

Disputed Accreditation Decisions

An organization issued a Nonaccreditation from an original survey, resurvey, or supplemental survey ("Survey") may request a site review ("Review").* Any Review is subject to the process set forth below for Review and Appeal of Nonaccreditation Decisions.

**If the accreditation decision is based on failure to satisfy one or more of the CARF Accreditation Conditions or unavailability of key organizational staff during the Survey, as determined in CARF's sole discretion, the accreditation decision is final and the review and appeal processes do not apply.*

Review and Appeal of Nonaccreditation Decisions

Review

1. Request for Review. CARF must receive a written request for a Review from the organization ("Request") within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey.
2. Review Fee. CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review fee, which is equal to CARF's current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.
3. Scheduling. Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.
4. Review. The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review ("Findings"); however, it is the responsibility of the organization to provide information to the survey team that

demonstrates conformance to the applicable standards. A Review is intended to be a full survey; accordingly, all standards applied on the Survey may be applied on the Review.

5. Accreditation Decision. CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings.
6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization's knowing and intentional waiver of this review process. All CARF policies and procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation decision, and all other matters related to the Review, are final; provided, however, that if the result of the Review is Nonaccreditation, the organization may be entitled to appeal pursuant to the process set forth below. All decisions and determinations related to and interpretations of this review process shall be determined at CARF's sole and binding discretion.

Appeal

1. Notice of Appeal. An organization issued a Nonaccreditation from a Nonaccreditation Review may request a videoconference hearing before an appeal panel ("Panel") if CARF receives written notice of appeal from the organization ("Notice") within ten calendar days of the date of the letter that communicates the accreditation decision from the Review. The sole issue on appeal shall be whether the Review was conducted in a manner consistent with CARF's published review process. The Findings are not at issue on appeal.
2. Statement and Materials. Within ten calendar days of the Notice date, CARF must receive from the organization a written statement that clearly and comprehensively explains the organization's position on the Issue, including but not limited to all rationale for its belief that the Review survey team did not conduct interviews, review documents and otherwise gather information to determine Findings ("Statement"). Contemporaneously with the Statement, CARF must receive from the organization any written materials it intends to present or to which it intends to refer at the hearing ("Materials").
3. Scheduling. Following receipt of the Statement, CARF shall make reasonable efforts to schedule the hearing to occur within 60 calendar days. Once scheduled, CARF shall notify the organization of the date and time of the hearing and the designated Panel.
4. Appeal Hearing. During the hearing, the organization shall have up to one hour to present any previously submitted Materials and other information it believes supports the organization's position on the Issue set forth in the Statement. Thereafter, the Panel may pose questions to the organization and Review survey team. Finally, the organization shall have up to 20 minutes to provide any concluding remarks. The organization and survey team shall not question each other.
5. Irrelevant Information. Any information deemed irrelevant to the Issue may be excluded from the hearing and/or not considered by the Panel. The Panel shall under no circumstances consider the Findings.
6. Accreditation Decision. CARF shall affirm the Nonaccreditation or issue another accreditation decision, with or without stipulations, based on consideration of the relevant information received by the Panel at the hearing.
7. Miscellaneous. If CARF does not timely receive Notice or the Statement, or if the organization fails to present information at the hearing relevant to its position on the Issue as set forth in the Statement, such shall constitute the organization's knowing and intentional waiver of this appeal process. Any Materials not timely received by CARF shall be excluded from the hearing. The accreditation decision and all other matters related to the appeal are final and not subject to review or appeal. All decisions and determinations related to and interpretations of this appeal process shall be determined at CARF's sole and binding discretion.

Changes in the 2026 Manual

The purpose of this section is to identify notable changes that have been made in the standards in this manual compared to the previous year's manual. Please be aware that some standards may have minor revisions that do not change the requirements of the standard and are not listed here.

In addition to the changes noted in this section, throughout the manual the Intent Statements, Examples and other supporting content have been revised and updated to remain current and/or to clarify the intent or requirements of the standards. Changes in the Accreditation Policies and Procedures, program descriptions, applicable standards information, Appendices, and reference materials are also not listed here.

Note: *CARF makes every effort to list all significant changes in the standards; however, not all changes are included. All sections that are applicable to an organization should be thoroughly reviewed to ensure that the current standards are implemented in the organization's accredited programs and services and those seeking accreditation.*

Section 1. ASPIRE to Excellence®

1.A. Leadership

- Standard 1.A.5. on policies and written procedures related to the use of augmented or artificial intelligence (AI) is new.
- Previous Standard 1.A.5. on implementation of a cultural competency, diversity, and inclusion plan has been deleted. The diversity of stakeholders, including the persons served, personnel, and other stakeholders, has been incorporated into the accessibility plan in Standard 1.K.2. (previously Standard 1.L.2.).

1.C. Strategic Planning

- Element l. in Standard 1.C.1. has been modified to address consideration of the use of technology and data, including current use and gaps and opportunities, in strategic planning.

1.D. Input from Persons Served and Other Stakeholders

- Standard 1.D.2.b.(8) on leadership use of input for technology planning is new.

1.G. Risk Management

- Standard 1.G.4. regarding policies and procedures for the use of technology and data was previously Standard 3. in subsection 1.J. The requirements are unchanged. Subsequent standards in this section are renumbered.

1.I. Workforce Development and Management

- Standard 1.I.13. regarding documented personnel training on cybersecurity and technology used in the performance of job duties was previously Standard 5. in subsection 1.J. The requirements are unchanged.

1.J. Rights of Persons Served (Previously Subsection 1.K.)

- This subsection was previously 1.J. Technology. Previous standards have been incorporated into other subsections of ASPIRE or have been deleted. Subsequent subsections have been re-lettered. Specifically:
  - Concepts from previous Standard 1.J.1. on the identification of gaps and opportunities in the use of technology have been incorporated into Standard 1.C.1. on strategic planning.
  - Previous Standard 1.J.3. regarding policies and procedures for the use of technology and data is now Standard 4. in subsection 1.G. Risk Management.

- Previous Standard 1.J.5. addressing initial and ongoing personnel training on cybersecurity and technology used in the performance of job duties is now Standard 13. in subsection 1.I. Workforce Development and Management.
- Previous Standards 1.J.2. on implementation of a technology and system plan and 1.J.4. on testing of the procedures for business continuity/disaster recovery have been deleted.

- In Standard 1.J.1. (previously Standard 1.K.1.), element c.(6) on freedom from discrimination is new.

1.K. Accessibility (Previously Subsection 1.L.)

- Elements a.(1)–(3) on the diversity of persons served, personnel, and other stakeholders were previously in Standard 1.A.5. and have been incorporated into Standard 1.K.2. (previously Standard 1.L.2.). Subsequent elements in the standard have been renumbered.

1.M. Performance Improvement (Previously Subsection 1.N.)

- Elements d.(1)–(5) in Standard 1.M.1. (previously Standard 1.N.1.) on the analysis of service delivery indicators at the level of each specialty program, specialty designation, or special population for which the organization is seeking accreditation are new. Subsequent elements in the standard have been renumbered.

Section 2. Care Process for the Persons Served

2.D. Skin Integrity and Wound Care Standards

- In Standard 2.D.1. regarding written procedures to address skin integrity and wound care, element c. on the definition of what constitutes a wound was deleted. Subsequent elements in the standard are renumbered.
- The stem of Standard 2.D.2. (previously Standard 2.D.6.) was slightly modified for clarity, and element c. on education of other healthcare providers was deleted. Subsequent elements in the standard are renumbered.
- The stem of Standard 2.D.3. (previously Standard 2.D.2.) was also modified for clarity, and element b. on referral to or coordination with appropriate healthcare professionals for skin integrity assessment is new.
- Standard 2.D.8. is revised to address service delivery indicators to measure performance related to skin integrity. Element c.(5)(d) on necessary education and training of other stakeholders is new.

2.E. Care Process for Personal Supports Services

- Standard 2.E.17. on recognizing the signs of aging-related decline or dementia and supporting the needs of the persons served has been revised for clarity and consistency.

Section 3. Program Specific Standards

3.B. Assisted Living

- In Standard 3.B.10., previous element b.(6) has been deleted as training for personnel on performance measurement and management is covered in Section 1.L. Subsequent elements have been renumbered.

3.D. Home and Community Services

- Based on feedback from the field, the description and standards in this section have been updated.

Glossary

The term *stakeholders* has been modified and is used in all standards manuals.

SECTION 1

ASPIRE to Excellence®

ASPIRE to Excellence® is a framework of standards introduced by CARF that specifically addresses business practice quality improvement.

This quality framework focuses on integrating all organizational functions while effectively engaging input from all stakeholders, including persons served. It provides a logical, action-oriented approach to ensure that organizational purpose, planning, and activity result in the desired outcomes.

Using these standards will help your organization identify and implement change and to maintain sustainability. The standards are organized into the following areas:

Assess the Environment. Environmental assessment are necessary to guide all organizational planning and action. Assessments are conducted within the context of an organization's location; sphere of influence; and purpose, vision, and mission. Social, economic, competitive, legal, regulatory, and political environments in which your organization operates are also evaluated. The role of leadership is critical to environmental assessment.

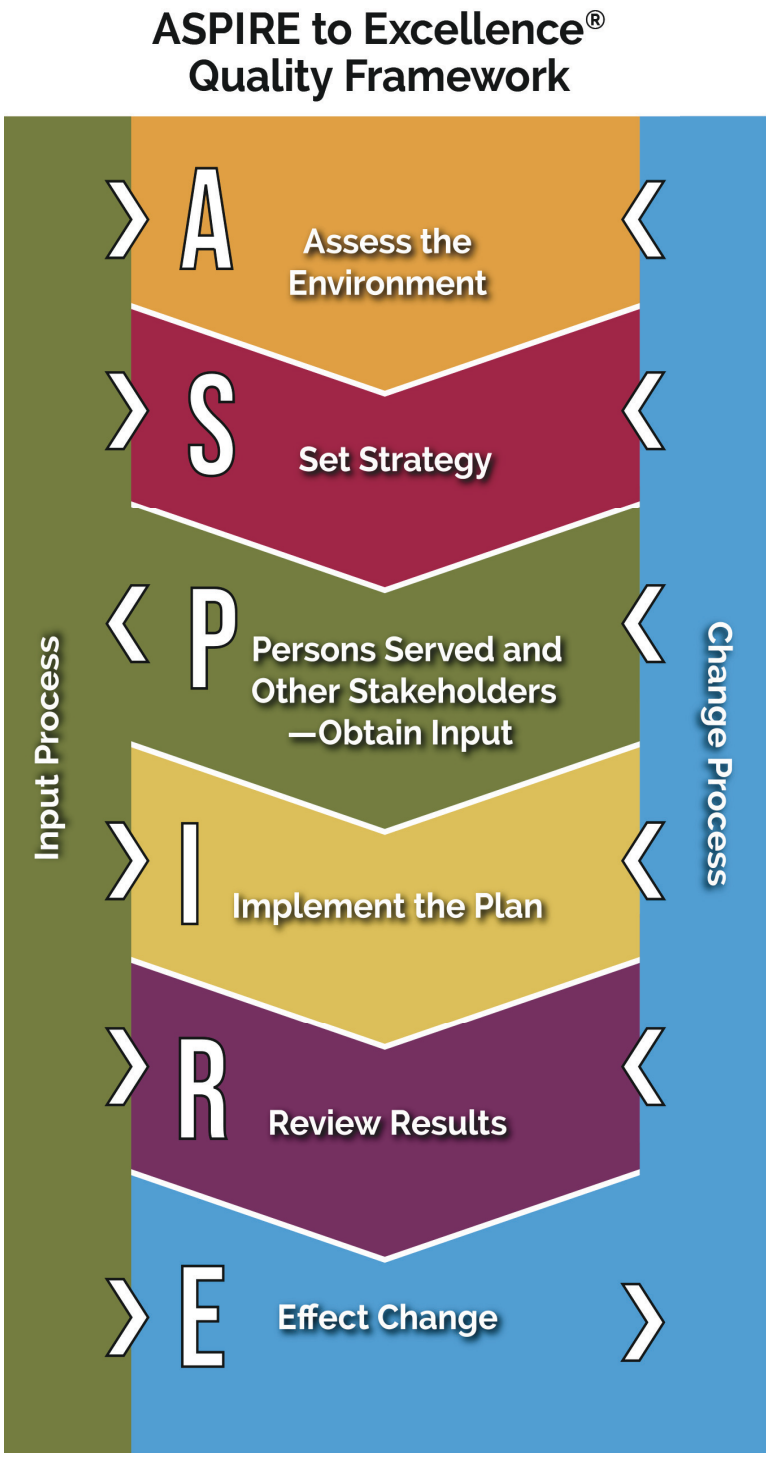
Set Strategy. Setting strategy means recognizing organizational competencies, identifying opportunities and threats, and articulating a high-level plan to sustain and advance your organization's purpose. Setting strategy translates the environmental assessment factors into planning efforts, sets goals and priorities, and aligns resources to achieve performance targets.

Persons Served and Other Stakeholders—Obtain Input. This input process engages all stakeholders to promote long-term organizational excellence. 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.

Implement the Plan. Implementation means translating strategic goals into tangible action. Sound implementation requires a solid foundation of service delivery, business practices, and organizational resources, including personnel, technology, and other assets.

Review Results. Setting specific, measurable goals and indicators allows an organization to track its performance and outcomes. Appropriate personnel and stakeholders must review and analyze results in order to determine areas for improvement. These activities position an organization to develop and implement quality improvement changes.

Effect Change. Effecting change means translating the results of analysis into focused actions. Your organization may renew or revise its strategy and tactics to improve performance against targets. Achieving excellence requires disciplined continuous improvement.


ASPIRE to Excellence®
Quality Framework
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

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. Responsibilities of leadership might be described in job descriptions, bylaws, policies, or narrative descriptions.

The survey team verifies that whoever is identified fulfills the responsibilities of leadership. This may be done by interviews with boards, councils, and management teams; by review of minutes of meetings; and by observation.

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 is 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.

See the Glossary for the definition of *stakeholders*.

Examples

An organization's person-centered philosophy reflects commitment to its values regarding the persons served, e.g., individuality, autonomy, respect for diversity, cultural competence, empowerment, partnership with persons served and families, participation in life roles, and quality of life.

Exploring the normal pattern of the day of a person served to best meet program scheduling.

Recognizing unique aspects of the person served and how these might be incorporated into the programming; for example, active in the community, religious, or social agencies; active volunteer, worker, leader of a group.

2.c. The person-centered philosophy could be communicated many ways, including:

- Posting it on the walls or website of the organization.
- Incorporating it into materials that are distributed to stakeholders, such as orientation handbooks for the persons served and their families, personnel, volunteers, and advisory and governing boards; fact sheets, plans, and performance reports; and marketing brochures and pamphlets.
- Articulating it during tours of the organization; presentations, such as orientation and training for personnel, volunteers, and advisory and governing boards; community education sessions; meetings and forums to seek input from stakeholders; and recorded messages, such as the voice response system.

The organization demonstrates respect for the persons served and other stakeholders through the materials and graphics selected to

communicate its person-centered philosophy, the provision of materials in different languages, and consideration of literacy levels in the intended audience.

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. Ongoing review of the organization's policies in accordance with organizational needs.**
- **l. Health and safety.**
- **m. Succession planning.**
- **n. Strategic planning.**
- **o. Technology planning.**

Intent Statements

3.k. 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). Through an ongoing systematic review of its policies an organization can address in real time the relevance, pertinence, and necessity of existing policies as well as the need for updates or new policies to guide its operations and practices.

3.m. Succession planning identifies actions to be taken by the organization should key personnel be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization. See Standards 1.I.4.g. and 1.I.12. in Section 1.I. Workforce Development and Management.

3.o. The leadership is actively engaged in planning related to the organization's implementation of technology systems and solutions that support and enhance its business and service delivery practices.

Examples

The delegation of activities, the feedback and collaboration of various levels of the leadership, and the checks and balances that the leadership has created are evident. This may be observed; heard in interviews; or read in minutes, reports, and orientation materials for boards and management.

3.a.–c. The leadership ensures that specific activities are conducted to guide the organization ethically, effectively, and efficiently in achieving its mission. As the organization's mission influences service delivery, the achievement of outcomes, and strategic planning activities, a regular review of the mission statement assesses and reinforces the vision of personnel and board members regarding the outcomes for persons served and focuses efforts toward achieving agreed-upon outcomes.

Input from the persons served and other stakeholders influences the mission as their needs, desired outcomes, and other factors change over time.

3.c. Leadership works together to achieve and improve identified outcomes, and these efforts and achievements are documented. The outcomes performance report is used to guide these efforts, for example, through the strategic planning process.

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

3.e. Leadership takes a proactive role by ensuring that specific activities, such as approval of the budget and review of the independent financial examination, are conducted at least annually to protect the organization's assets, maintain its viability, and move it forward as the stakeholder environment changes.

3.f. Leadership guides planning to manage risk and reduce the severity of any potential threats to its people, property, income, goodwill, and ability to accomplish goals. One component of this is arranging for insurance coverage, which can protect many of the assets of the organization. A review of coverage is conducted with the assistance of someone qualified to provide guidance about insurance needs and types of coverage.

3.h.–i. These standards relate to the organization's responsibility to be prepared to respond to questions from the public regarding its accredited services. Questions that might be expected include: those about its CARF survey results and the accreditation report; the quality and effectiveness of services; descriptions of services and persons served; performance outcomes of the services; experience of persons served and other stakeholders with services; and other information that persons may use to make informed choices about services and service providers. Some organizations may post their annual report on their website to share information.

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

See also Standards 1.A.6. and 1.A.7. in this section regarding corporate responsibility.

3.j. The organization demonstrates its implementation of applicable laws and regulations. The organization has a system that ensures that it receives information about and complies with changes in these. An organization might become a member of a trade association as one way to stay abreast of regulatory and legal requirements.

3.k. Leadership may delegate responsibility for review as it chooses. In some organizations, such as those operated by governmental or public agencies, personnel and other policies may be established by the agency and not by the organization. Human resources policies may also include union contracts or may be identified in statute, administrative rule, or other governmental document. The expectation is that the organization reviews the policies to ensure continued relevancy and attainability and brings forward suggested changes to provide input for consideration in policy revisions.

Systemwide policies that directly affect the programs seeking accreditation may be reviewed by the program leadership and suggestions for revisions forwarded for consideration to the departments responsible for the specific policies.

3.m. Succession planning might identify which employees within the organization could move into key positions, consider how to develop employees to fill leadership positions, and highlight the need or opportunity to identify potential leaders external to the organization or even external to the field.

1.A. **4. The leadership of the organization is accessible to:**

- **a. Persons served.**
- **b. Personnel.**
- **c. Other stakeholders.**

1.A. **5. If the organization uses artificial or augmented intelligence (AI), it implements policies and written procedures that:**

- **a. Include:**
  - **(1) How the organization uses AI.**
  - **(2) Disclosure to the persons served regarding the use of AI:**
    - **(a) In service delivery.**
    - **(b) For health data analysis and processing.**
  - **(3) Privacy of health information.**
  - **(4) Protection of sensitive data.**
  - **(5) Human oversight/accountability.**

(6) What constitutes an incident requiring a response:

(a) Within the organization.

(b) To the person(s) served.

b. Are reviewed at least annually.

c. Are updated as needed.

Intent Statements

5.a.(1) The organization's leadership determines the scope and types of artificial or augmented intelligence (AI) tools permitted to be used by the organization, keeping in mind that there are obligations to the persons served and to personnel regarding their use. Organizations should consider ethical responsibilities, consent to use, and ongoing oversight of the effectiveness of the tools.

5.a.(2)(a) The program provides clear, understandable information to the persons served about the use of AI in the delivery of services. This disclosure is designed to let the persons served know when and how AI is being used in a way that directly impacts their care.

5.a.(3) Policies and written procedures protect the privacy of health information in accordance with applicable state, provincial, and federal laws and regulations.

5.a.(4) Organizations have specific obligations to protect sensitive data from unauthorized access or theft. AI tools and the large datasets they rely on and produce emphasize this need. Organizations promote data security and establish requirements within their data use agreements to limit the permissible uses of exported data. This applies to employees, contractors, or third-party vendors who may have access to specific data about persons served or other sensitive information in the organization, including datasets used for algorithm training.

5.a.(5) Human oversight is the practice of having personnel actively monitor and manage AI systems. This is not a passive role; rather, it involves continuous engagement with the technology. Accountability refers to the clear assignment of responsibility for the AI's actions and outcomes. If an AI system contributes to an error or harm, it is the organization's responsibility to have a clear chain of accountability.

5.a.(6) The organization has a clear procedure in place for identifying and reporting any incidents or adverse events related to the use of AI and who needs to be notified when an incident is identified.

Examples

5.a.(5) The organization can demonstrate human oversight/accountability a variety of ways such as:

Human oversight

- Final Decision-Making Authority: Direct service personnel always retain the final say on care decisions regarding the persons served. AI tools are used as decision-support aids, not as autonomous decision-makers. The knowledge, critical thinking, and empathy of direct service personnel are essential components in the delivery of care that AI cannot replicate.
- Review and Validation of AI Outputs: Personnel critically evaluate the recommendations or data provided by AI. This includes questioning results that do not align with their clinical experience, a person's history, or other evidence. Personnel are trained to recognize the limitations and potential biases of the AI tool.
- Continuous Monitoring and Auditing: Organizations have a system for ongoing monitoring of the AI tool's performance. This includes regular audits to check for algorithmic bias, data drift (i.e., the data used for training are no longer relevant), and any errors or unexpected outcomes that may arise over time.
- Training and Education: All personnel who interact with the AI system receive training. Training covers how the AI works, its capabilities and limitations, ethical considerations, and how to effectively integrate it into clinical workflows.

Accountability Measures

- Establish a Governance Committee: A multidisciplinary committee oversees all AI initiatives. This committee could include clinicians, IT experts, legal counsel, and persons served. The role of the committee is to vet new tools, create policies, and ensure compliance with ethical and regulatory standards.

- Vendor and Data Transparency: The organization should require a high level of transparency from AI vendors. It should understand how the AI's algorithm works (avoiding "black box" systems), what data were used to train it, and whether the data are representative of the population served by the organization.
- Ethical and Legal Compliance: The organization is responsible for ensuring AI tools comply with regulations such as HIPAA/PIPEDA for patient privacy. It also has policies to address potential algorithmic bias, which can lead to health disparities by providing less accurate or appropriate care to certain groups of persons served.

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) Conflicts of interest.**
  - **(5) Use of social media.**
  - **(6) Service delivery, including:**
    - **(a) Exchange of:**
      - **(i) Gifts.**
      - **(ii) Money.**
      - **(iii) Gratuities.**
    - **(b) Personal fundraising.**
    - **(c) Personal property.**
    - **(d) Setting boundaries.**
    - **(e) Witnessing of legal documents.**
  - **(7) Professional responsibilities.**
  - **(8) Human resources.**
  - **(9) Organizational fundraising, if applicable.**
  - **(10) 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) Timeframes 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 positions and actions reflect an understanding of the complexity and diversity of the people with whom the organization interacts—including persons served, families/support systems, personnel, and other stakeholders—and assists in:

- Advocating for the persons served.
- Developing services, supports, and resources to achieve the desired outcomes and advance the well-being of persons served in their communities of choice.
- 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

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, human

resources management associations and organizations that evaluate charities; and the organization's own mission and core values statements and corporate compliance programs.

6.a.(4) Examples of conflicts of interest might include:

- Referral fees, self-referrals, and fee splitting.
- Accepting gifts or money from a vendor who does or is trying to secure business with the organization.
- Preferential treatment of an individual or entity due to a personal relationship with someone in the organization.
- Use of confidential information for one's own advantage.
- Employment by more than one organization, resulting in competing interests.
- A board member who also serves on the board of a competitor organization.

6.a.(5) This standard relates to Standard 1.G.3. on media relations and social media in the context of risk management. With the ubiquity of social media, it is increasingly important that organizations address related risks and ethical considerations as part of their codes of conduct. Topics an organization might address include acceptable use of social media by personnel as it relates to the organization, such as posts that positively reflect on the organization and its activities; privacy and confidentiality considerations, such as seeking permission from persons served for posts or pictures that include them and not sharing information about persons served in personal posts; how an organization's social media will be monitored for adherence to its expectations and how violations will be dealt with; and engagement on social media during work hours. Additionally, the organization may address how it uses social media searches as part of its applicant vetting process.

6.a.(6)(b) 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, candy, or wrapping paper for a child's school or scout program; 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.(6)(c) 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.(6)(d) The code of ethical conduct might address relationship issues, such as personnel dating other personnel or persons served, sexuality, and boundaries in the relationships between providers and the persons served.

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

6.b. An organization could use a mechanism such as an ethics committee to investigate and act on allegations of violations of ethical conduct.

6.d. An organization may demonstrate advocacy through the incorporation of its values related to diversity, equity, and inclusion in its person-centered philosophy, organizational plans, and workforce development and management practices.

6.d.–e. 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.
- Substance use disorder programs.
- Education on health issues.
- Employment opportunities.
- Active involvement in community organizations and service groups, such as chambers of commerce, rotary clubs, governor councils, 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 and sustainable environment, such as recycling, use of environmentally friendly products, reduction of consumption in the areas of water and energy, or reduction of greenhouse gas emissions.

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. Implementation of written procedures that address exclusion of individuals and entities from federally funded healthcare programs.

c. Designation of a staff member to serve as the organization's compliance officer:

(1) That is documented.

(2) Who:

(a) Monitors matters pertaining to corporate compliance.

(b) Conducts corporate compliance risk assessments.

(c) Implements an annual work plan.

(d) Reports on matters pertaining to corporate compliance.

d. 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.

e. 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 includes direct and indirect federal funding. The receipt of federal funding may occur in a variety of ways, including, but not limited to, 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.b. The Office of Inspector General has the authority to exclude individuals and entities from federally funded healthcare programs. Hiring an individual or entity on the List of Excluded Individuals/Entities (LEIE) may subject an organization to monetary penalties. Written procedures address the organization's process and timeframes for verifying that personnel are not on the LEIE and actions to be taken in response to the information received. For further information, see **https://oig.hhs.gov/exclusions/index.asp**.

7.e. 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.

Generally, 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 the 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.c.(2)(a) The compliance officer may perform compliance-related activities or monitor activities delegated to other personnel.

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

7.c.(2)(c) While specific requirements will vary depending on the organization's size and complexity, typical elements of an annual compliance work plan may include:

- Identifying and assessing compliance risks. This involves identifying the laws, regulations, and standards to which the organization is subject and potential risks associated with non-compliance.
- Developing and implementing policies and procedures to mitigate compliance risks. This may include training employees on compliance requirements, establishing a process for responding to whistle blower complaints, and conducting regular audits of compliance activities.
- Monitoring compliance activities and reporting on progress. This involves tracking the organization's compliance performance and identifying areas where improvement is needed.
- Correcting compliance violations. If a compliance violation occurs, the organization takes steps to correct it promptly and prevent it from happening again.
- Documenting all compliance activities. This will help the organization demonstrate its compliance with the law in the event of an audit or investigation.

In addition, the work plan may include:

- A description of the organization's compliance program, including its goals, objectives, and strategies.
- A schedule of compliance activities that will be conducted during the year.
- A process for monitoring and evaluating the organization's compliance program.
- A process for reporting on the organization's compliance program to stakeholders.

7.c.(2)(d) 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.e. 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.

Applicable Standards

Standard 1.A.9. applies to organizations that directly solicit charitable financial support in connection with any program seeking accreditation. It does not apply to organizations whose fundraising is conducted by a foundation, third party, or other separate legal entity, or in connection with programs not seeking accreditation.

1.A. **9. To demonstrate accountability, an organization that engages in fundraising:**

- **a. Implements written procedures that address, at a minimum:**
  - **(1) Oversight.**
  - **(2) Donor:**
    - **(a) Solicitation.**
    - **(b) Communication.**
    - **(c) Recognition.**
    - **(d) Confidentiality.**
  - **(3) Valuing of donations.**
  - **(4) Use of donations in accordance with donor intent.**
  - **(5) Documentation and recordkeeping.**
  - **(6) Use of volunteers in fundraising efforts, if applicable.**
- **b. Provides training related to fundraising written procedures to appropriate personnel, including:**
  - **(1) Initial training.**
  - **(2) Ongoing training.**

Intent Statements

To aid in success of fundraising initiatives, many individuals and organizations want to direct funds with confidence toward programs and organizations that demonstrate well-managed fundraising efforts. Organizations may engage in fundraising endeavors using various solicitation approaches such as letters, phone calls, email, social media, or in-person events. To reduce risk and ensure the integrity of its fundraising programs, it is important that organizations establish and assign responsibility and authority for their fundraising functions and activities.

9.a.(2) Engaging donors is key to an organization's fundraising efforts. A variety of mechanisms allow an organization to reach and establish relationships with donors based on their connection to the organization's mission, services, results, or other factors.

9.a.(4) Donors want to know that their donations make an impact for the persons served and that donations made to a specific fund or toward a specific purpose are actually used for that purpose. Organizations demonstrate fiscal responsibility and transparency regarding their use of funds for identified purposes.

Examples

9.a.(1) Written procedures might address which individual, committee, or department has authority and responsibility for the organization's fundraising activities; how the individual, committee, or department responsible for oversight fits into the larger organizational structure; and requirements for reporting.

9.a.(2)(a) Written procedures might address the mechanism(s) for and frequency of donor solicitation, what groups or individuals (e.g., persons currently participating in a program) can or cannot be solicited), and any state/provincial or other type of registration required to conduct certain charitable solicitations.

9.a.(2)(b) Written procedures might address how the organization will communicate with donors (e.g., in person or by mail, email, telephone, or social media channels), at what frequency, and what information will be exchanged. Written procedures might also include how the organization will handle requests to discontinue or restart communication with a donor and how it will maintain the currency of its records used for communication; e.g., relocation or death of a donor.

9.a.(2)(c) Written procedures might address the recognition of donors by name, donation amounts or other descriptors, and matching donations.

9.a.(2)(d) Written procedures might address how the organization will maintain the confidentiality of donors in accordance with applicable laws and regulations, such as HIPAA or PIPEDA, and donor wishes; e.g., a donor who wants to remain anonymous.

9.a.(3) Written procedures might address how the fair market value of noncash donations such as clothing, electronics, furniture, and other goods or services is determined and who may make such determinations; and what to do if a donor requests a receipt for a higher value than the donation is worth.

9.a.(4) Written procedures might address how funds or other donations will be applied in accordance with donor intent, such as a capital campaign to fund a new building or renovations; a golf tournament, casino night, or auction to fund the purchase of a vehicle to transport persons served or new equipment that will be used by persons served; or ongoing efforts to raise funds to support services for persons who would otherwise be unable to participate in the organization's programs/services.

9.a.(5) Written procedures might address what documentation is required to comply with legal and regulatory requirements and/or to satisfy the organization's requirements; how long documentation is retained; how documentation regarding fundraising and donors is kept separate from other administrative recordkeeping; and whether information such as credit card and bank account numbers is kept on file.

9.a.(6) Written procedures might address in what capacity volunteers may be involved in fundraising activities and what the expectations are of those roles, recruitment of volunteers, use of persons served as volunteers, training and supervision of volunteers, dismissal of volunteers, and background checks if necessary.

9.b.(2) Ongoing training may be provided when there is a change in fundraising procedures or practices, a change in the scope of an organization's fundraising efforts, or a change in the legal or regulatory requirements related to fundraising to which the organization is subject.

B. Governance

Description

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

Applicable Standards

These standards must be applied to all organizations seeking accreditation for a Continuing Care Retirement Community. For all other organizations the Governance standards are optional.

When applied, these standards refer 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.

1.B. **1. The board implements 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.
- How board members understand the organization's fundraising goals and strategies, identify prospective donors, and engage with donors.

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) Self-assessment of the entire board at least annually.**
  - **(4) Periodic self-assessment of individual members.**
  - **(5) Written conflict-of-interest declaration that is signed at least annually.**
  - **(6) Written ethical-code-of-conduct declaration that is signed at least annually.**
  - **(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 persons 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 that 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 are lost to the organization. The board must determine its approach in the context of the organization.

Board member independence and unrelatedness to executive leadership allow 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 nonprofit 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, persons served, and other stakeholders.

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 member 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 understanding of the community in which the organization serves 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 a review at least annually 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® (**https://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. A formal written review of executive leadership performance:

(1) At a frequency determined by the governance.

(2) In relation to:

(a) Overall corporate performance versus target.

(b) Individual performance versus target, if applicable.

(c) Professional development.

(d) **Professional accomplishments.**

(e) **Professional opportunities.**

b. **An executive leadership succession plan that is:**

(1) **Reviewed at least annually for relevance.**

(2) **Updated as needed.**

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 a 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 thorough competency-based succession program should assess competencies necessary for organizational leadership positions, match against a 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) **Review of executive compensation records at least annually.**

(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 nonprofit. 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 compensation decisions at least annually 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 nonprofit organizations.

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

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

Examples

Examples of how to conduct this 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.

Set Strategy

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. Social determinants of health.**
- **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 and data:**
  - **(1) Including:**
    - **(a) Current use.**
    - **(b) Gaps and opportunities.**
  - **(2) To support:**
    - **(a) Efficient business processes.**
    - **(b) Effective service delivery.**
    - **(c) Increased access to services.**
    - **(d) Performance improvement.**
- **m. Information from the analysis of performance.**

Intent Statements

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

1.g.–h. The World Health Organization describes social determinants of health as the conditions in which people are born, grow, live, work, and age. According to Healthy People, these conditions can affect a wide range of health, functioning, and quality-of-life outcomes and risks. Through consideration of the demographics of the service area, an organization may identify social determinants of health that can impact results for the persons served and the durability of outcomes they achieve. Strategic planning may include efforts to improve those conditions and reduce barriers for the persons served.

1.l. Technology has an ever-increasing role and presence in today's human services environment. Although 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 efficient business processes, effective service delivery, increased access to services, and performance improvement.

Examples

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

1.g. Examples of social determinants of health include, but are not limited to:

- Availability of transportation options.
- Availability of affordable, accessible, safe housing and utilities.
- Availability of nutritious food, clean water, and toxin-free environments.
- Socioeconomic conditions such as poverty.
- Access to healthcare services.
- Access to social support.
- Exposure to trauma, violence, or crime.

- Social support and community inclusivity.
- Recreation and leisure activities.
- Availability of community-based resources in support of community living.
- Access to educational, economic, and job opportunities.

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

1.i. External stakeholders may include educational institutions.

1.k. An organization evaluates changes in public funding from legislation, such as the Patient Protection and Affordable Care Act and Medicaid waivers, and integrates the information into the planning process.

1.l.(1) Ongoing assessment of gaps and opportunities relies, in part, on consistent management of the organization's existing technology and data assets. This includes tracking of the lifecycle of assets and, in advance of those timeframes, assessing the best course of action. For example:

- The organization has software maintenance contracts and cloud subscriptions that require regular renewal. Throughout the periods of those contracts, the organization is assessing whether the services are meeting its needs, whether resolution of issues has been adequate, costs of renewal, duration of the contracts, and whether it will renew or seek new options.
- Patching and malware prevention, including regular assessment of the organization's operating systems and application updates. Anti-malware/anti-virus software should be updating regularly; typically updates are automatic and multiple times a day. It is also good practice to keep the firmware of network switches and routers up to date.
- Perimeter security, which includes firewall/intrusion prevention; documentation of rules regarding what resources are open externally and why; keeping firmware/operating systems up to date; making sure that updates for malicious prevention are occurring and working; and checking log files for indications of problems, errors, failures, and traffic that has been prevented.
- Data security, which includes patching and software updates and controlling input to prevent database server exploitation. Sensitive data might include confidential corporate information and personal data about persons served or personnel that are protected by data privacy laws.

Through close tracking the organization minimizes its risks related to technology and data assets, assets continue to effectively and efficiently serve the intended purpose, and it has ample opportunity to consider and plan for updates and upgrades.

To support effective service delivery for the persons served, programs/services may use assistive technology to improve functional capabilities and independence, and the individual plans of persons served may include technologies such as screen-reading software, adaptive technology for cell phone and computer access, augmentative communication devices, environmental controls, wander management equipment, and voice-activated technology.

1.l.(2)(a)–(d) As part of strategic planning, the organization explores technology that would allow point-of-service entries into the electronic medical record by nurses, physicians, and therapists and immediate access to diagnostic test results. A multi-step hardware and software acquisition and implementation plan is proposed for integration into the organization's strategic plan.

1.C. **2. The organization implements a strategic plan that:**

- **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 in the following areas:**
    - **(a) Financial.**
    - **(b) Workforce.**
- **c. Sets:**
  - **(1) Goals.**
  - **(2) Priorities.**
- **d. Is reviewed at least annually for relevance.**
- **e. 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

The strategic plan addresses the programs/services seeking accreditation. If the programs/services are part of a larger organization and not specifically addressed in its strategic plan, the programs/services may establish a separate plan or generate a supplement to the organization's plan that addresses input, financial position, and goals and priorities pertinent to the programs/services.

2.a. Input from persons served, personnel, and other stakeholders considered in developing the strategic plan might include information from input forums, surveys, and performance improvement activities.

2.b.(2) An organization is better able to define success with proactive long-term financial planning measures. As 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.d.–e. An organization determines the method of review and update. Significant changes in factors impacting the strategic plan could prompt leadership to consider reviewing or updating more often than annually to maintain a dynamic and relevant plan.

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.

Persons Served and Other Stakeholders—Obtain Input

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 persons served and the organization's service delivery and business practices. The organization identifies the relevant stakeholders, in addition to the persons served and personnel, from whom it solicits input and strives to be inclusive by making a variety of opportunities and mechanisms for input accessible to all stakeholders.

Examples

Please refer to the Glossary for a definition of *stakeholders*.

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

1.b. Related to the organization's use of technology, input may be sought from persons served on the ease with which they can use the technology available, the technology they would like to see implemented in the future, and potential barriers to implementation of technology.

Personnel may provide input on technology they use to perform their job duties such as electronic medical record systems, mobile technology used for communication or documentation, billing software/systems, remote access to organizational systems/ resources, and intranet that provides access to policies and procedures, databases, and reporting.

The organization may have requirements from other stakeholders such as funders who require electronic exchange of information about persons served or electronic claims submission.

1.c. There are a variety of mechanisms to solicit and collect input. They range from the informal to the formal. An organization may use different mechanisms to collect input from different stakeholder groups.

Mechanisms may include:

- Input forums such as advisory groups, forums of persons served, or focus groups.
- Boards/councils of persons served.
- Conferences.
- Presentations to stakeholders.

- Individual meetings or telephone conversations.
- Social media and online forums.
- Communication logs.
- Telephone, written, or online surveys.
- Suggestion boxes.
- Complaint or incident summaries.
- Performance improvement activities.
- Strategic, financial, and human resource planning
- Environmental scans
- Program/service development.

Mechanisms to solicit and collect input may also consider the diversity of the target group relative to language/communication preferences, literacy levels, cultural preferences for communication, and access to technology to participate versus in-person opportunities.

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.

(7) Workforce planning.

(8) Technology 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

During the survey, the organization should be prepared to share how it has used its analysis of information for program planning, performance improvement, strategic planning, organizational advocacy, financial planning, resource planning, and workforce planning.

Examples might be the opening of a new wellness program after collecting information from persons served and key referral sources in the community, a plan to expand the parking lot for a community-based program because of complaints of no parking spaces, the addition of new lighting in common areas due to low satisfaction of persons served with their ability to see while engaging in social activities, or the addition of new volunteer opportunities due to the increased presentations to business groups about the advantages of successful volunteer work with the aging services continuum.

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

2.b.(4) Organizational advocacy may be defined as intentional, possibly ongoing value-added activities of workplace members made to enhance the achievement and well-being of the members of the organization. These activities are also referred to as social accountability. Examples include having the organization engaged in legislative advocacy for research on certain conditions impacting persons served or employment-related issues that may impact the workforce of the organization. It might be related to neighborhood safety or zoning-related topics.

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 and 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

Human resources and/or a lead operations staff person can identify the applicable legal and regulatory requirements that are important in various staff responsibilities and may ensure that the job descriptions reflect this. Alerts or other communications could be provided to personnel and others regarding legal/regulatory topics to be aware of. The systems, such as meetings or other methods to help personnel stay current on new topics, are identified. Regulatory content may be included in trainings to ensure accurate knowledge and compliance. This process might also include retaining a legal advisor.

1.a.–e. With regard to fundraising practices, compliance with legal, regulatory, confidentiality, reporting, and licensing requirements may include valuing donations according to guidelines, annual tax filings, documentation provided to donors, and obtaining the required licenses to conduct fundraising activities and events.

1.d. Reporting requirements may include financial solvency.

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 are implemented that 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. Timeframes 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 Health Information Technology for Economic and Clinical Health [HITECH] in the U.S. and Personal Information Protection and Electronic Documents Act [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 mechanisms such 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 timeframes and procedures for retention and destruction of records.

3.a. Confidential administrative records could include personnel records, contracts, budgets, billing information, legal information, records of donations and/or donors, and other protected or sensitive information and records.

3.b. Records are not required to be kept in a single location. However, if they are kept in several locations, they may be controlled from a central location by a designated staff member, with the location of each file readily identified. If records are stored in locations other than the central location, the safeguards for each of these locations may be similar to the safeguards for the central location.

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

3.f. An organization would establish its own timeframes for entries into records which could include timeframes for entering critical incidents or interactions into the records of the persons served and timeframes 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.

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 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

Strategic planning and financial planning are integrated to ensure that initiatives or changes in programs are adequately funded or supported to maximize success.

1.a. This may tie to Section 1.L. Performance Measurement and Management standards on identifying and measuring service delivery performance indicators such as results achieved for the persons served, experience of services and other feedback, efficiency, and service access.

1.b. The organization's performance objectives may include, but are not limited to areas of potential financial risk such as reductions in funding or new regulations that might impact services or expand the population to be served. This may tie to Standard 1.L.9. related to setting and measuring performance indicators for business function improvement.

1.F. **2. Budgets:**

- **a. Are prepared prior to the start of the fiscal year.**
- **b. Reflect:**
  - **(1) Input from various stakeholders, as required.**
  - **(2) Comparison to historical performance.**
  - **(3) Consideration of necessary cash flow.**
  - **(4) Consideration of external environment information.**
- **c. Document:**
  - **(1) Reasonable projections of:**
    - **(a) Revenues.**
    - **(b) Expenses.**
    - **(c) Capital expenditures.**
  - **(2) Approval by the identified authority.**
- **d. Are disseminated, as appropriate, to:**
  - **(1) Personnel.**
  - **(2) Other stakeholders.**

Examples

The annual budget reflects projected income and expenses. Input from professional and administrative personnel in budget development may demonstrate 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 personnel.
- Through participation on the board or advisory groups.

2.c.(2) Approval of the budget could be conducted by an owner, executive leadership, governing board, or other authority. If an organization is dependent on funding from an external entity's budget that has not been finalized prior to the beginning of the fiscal year, an organization may adopt a provisional budget until the final 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.b.(2) Persons served may be interested in the financial status, stability, or viability of an organization for a variety of reasons; e.g., they are personally responsible for the payment of fees; they anticipate being engaged with the organization for an extended period of time; they are seeking new or enhanced equipment, technology, facilities, or programs/services and want to know whether the organization's budget will support these; or they are considering donating to or investing in the organization.

Nonprofit organizations are subject to reporting requirements, including financial reporting, with information publicly available. In some settings, a contract for services between an organization and a person served may include requirements for reporting specified information. An organization may publish annual reports, performance reports, newsletters, or news releases, or it may post information on a website that reflects its overall status and plans, including the finances needed to support them.

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

1.F. **4. The organization:**
- **a. Identifies and reviews, at a minimum:**
  - **(1) Revenues.**
  - **(2) Expenses.**
  - **(3) Internal:**
    - **(a) Financial trends.**
    - **(b) Financial challenges.**
    - **(c) Financial opportunities.**
    - **(d) Management information.**
  - **(4) External:**
    - **(a) Financial trends.**
    - **(b) Financial challenges.**
    - **(c) Financial opportunities.**
    - **(d) Industry trends.**
- **b. Identifies areas needing improvement.**
- **c. Implements actions to address the improvements needed.**
- **d. Reviews financial solvency, with the development of remediation plans if appropriate.**

Examples

External events that have a financial impact on the organization can include items such as:

- Changes in reimbursement rates.
- Competition in the marketplace.
- Changes in preferences of persons served.
- Interest rates and the availability of financing.
- Regulatory and legislative changes.

Management information can include items such as:

- Amount of time it takes to sell or lease a vacant unit.
- Percentage of private pay versus Medicare/Medicaid or pay from other public funds.

An organization might benefit from knowing how sensitive it is to a variety of issues and how much of a drop in certain areas of revenue can occur before it begins to lose cash, possibly leading to a default on debt repayment. For example, how low can persons served census from a certain payer source become before the decline causes the organization stress in cash flow or with meeting the terms of debt.

An organization might develop a remediation plan to determine underlying causes of the decline in number of persons served through a variety of means, which might include reassessing the performance of the liaisons to referring hospitals, community-based providers, and referring physicians; conducting a survey of past persons served; or conducting a competitive analysis to determine if the census decline is widespread or only at one organization.

A remediation plan could identify strategies to increase the number of persons served through strategies such as advertising and/or senior management meetings with referring hospitals, physicians, or other referral sources to ensure that they are informed about the services offered by the organization.

An organization can demonstrate that consideration of these items occurs through meeting minutes or other type of document.

4.a.(3) Key metrics can include census and utilization.

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

1.F. **5. The organization:**

- **a. Implements fiscal policies and written procedures, including internal control practices.**
- **b. Provides training related to fiscal policies and written 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, fundraising, and billing.

Examples

5.a. Policies and written procedures may address methods for receiving cash, checks, donations, or other financial instruments; disbursing funds, including petty cash, other cash, checks, or other financial instruments; managing the use, receipt, or disbursement of funds through purchase orders, invoices, organizational credit cards and debit cards, and/or lines of credit with outside vendors; managing donations; and investing funds.

Written internal controls provide management with some assurance that information provided by the accounting system is reliable and timely; therefore, an auditor's report on internal control is not a substitute for an organization having internal control procedures.

1.F. **6. If the organization bills for services provided, it conducts a documented review of a representative sample of bills of the persons served:**

- **a. At least quarterly.**
- **b. That addresses:**
  - **(1) Whether bills are accurate.**
  - **(2) Trends.**
  - **(3) Areas needing improvement.**
  - **(4) Actions to be taken.**

Intent Statements

A review of bills of the persons served to determine that they are accurate is a proactive method for an organization to help reduce or eliminate costly audit exceptions. This review and corresponding action will assist in that process.

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

Examples

6.b.(3)–(4) Actions to be taken address the areas identified as needing improvement. For example, errors in billing may be addressed with education for billing personnel on why bills were rejected or declined, training on proper coding, issuing corrected bills, or return of overpayments to persons served or payers. Service delivery personnel may be trained on requirements for documentation in the records of persons served that justifies the billing.

1.F. **7. 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 services, third-party/funder rate adjustments, and the local market.

CCRCs can use a variety of techniques to determine fees, including actuarial studies and financial analyses. For example, CCRCs may use actuarial studies with mortality and morbidity tables to assess the likely inflow, outflow, and turnover of CCRC residents. Other CCRCs might use some combination of resident statistics, government reimbursement rates, marketing data, and operating costs. Although CARF does not require CCRCs to use actuarial studies, they may be required as part of financial feasibility studies necessary in the CCRC licensing process. Actuarial studies can be a useful tool for CCRCs that offer contracts which incur long-term liabilities such as guaranteeing healthcare services over the long term.

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

7.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 or other organizations. It does not require that it be external to the organization.

7.c. These may be called unfunded services, or services that include the beauty shop, meals, tuck shop, country store, café, carports, or covered parking spaces. Although disclosure in writing is not required, it may be useful to provide written disclosure to persons served.

1.F. **8. The organization:**

a. Obtains annual review or audit of its financial statements conducted by an independent accountant authorized by the appropriate authority.

b. Provides documentation of:

(1) The results of annual financial statement review or audit, including any resulting recommendations.

(2) Management's response to recommendations, if applicable, resulting from annual financial statement review or audit, including corrective actions taken or reasons why corrective actions will not be taken.

Intent Statements

An *accountant authorized by the appropriate authority* means a CPA in the U.S.; in countries outside the U.S., the terminology for a similar accountant qualified to conduct a review or audit would be used. The CPA, chartered accountant, or similar accountant retained must be independent of the organization; i.e., may not be contracted with the organization for its regular accounting needs, represent the organization's funding sources, or be a member of the governance authority.

It is important for the 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.

The scope of this independent examination may vary based on the accounting requirements to which the organization is subject. For CARF either a full audit or a review is acceptable. A compilation will not meet this standard. An organization should always be sure it is meeting other applicable requirements.

Examples

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

8.a. An organization that is part of a larger entity may be included in the audit or review of the larger entity. In addition to documentation of the audit or review, the organization is expected to provide evidence that it was included in the process of the larger entity. This may be demonstrated through financial reports, subsidiary agreements, annual reports, or other business-related documents that provide evidence of the relationship of the organization to the larger entity.

Applicable Standards

Organizations seeking accreditation for a Continuing Care Retirement Community must also meet Standards 9.–18.

1.F. **9. The organization provides documented evidence that an independent financial audit is completed within 120 days of fiscal year end.**

Examples

An organization may demonstrate conformance by sharing the cover letter that is received from the auditing firm.

Long-Term Financial Planning

CCRCs are complex organizations that often rely on a variety of revenue sources. Some CCRCs offer a resident contract that includes prepaid healthcare. Prudent financial management requires these organizations to have financial analysis and planning skills in order to monitor their financial operations, liquidity, and the capital structure of the organization, and to translate their analysis into financial plans that will ensure the long-term solvency of the organization.

1.F. **10. The organization addresses:**

- **a. Margin/profitability, including:**
  - **(1) Revenue and expenses related to the persons served.**
  - **(2) Earnings related to businesses not directly related to the persons served (ancillary revenue) and third-party sources of revenue.**
  - **(3) Expense management.**
- **b. Liquidity.**
- **c. Capital structure to ensure:**
  - **(1) Financial flexibility.**
  - **(2) Ability to meet the needs of persons served and other stakeholders.**
- **d. Use of financial ratio information.**
- **e. Bond covenant compliance, if the organization has bond covenants that must be met.**

Intent Statements

Financially savvy organizations analyze the various components of their revenues and expenses in order to make well-informed decisions. It is critical that organizations understand the revenues and expenses related to activities serving residents. They will need to identify revenues from nonresident income, such as contributions, investment earnings, and other income from non-core operations. Each organization will have its own degree of operational impact from these various revenue and expense items. Understanding these operational impacts will help management navigate the environment in which they work.

For CCRC programs, conformance to these standards is determined by the organization's financial ratios calculated from the audit report for the most recent fiscal year. These financial ratios are then benchmarked against the average of three years of financial ratios data for the purpose of determining a level of conformance:

- **10.a.(1)** Net operating margin ratio
- **10.a.(2)** Total excess margin ratio
- **10.a.(3)** Operating ratio
- **10.b.** Days cash on hand ratio
- **10.c.(1)** Cash to debt ratio
- **10.c.(2)** Debt service coverage ratio

Effective asset/liability (balance sheet) management is key to an organization's long-term survival. Goals include ensuring that funds are available to meet the long-term contractual needs of residents, for both healthcare and contract refunds, upkeep of the physical plant, as well as strategic growth objectives relating to existing and future facilities, affiliations, and new service line opportunities.

Examples

NOTE: *Organizations submit audited financial statements and Ratio Pro for their most current fiscal year end with the survey application. If the organization has more current audited financial statements available once the survey has been scheduled, the most current audited financial statements and updated Ratio Pro should be submitted for use in assessing conformance to accreditation standards during the survey. CARF must receive the more current audited financial statements and updated Ratio Pro at least two weeks prior to the start of the site survey in order to be considered for inclusion.*

If CARF does not receive more current audited financial statements two weeks prior to the survey, the financial statements submitted with the Application will be used to determine conformance to the standards during the survey.

Refer to the annual publication *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities,* Section 2. Margin (Profitability) Ratios for assistance in analyzing your organization's margin (profitability).

Ratio Pro has five margin/profitability ratios that will assist in your analysis:

- Net Operating Margin Ratio (NOM)
- Net Operating Margin—Adjusted Ratio (NOM-A)
- Operating Ratio (OR)
- Operating Margin Ratio (OM)
- Total Excess Margin Ratio (TEM)

If an organization's cash operating expenses exceed cash revenue, either unintentionally or by design, this shortfall will need to be funded.

Examples of non-operating funding sources include:

- Admission fees of new residents.
- A parent or affiliate organization.
- Owners, including limited partners.
- Contributions.
- Debt.
- Unrestricted cash balances.
- Release of temporarily restricted net assets.
- Sale of investments.

Financial flexibility can be obtained by a variety of mechanisms, including:

- Legally structuring an organization to provide flexibility for debt cross-collateralization.
- Targeting a mix of fixed versus floating rate debt.
- Hedging variable rate debt with swaps, caps, and other derivative products.
- Hedging fixed rate debt with swaps.
- Using obligated groups.
- Using bond ratings and insurance.

Refer to the annual publication *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities*, Section 3. Liquidity–Days Cash on Hand Ratio (DCH) and Appendix A. Discussion of Unrestricted Cash & Investments for assistance in analyzing your organization's unrestricted cash reserves. *Ratio Pro* has one ratio, Days Cash on Hand, to assist you in your analysis.

Unrestricted cash and investment balances are funds available to pay current operating expenses. Unrestricted cash and investments

generally exclude trustee-held funds (held by trustees in connection with long-term debt), assets restricted by donors, prospective resident deposits, and collateral for bank loans.

Unrestricted cash and investments include:

- Operating cash and cash equivalents.
- Investments without donor restrictions.
- Board-restricted or designated assets.
- State operating reserves (if not required to be maintained in as separate escrow account).
- The financial statements of foundations set up solely for the benefit of the operating entity are generally consolidated with the operating entity. Accordingly, unrestricted cash and investments of these foundations would be included.

NOTE: *Exclude trustee-held funds (e.g., debt service reserve funds or debt service reserves) as these are not considered unrestricted.*

The amount of days cash on hand will vary among organizations and is dependent on many factors, such as ownership type (for-profit/non-profit), resident contract type (A, B, C, rental), and the philosophy of boards and senior management. For example, although both nonprofits and for-profit CCRCs take in cash entrance fees, the nonprofit is restricted by tax laws as to the amount of cash that can be legally removed from the organization. Conversely, for-profits are not limited on cash removal and may choose to withdraw the cash and maintain an alternative source of cash to fund operating shortfalls. Hence a for-profit may have lower days cash on hand.

Contract types will also influence the amount of days cash on hand. Contract type A organizations take in a larger upfront entrance fee and may invest these monies until they are needed for future healthcare costs. On the other hand, rental communities do not charge entrance fees and hence tend not to have large days cash on hand as they price their monthly service fees to cover their monthly expenses. Hence contract type A CCRCs will have a higher days cash on hand benchmark.

The *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities* publication lists financial ratio benchmarks for CCRC contracts type A, B, and C.

Regardless of contract type or ownership type (for-profit or nonprofit), it is essential that organizations have access to liquidity, either through direct cash on hand or via third-party support.

Third-party sources of liquidity may include:

- A parent or affiliate organization's legal guarantee to fund operating shortfalls.
- A parent or affiliate organization's history of funding operating shortfalls without a guarantee ("moral obligation").
- Debt.
- Foundations.
- Annual subsidies.
- Annual appropriation from Congress.
- Owner/limited partners.

Refer to the *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities,* Section 4. Capital Structure Ratios for a discussion of how to measure and interpret balance sheet ratios. *Ratio Pro* has the following capital structure ratios to assist you in your analysis:

- Debt service coverage (DSC)
- Debt Service Coverage — Revenue Basis Ratio (DSC-R)
- Debt Service as a Percentage of Total Operating Revenues and Net Nonoperating Gains and Losses Ratio (DS-TR)
- Unrestricted Cash and Investments to Long-Term Debt Ratio (CD)
- Long-Term Debt as a Percentage of Total Capital Ratio (LTDC)
- Long-Term Debt as a Percentage of Total Capital-Adjusted Ratio (LTDC-A)
- Long-Term Debt to Total Assets Ratio (LTD-TA)
- Average Age of Community Ratio (AGE)
- Capital Expenditures as a Percentage of Depreciation Ratio (CED)

10.d. The organization may describe ways that it has used current financial ratio information to make planning decisions, or it may explain how using financial ratio data to benchmark itself to other organizations might inform changes to operations or service delivery, or perhaps affirm current practices.

10.e. Examples shared with surveyors regarding how bond covenants are met might include periodic reports to bondholders, audit compliance reports, or other methods.

1.F. **11. If the organization has material investments, it implements an investment policy that:**

a. Addresses, at a minimum:

(1) Portfolio return.

(2) Portfolio risk.

(3) Restricted cash reserves.

(4) Investment instruments.

b. Is reviewed at least annually for relevance.

c. Is updated as needed.

Intent Statements

Organizations, especially those that offer life care contracts, generally have material assets to invest. Organizations with investment assets that are material to the organization must have policies and procedures in place to address investment portfolio return and risk.

Financially sound organizations maintain adequate unrestricted cash and investment reserves, or have access to third-party cash/reserves, to fund any unforeseen operating cash shortfalls and to meet the commitments of their residents and other persons served.

If an organization is required to maintain restricted reserves, it must have procedures to ensure that account balances are adequate and that time and usage restrictions are adhered to.

Examples

A sound investment policy should incorporate a variety of themes. For example:

- Investment objective: a statement outlining the purpose of the portfolio.
- Approved investments: the risk tolerance of an organization will dictate the percentage of investment assets in less risky, more liquid investments (cash, bank CDs, money market fund) and the percentage in riskier stocks and bonds.
- Investment restrictions: outlines the type of investments that have been prohibited; e.g., investments are restricted to bonds with a BBB rating or better.
- Investment safekeeping: what entity will hold the investment certificates and other documentation.
- Portfolio management:
  - How is portfolio performance monitored?
  - How often are results reviewed?
  - Whose responsibility is it to monitor the portfolio?

11.a.(3) This standard applies if the organization is required to maintain restricted reserves under debt agreements, state statutory requirements, and/or restricted endowments.

11.b. Review of the investment policy may be conducted by a finance committee, a management team, a financial expert that is retained by the organization for this review, or by another entity that the organization identifies as having the appropriate knowledge. The review could result in revision of the policy or it may result in affirmation that the policy is still relevant.

1.F. **12. Identified leadership of the organization reviews investment results at least annually in accordance with the investment policy.**

1.F. **13. The organization implements a cash management strategy that:**

a. Addresses, at a minimum:

(1) Accounts receivable management.

(2) Accounts payable management.

b. Is reviewed at least annually for relevance.

c. Is updated as needed.

Intent Statements

Effective management of accounts receivables ensures a steady stream of cash that can be invested to earn additional income for the organization.

Examples

Accounts receivables must be analyzed periodically to determine if the receivables are being paid according to the invoice due date. Receivable conversion can vary depending on the type of receivable; generally government reimbursement receivables take longer to collect than private pay. Therefore, the receivable mix will influence your overall days in accounts receivable that are outstanding.

A key financial benchmark of the efficiency of accounts receivable management is "Days in Accounts Receivable." Refer to the annual publication *Financial Ratios & Trend Analysis of CARF-Accredited Continuing Care Retirement Communities*, Section 3. Liquidity Ratios for a discussion of Days in Accounts Receivable ratio. *Ratio Pro* has a "Days in Accounts Receivable" ratio against which to benchmark.

Examples of current assets include:

- Cash and current investments.
- Accounts receivables.

Examples of current liabilities include:

- Short-term debt.
- Accounts payable

1.F. **14. The organization evaluates key performance indicators that include, but are not limited to, contract types identified by:**

a. Level or type of care or service.

b. Number of residents per contract type.

Intent Statements

Accredited organizations evaluate key financial performance indicators, such as contract type information, to aid in strategic fiscal planning efforts.

1.F. **15. The organization has a mechanism to make the audited financial statements and footnotes available to:**

a. Prospective persons served.

b. Current persons served.

c. Other stakeholders.

Intent Statements

To demonstrate an organization's commitment to excellence and transparency, the organization fully discloses the financial information contained in the audited financial statements and footnotes.

Examples

Copies could be made available in the marketing office or resident service office. A summary could be made available in the resident newsletter.

1.F. **16. The organization conducts a capital needs assessment that:**

a. Addresses:

(1) Existing capital assets.

(2) Future capital asset needs.

b. Is documented.

c. Is reviewed regularly and updated as needed.

Intent Statements

A capital needs assessment is a valuable guide to understanding the life expectancy and cost of major items needed to maintain and update an organization. It serves as a process to identify, predict, budget, and make critical decisions regarding major upcoming expenditures, maintenance of existing facilities, planned expansions, and associated financing strategies to support such needs (i.e., growth of new assets, debt capacity, etc.). Although a capital needs assessment may involve multiple experts and consider various types of information, the assessment process should result in a document to help the organization identify major capital needs that should be considered for long-range financial planning.

16.c. The organization determines the frequency at which it will review the capital needs assessment to ensure that the information is current.

Examples

16.a. Existing capital assets may include property, plant, and equipment items, such as:

- Bricks and mortar.
- Sidewalks.
- Landscaping.
- HVAC systems.
- Personal computers/servers/electronic medical records.
- Buses and other vehicles.

For each item identified, the following information may be addressed:

- Date put into service.
- Estimated repair/replacement date.
- Estimated cost of repair/replacement.

Building assessment reports may be part of the capital needs assessment.

16.b.–c. Changes in capital needs, the organization's strategic planning process, and its annual budgeting process may be considered in determining the frequency at which the capital needs assessment is reviewed. This review documents that the budgeting for cash and investments required for the capital needs of the organization is addressed. Cash flow projections include what is required to address upcoming capital spending.

1.F. **17. The organization's long-range financial planning process considers:**

a. The results of the capital needs assessment.

b. Debt management risks.

c. Investment risks.

d. Input from:

(1) Persons served.

(2) Personnel.

(3) Other stakeholders.

Intent Statements

To engage in planning that considers both fixed assets and monetary capital, organizations benefit from considering a variety of perspectives and information. Combining the insights gained from the capital needs assessment, looking at the risks associated with the organization's debt, considering the potential risks of the organization's investment strategy, and obtaining input from key stakeholders are part of a comprehensive approach to identifying future financial opportunities and challenges.

Examples

17.b. The organization reviews how assets are safeguarded and how it is currently managing financial obligations such as debt. The organization can describe its outstanding long-term debt and the approaches it will employ to continue to meet debt obligations. It may use long-term financial projections or projected financial ratios to inform debt management. The organization may have a plan in place for replacing a letter of credit.

17.c. Planning might include approaches such as exploring diversification of the investment portfolio, reviewing long-term investment goals and how they may be impacted by short-term volatility in financial markets, monitoring and tracking the organization's investment performance and making necessary adjustments in the portfolio, and considering external financial expertise regarding use of various financial products based on the organization's risk tolerance.

17.d.(3) Other stakeholders may include board members, advisory groups, donors, financial institutions, bondholders, and credit rating agencies.

1.F. **18. A long-range financial plan is implemented that:**

a. Includes:

(1) Timelines for capital asset repair and replacement projects.

(2) Cash flow projections for capital asset needs.

(3) Sources of funding to support identified needs related to:

(a) Fixed asset repair and replacement.

(b) Organizational growth.

(4) Management of debt obligations.

(5) Management of investment risks.

b. Aligns with the organization's strategic plan.

c. Is shared, as relevant to the needs of:
- **(1) Persons served.**
- **(2) Personnel.**
- **(3) Other stakeholders.**

d. Is reviewed at least annually for relevance.

e. Is updated as needed.

Intent Statements

When properly developed and implemented, the long-range financial plan serves as a tool to facilitate future financial performance. It matches the organization's financial resources with the goals and priorities set in the strategic plan addressed in Section 1.C. A well-thought-out long-range financial plan provides the organization with the information needed to make informed strategic and operational decisions. The long-range financial plan should therefore address both maintenance and growth capital, and it should identify the financial instruments being used to meet future needs.

Maintenance capital is typically provided by cash and cash flow. Growth capital may be financed through internal and external sources. Internal sources may include reserves, proceeds from a capital campaign, or other sources; external sources may include various types of debt that could be structured in different ways based on interest rates, maturity/amortization, and other factors.

The intention of the long-range plan is to provide forecasting and projections for multiple years beyond the current annual budget. CARF does not identify a specific timeframe for such planning; organizations should identify their timeframe for "long-range" based on their market.

The long-range financial plan may be a separate document or it may be clearly integrated with the organization's strategic plan. If the long-range financial plan is integrated with the strategic plan, surveyors must be able to easily identify the required written elements of the long-range financial plan within the strategic plan.

Examples

18.a.(1)–(3) Based on the information in the capital needs assessment, organizations identify funding source(s) for estimated costs of repair/replacement.

Projected financial statements are prepared in a format consistent with the organization's annual audited financial statements and include:

- Financial position.
- Activities.
- Cash flow.

18.a.(4) To manage debt, an organization may explore long-range approaches such as reviewing the type of debt it takes on to ensure that it best aligns with organizational needs, prioritizing existing debt payments, or restructuring debt.

18.a.(5) To manage investment risk, an organization may include different asset classes in its investment portfolio; e.g., stocks, bonds, real estate, and cash, to increase the probability that some investments will provide satisfactory returns even if others are flat or losing value. An organization might also diversify by dividing the money allocated to a particular asset class, such as bonds, among various categories of investments that belong to that asset class.

18.c.(3) The organization shares the information in the long-range financial plan, including but not limited to information related to continuing disclosure requirements for public debt and investor relations, with various stakeholders. Other stakeholders might include, but are not limited to, organizational leadership and governance, lending institutions, and credit rating agencies.

18.d.–e. The organization determines the method of review and responsibility for plan updates. Although the long-range financial plan should have some type of review at least annually, it may not need to be updated that frequently because it is long-range in nature. Significant market changes impacting the long-range financial plan could prompt leadership to consider an update.

G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their 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

A risk management plan can include written, action-oriented documents developed with a goal to mitigate, reduce, or eliminate an organization's potential losses or exposure to risk. The plan may be present and future oriented and identify current risk management priorities and any new measures to be implemented. To maximize the usefulness of the risk management plan, it might be specific in identifying the necessary steps to achieve goals, timelines, and persons responsible for implementation.

There could be seven components that constitute an organization's risk management plan.

1.a.(1) *Identify loss exposures*—Take inventory of threats to all areas of the organization, including personnel, property, reputation, income, and ability to accomplish mission and goals. These areas include internal or external events that could expose the organization to litigation, government sanction, property loss, or business interruption. Some areas to be considered are:

- Governance—fiduciary responsibility, conflicts of interest.
- Facility/plant/grounds—property loss or damage, capital replacement, environmental safety, emergency preparedness, life safety requirements.
- Financial—billing accuracy, fraud, investment risk, accounting practices.
- Human resources—employment laws, workers' compensation, worker's safety.
- Transportation—accident liability, property loss, personal injury.
- Information technology—data integrity, privacy of information, system failure, data loss.
- Care process—wounds, falls, injuries, abuse or neglect, medication errors, elopement, wandering.

1.a.(2) *Evaluate and analyze identified loss exposures*—Consider the nature of each area of risk. What is the likelihood of an adverse event occurring? If an event were to occur, how would it impact the organization? Are there certain areas of the organization or programming where the risk is greater? What factors cause or contribute to increased risk exposure?

1.a.(3) *Identify how to rectify identified loss exposures*—Pinpoint actions that can be taken to mitigate, reduce, or eliminate risks. Such actions could include policies and procedures, staff education and training, practices of verifying credentials, safety and performance improvement initiatives, reporting processes, and maintenance of adequate insurance coverage.

1.a.(4) *Implement actions to reduce risk*—Develop timelines for action and identify the individual(s) responsible for carrying out the actions. This will lend accountability for the implementation of

risk-reduction strategies. Consider tracking methods to assist in verifying implementation of the strategies.

1.a.(5) *Monitor actions to reduce risk*—Establish mechanisms and responsibilities for maintaining awareness of risk exposure and reduction strategies. Who is responsible for monitoring various areas of risk? What types of events should be reported and to whom should reports be submitted? Are individual incidents reported, or are indicators tracked monthly or quarterly?

1.a.(6) *Report the results of actions taken to reduce risk*—Determine if the actions taken to reduce risk have been effective. Based on information received through the established monitoring processes, are there any positive or negative trends in risk exposure? How and to whom is this information communicated?

1.a.(7) *Include risk reduction in performance improvement activities*—Areas of risk could be periodically reviewed as part of continuous performance improvement. When the desired or necessary results are not achieved, the organization can complete a new analysis of risk, add new or change existing strategies to rectify risk, monitor the effects of the changes, and report the new results.

1.G. **2. As part of risk management, the insurance package of the organization:**

- **a. Is reviewed:**
  - **(1) For adequacy.**
  - **(2) At least annually.**
- **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. The organization's insurance package includes appropriate coverage for any services it may provide in more than one state/province or other jurisdiction.

Examples

The organization recognizes that although insurance is only one aspect of an organization's overall risk management strategy, adequate insurance coverage is essential. The organization's insurance coverage might include:

- Professional liability.
- Property and loss.
- Fire and flood.
- Business interruption.
- Directors and officers.
- Automotive.
- Cybersecurity.

As an element of risk management, the leadership ensures that coverage is put in place to protect the needs, risks, and assets of the organization. The intent is that the review be conducted with the assistance of someone who is knowledgeable about insurance needs and types of coverage. This may be an insurance broker or anyone else with experience who also knows and 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.

1.G. **4. The organization implements policies and procedures regarding technology and data that address:**

- **a. Acceptable use.**
- **b. Backup/recovery.**
- **c. Business continuity/disaster recovery.**
- **d. Security, including:**
  - **(1) Access management.**
  - **(2) Audit capabilities.**
  - **(3) Data export and transfer capabilities.**
  - **(4) Decommissioning of physical hardware and data destruction.**
  - **(5) Protection from malicious activity.**
  - **(6) Remote access and support.**
  - **(7) Updates, configuration management, and change control.**

Examples

4.a. Acceptable use policies and procedures might address authorized use of organization-issued technology, such as computers, tablets, cell phones, and USB drives, and use of email, the internet, information systems, networks, etc., including what a user is and is not allowed to do with those resources, such as whether an organization-issued laptop may be taken off the premises, whether personnel can use the internet for personal purposes during breaks, and whether printing of personal documents is allowed. Policies and procedures may also address the use of personal devices and technology for business operations.

4.b. Backup/recovery refers to the process of backing up data and setting up systems that allow data recovery in case of data loss or corruption. Policies and procedures might address the type of backup used; e.g., on site (backing up data onto a local storage device, such as a tape drive or another server's hard drive) or off site (backing up data to a remote location or a co-location facility, or using an online cloud backup service); regular monitoring and testing of backup and restore processes to verify they function as expected; data retention timeframes; the need for multiple copies of data; and distribution of data in backup and recovery planning. An organization will want to broadly consider its use of technology for both business processes and service delivery in establishing adequate procedures and what could be at risk should data be lost from systems such as payroll; billing; scheduling; medical records; or portable devices used for communication, documentation, or other transfer of data about persons served.

4.c. Business continuity/disaster recovery is a set of processes used to help an organization recover from a disaster and continue or resume routine business operations. Business continuity addresses the availability of essential business functions and processes during and after a disaster and may include the replacement of personnel, service availability issues, business impact analysis, and change management. Disaster recovery processes may include server and network restoration, copying backup data, and provisioning backup systems.

Testing of business continuity/disaster recover procedures may assist in determining if the procedures function as expected to protect the organization's technology and data assets and identifying areas where performance improvement is needed.

4.d.(1) Access management refers to identification and management of access to and use of technology and information resources, including authorization and de-authorization or deactivation, physical access, and electronic access. User authorization and de-authorization may address password settings; e.g., complexity, expiration, use of temporary passwords; what happens when someone begins or leaves employment; supervisor access to confidential records of their employees; etc.

4.d.(2) Audit capabilities refers to a record or audit log showing who has accessed a computer system and what operations the person has performed during a given period of time.

4.d.(3) Data export and transfer capabilities may include defining what data are proprietary and secure, how data may be exported or transferred (e.g., email, on a flash drive, etc.), and whether data can be transferred to personal devices and back to organization-owned equipment.

For example, an organization may have a policy that electronic medical records are not to be transferred via email or accessed from/stored on personal devices.

4.d.(4) Decommissioning of physical hardware and data destruction refers to the removal of hardware from active status and how that hardware will be disposed of without risking access to data; e.g., what an organization does with hard drives and backup tapes that are no longer used.

4.d.(5) Protection from malicious activity addresses protection from malicious software such as worms, viruses, trojans, spyware, adware, rootkits, etc., that accesses protected data, deletes data, or adds software not approved by the organization or user. Protection may be accomplished by firewalls, spam filtering, and other systems designed to prevent abuse or unauthorized use of systems.

4.d.(6) Remote access is the ability to access a computer or network from a separate location; e.g., someone at a branch office, a telecommuter, and/or someone traveling who may need access to the organization's network or resources. Procedures may address who can remotely access organization information and technology and for what purpose, what equipment can be used to perform the remote access (organization-owned devices vs. personal devices), whether access is temporary or ongoing or limited to specific days or hours, and how access is accomplished. Remote access can be set up using a local area network (LAN), wide area network (WAN), or a virtual private network (VPN) so that resources and systems can be accessed remotely.

4.d.(7) Configuration management tracks an organization's hardware, software, and related information; e.g., software versions and updates installed on the organization's computer systems, network addresses belonging to the hardware devices used, etc. Change control is a systematic approach to modifying software applications or systems, patch installation, or network upgrades. Change control reduces the risk when introducing new technology (hardware or software) or changes to existing technology (e.g., software changes, operating system updates, firmware updates) by ensuring that testing and analysis are performed to understand the impacts of the change and by having procedures defined for the deployment of changes to ensure an orderly transition.

1.G. **5. If any of the services delivered by the program seeking accreditation are provided under contract with another organization or individual, documented reviews of the contract services:**

a. Assess performance in relation to the scope and requirements of their contracts.

b. Ensure that they follow all applicable policies and procedures of the organization.

c. Ensure that they conform to CARF standards applicable to the services they provide.

d. Are performed at least annually.

Intent Statements

Refer to the Glossary for the definition of *contract*.

This standard relates to Standard 2.A.1. in Section 2 on scope of services and applies to contracted personnel, the contracting of any part of an accredited program, and all other contracted services related to service delivery to the persons served by the program(s) seeking accreditation.

Organizations that contract transportation services for persons served please refer to Standard 1.H.13.

The organization complies with all applicable legal and regulatory requirements relative to the management of its workforce. This standard applies to independent contractors, as defined by the Internal Revenue Service (**www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee**), the Canada Revenue Agency (**www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4110/employee-self-employed.html**), or similar entities in other countries.

Examples

Reviews of contract services may be conducted by leadership, a contract manager/management office, risk management, or human resources.

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/spaces* 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.4.–1.H.9. and 1.H.12.–1.H.16. are not applied to programs that regularly use information and communication technologies (ICT) for all components of service delivery, if no physical locations are used by the organization for administration or delivery of any services.

Standards 1.H.5., 1.H.7., 1.H.14., and 1.H.15. 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 individual personnel member 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.

If the organization provides any services in locations that it does not own/lease or control/operate, Standard 1.H.8. applies.

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

1.H. **1. The organization demonstrates ongoing attention to the health and safety of the environment.**

Intent Statements

The organization demonstrates an overall concern for the health and safety of the persons served and personnel including ongoing attention to safe practices and reduction of health and safety risks in the environment and consideration of any applicable health and safety requirements of local or other governmental authorities. Documentation of daily maintenance tasks is not required.

1.H. **2. The organization implements 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

Classes may be provided or arranged for persons served on emergency preparedness, minimizing trip hazards, crime prevention, or self-defense.

For programs that equip individual units with emergency call or monitoring systems, the program provides education for persons served and their family/support system on the use of these systems addressing topics such as when to use them, what to expect when used, and how to know whether they are in working order.

In exclusively virtual programs/services, education may address how persons served should prepare or arrange their physical space to be conducive to and safe for service delivery. Depending on the type of program/service being delivered this could include attending to the cleanliness of the space, reducing clutter or trip hazards, setting up equipment used for service delivery, identifying space away from other persons or pets that could interfere with service delivery, or soliciting others to assist when needed.

1.H. **4. Personnel receive documented competency-based training:**

a. At orientation 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.
(9) Workplace violence.

b. At least annually 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.
(9) Workplace violence.

Intent Statements

See the Glossary for the definition of *competency-based training*.

Examples

Ways to structure training so that they are competency based may include "demonstration and return demonstration" in which the trainer demonstrates a skill (such as using a fire extinguisher or other equipment) and the trainee performs the same skill in return to ensure competency. Another technique might be to have a written quiz or assessment following a training presentation to ensure that key concepts are understood. Verbal quizzes in which the trainee describes to the trainer the expected response in an emergency may also be useful in assessing competencies.

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:

- 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 may be conducted after each training activity. Training participants can be 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 inadequate lighting 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.

4.a.(9) and **4.b.(9)** Training might include what types of behaviors, actions, or communication constitute workplace violence; e.g., bullying; intimidation; sexual harassment; disruptive behavior; assaultive behavior; or unauthorized possession and/or use of a weapon such as a gun, knife, Taser, or bomb. Training may also include actions to take under such circumstances; e.g., communication with the offending party, the mechanism to seek assistance within the organization, and reporting requirements.

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.

(11) Communication with relevant stakeholders.

Intent Statements

Established emergency procedures that detail appropriate actions to be taken, including communication with relevant stakeholders, consider any unique needs of persons served, and are appropriate and specific to the service delivery site or location 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 procedure guides personnel to assess the situation, to take appropriate planned actions, and to lay the foundation for continuation of essential services.

Examples

Depending 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.(3) The organization evaluates safety concerns related to possible natural disasters and their potential effects on the organization's personnel, 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, snowstorms, landslides, and volcanic eruptions.

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.(5) Medical emergencies might include someone unable to get up from a fall; a severe cut or allergic reaction; loss of consciousness due to a change in blood pressure, stroke, cardiac event, or medication misuse; or severe emotional distress that may contribute to suicide risk.

5.a.(6) Violent or other threatening situations may include explosions, gas leaks, biochemical threats, acts of terrorism, use of weapons, and aggressive or assaultive behaviors of persons served, personnel, or visitors.

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 identify when evacuation versus sheltering in place is appropriate. 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 that is safe to the extent possible from environmental conditions such as extreme weather or traffic 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.(7)–(8) While many emergencies are resolved in a discrete timeframe, there may be situations (such as a pandemic or ongoing environmental concerns) that last for an extended period of time. Such circumstances may necessitate changes in priorities and routine practices in order to safeguard the health and safety of persons served and personnel and continue to deliver essential services. For example, the organization may consider whether an expedited onboarding process is indicated to manage workforce issues, whether personnel are asked to fulfill alternative service delivery roles on a time-limited basis, or whether there is a need to use temporary staffing agencies. The organization may need to collaborate with vendors or other providers to ensure adequate supplies such cleaning and paper products or masks are available.

5.c.(9) Emergency phone numbers might include emergency call lists; contact numbers for family/support systems of the persons served; organizations that will provide temporary shelter or accept transfer of persons served; transportation companies; and resources such as hospitals, utilities, and suppliers of emergency equipment.

5.c.(11) During sustained emergency conditions the organization may implement new or supplemental communication methods and systems. For example, the leadership team may record daily updates that are then widely disseminated or hold weekly interactive Q&A sessions, the organization may post information on its website or portals in order to efficiently reach more people, members of the leadership may be assigned to serve as designated liaisons for various stakeholder groups, or the organization may deploy automated calling or texting systems.

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. Evacuation routes refer to the clearly visible and known routes of egress. Signage such as a posted map or diagram is not required. If an organization chooses to use signage, this may be simple Exit signs over doors, Braille representation, diagrams, or directional signs showing corridors and line of travel to exit doors. Accessibility of the signage would consider location, height, and other needs relative to the persons served and other stakeholders. Additionally, the exit ways should have adequate lighting and 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. An unannounced test of each emergency procedure:**
- **a. Is conducted:**
  - **(1) At least annually.**
  - **(2) On each shift.**
  - **(3) At each location.**
- **b. Includes, as relevant to the emergency procedure, a complete actual or simulated physical evacuation drill.**
- **c. Is analyzed for performance that addresses:**
  - **(1) Areas needing improvement.**
  - **(2) Actions to address the improvements needed.**
  - **(3) Implementation of the actions.**
  - **(4) Necessary education and training of personnel.**

(5) Whether the actions taken accomplished the intended results.

d. Is evidenced in writing, including the analysis.

Intent Statements

It is expected that each emergency procedure addressed in Standard 1.H.5. (fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations) is tested, analyzed for performance, and documented, including the analysis. 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

Emergency tests may be done in a variety of ways. There can be a drill that simulates emergency procedures for persons served and personnel. Actual physical tests or drills that move personnel through the procedure allow for practice and provide an indication of how personnel might respond in an actual emergency. With the exception of evacuation drills, tests of the emergency procedures could also be accomplished with unannounced written tests that detail what should be done in the event of an actual emergency. All personnel who would be expected to participate in an emergency procedure should be included in the testing. An organization that tests emergency and evacuation procedures at the time of a shift change is cautioned to consider whether that timing provides a realistic representation of the resources that would be available to respond to an emergency during a regular shift. For example, the number of personnel present overnight at a residential program may vary considerably from mid-day, resulting in different expectations of personnel on those shifts in the event of an emergency. The emergency procedure testing is used to improve the knowledge and readiness of personnel in the event of actual emergency situations.

During these tests, the persons served may be involved in the emergency evacuation. If persons served are not involved in the test, personnel simulate the types of restrictions that persons served may have during an evacuation when actually moving through the process of evacuation.

An organization may establish a benchmark or target prior to the test. Many times this is met and no improvement is needed. This confirms that current practice is appropriate.

Use of a grid to track tests of all emergency procedures may help facilitate completion of all tests at least annually at all locations and on all shifts.

1.H. **8. If an organization provides services in locations that are not owned/leased or controlled/operated by the organization, it implements written procedures that address safety at the service delivery site:**

a. For:

(1) Persons served.

(2) Personnel.

b. Including:

(1) Consideration of any emergency procedures that may already be in place at the service delivery site.

(2) The physical environment, including accessibility, of the service delivery site.

(3) Basic needs in the event of an emergency.

(4) Actions to be taken in the event of an emergency.

(5) Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

Intent Statements

Please see the Glossary for a definition of *controlled/operated.*

Written procedures address the uniqueness of the settings and types of situations that may be encountered, and when decisions need to be made, potentially on an immediate basis, to

ensure the safety of persons served and personnel under a variety of circumstances.

This standard applies to programs that include community outings or community integration activities for the persons served and to programs that provide all of their services in locations that are not owned/leased or controlled/operated by the organization, including private homes.

8.b.(1) If services are provided in a location that is separately licensed or regulated, there may already be emergency procedures in place. If personnel or persons served are present in the event of an emergency, they would follow those procedures.

Examples

Services may be provided at sites including, but not limited to, a library, school, sports or performing arts venue, movie theatre, volunteer site, job site, or private home. Based on the service delivery site, the organization considers actions to be taken in the event of emergencies such as fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or other threatening situations.

1.H. **9. There is ready access:**

- **a. At each location.**
- **b. To:**
  - **(1) First aid expertise.**
  - **(2) First aid equipment.**
  - **(3) First aid supplies.**
  - **(4) Relevant emergency information on the:**
    - **(a) Persons served.**
    - **(b) 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 and 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 hours of operation. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

9.b.(4) The organization has a mechanism in place to ensure that emergency information is kept current on persons served and personnel.

Examples

The organization defines how it will have ready access to first aid. This may be accomplished by training key personnel in first aid. If in a hospital setting, hospital personnel within the program/service site could be used, or an external emergency response team (e.g., 911) could be called.

It is critical to have emergency information on the persons served and personnel readily available in the event that, during an emergency, the building could not be reentered or an emergency situation occurs in which information is needed immediately. Many organizations have a portable file with critical information. An organization may also be able to use existing personnel files and records of the persons served if these would be readily accessible in an emergency.

The adequacy of first aid expertise reflects the needs of the population being served as well as the services setting and may include first aid, CPR, standard precautions, or other safety training.

First aid and CPR classes are available from local agencies such as the Red Cross, the YMCA, and various other service organizations. The organization may choose to have designated personnel become trainers in first aid and CPR, or it may contract with other agencies to provide training.

1.H. **10. The organization implements written procedures regarding critical incidents that:**

- **a. Specify the following critical incidents:**
  - **(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 and attempted suicide.
(17) Sexual assault.
(18) Overdose.
(19) Other sentinel events.

b. Include:
(1) Prevention.
(2) Reporting.
(3) Documentation.
(4) Remedial action.
(5) Timely debriefings conducted following critical incidents.

Intent Statements

Any of the incidents listed above could occur in any organization. In developing its procedures for critical incidents, an organization should consider the persons served, personnel, and other stakeholders, such as visitors to its program. An organization is not required to have a separate procedure for each type of incident; however, the organization's written procedures for prevention, reporting, documentation, remedial action, and timely debriefings should consider the possibility of each type of occurrence.

This standard may relate to other standards on similar topics and how a program/service addresses these circumstances in the context of service delivery, such as how a program manages medication errors when they occur, suspected abuse or neglect, or suicide risk.

Examples

The organization ensures that it follows legal requirements regarding the reporting of incidents to the proper authorities. The terminology used in Canada may be serious occurrences. Reporting requirements can be obtained from licensing agencies, protection and advocacy services, and funding sources.

The organization may have written procedures in separate or combined documents.

10.a.(1) Examples may include errors by a provider in prescribing, dispensing, or administering medications; issues related to medication reconciliation, inventory, technology, or spill-age; errors by a person served such as taking the wrong dose of a medication, not taking the medication according to the prescribed schedule, storing a medication incorrectly (e.g., not refrigerating a medication that should be kept at a certain temperature); and adverse reactions to a medication.

10.a.(10) Elopement refers to circumstances in which a person served leaves a program or environment unsupervised, unnoticed, and/or prior to the scheduled discharge. This may be intentional on the part of the person served, e.g., when a child or adolescent runs away from a residential program or an adult leaves an inpatient or residential program without authorization, or it may be unplanned, e.g., when someone with a cognitive or other impairment gets unintentionally separated from others or confused about where they are and how to find their way back to where they are supposed to be.

10.a.(13) In its written procedures the organization addresses the possession and use of medical marijuana, including topics such as whether it is legal or illegal, how it is managed, the impact of its use on other persons served, and sharing with or selling to other persons served.

1.H. **11. 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) Areas needing improvement.
(4) Actions to address the improvements needed.
(5) Implementation of the actions.
(6) Whether the actions taken accomplished the intended results.

(7) Necessary education and training of personnel.

(8) Prevention of recurrence.

(9) Internal reporting requirements.

(10) 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 organization-wide report.

This report is a critical piece of information in both risk management and performance improvement activities. A critical component is the concept of prevention. Changing the environment, attitudes, and service delivery techniques are all part of the process, but if the organization is not committed to the prevention of incidents, the improvement will not last.

The organization may be analyzing critical incidents monthly, quarterly, or even more frequently. However, this standard prompts the organization to look back throughout the year to identify trends or issues for performance improvement.

1.H. **12. The organization implements written procedures regarding infections and communicable diseases:**

a. That address:

(1) Prevention, including:

(a) Appropriate use of standard or universal precautions.

(b) Vaccination, if applicable.

(c) Screening, if applicable.

(2) Identification.

(3) Reporting.

(4) Investigation.

(5) Control/mitigation.

b. That include training on the procedures for:

(1) Persons served.

(2) Personnel.

(3) Other stakeholders.

Intent Statements

The organization takes a comprehensive approach to prevention and management of infections and communicable diseases. This includes consideration of legal and regulatory requirements to which the organization is subject, which may vary by state/province or other jurisdiction as well as type of organization, and relevant training for persons served, personnel, and other stakeholders.

12.a.(1)(a) In Canada this may be referred to as *routine practices*.

Examples

Written procedures consider facility- or program-acquired infections and community-acquired infections.

The organization might identify an infection control officer or partner with an infection preventionist to lead its efforts.

If the organization identifies infection control as a priority it could incorporate these activities into its performance measurement and management plans.

Protocols address the occupational health needs of personnel such as immunizations and post-exposure evaluation, care, and operational strategies including quarantine or isolation.

Organizations providing residential services may benefit from developing a bed bug management plan. It is suggested that the process for managing bed bugs include defining responsibilities; training and education for personnel and persons served; identification and detection; documentation of infestations, including mitigation activities and infestation treatment; health and safety, which can include personal protective equipment and disinfecting facilities; acting

promptly on reports of possible infestations; eradication processes; and preventive measures. Further information can be found on the U.S. Environmental Protection Agency website at **www.epa.gov/bedbugs** and the Centers for Disease Control and Prevention website at **www.cdc.gov/parasites/bedbugs**.

12.a.(1) Procedures may address a variety of prevention techniques, such as isolation precautions, guidelines for visitors, and sterilization or cleaning of equipment.

12.a.(2)–(4) Epidemiological and other essential data are tracked and reported as required by local health departments and state/provincial and federal guidelines or regulations.

12.a.(2) Identification could include the use of screening protocols, testing, and diagnosis, with an emphasis on early detection and management.

12.a.(3) As appropriate, reporting considers critical incident reporting requirements and processes. In an effort to be transparent, reporting activities also include timely communication of key information to personnel, persons served, families/support systems, and other stakeholders.

12.a.(4) Investigation may include activities such as contact tracing.

12.a.(5) In some settings, antibiotic and antimicrobial stewardship might be considered in procedures for control/mitigation. Written procedures for control/mitigation may also include protocols for outbreak management, and the organization may incorporate tests of those protocols into its schedule of emergency procedures testing, allowing it to assess their effectiveness and identify areas for improvement.

Control/mitigation measures related to the physical facility may address ventilation/filtration systems, modifications to accommodate social distancing, sanitizing strategies, installation of physical barriers, accessibility of infection control devices, temperature checks, restricting doors for entry or exit only, etc.

12.b. Training for the persons served is based on individual needs and risks and could be provided during orientation, in individual or group sessions, and through the provision of printed materials. The organization considers the need for supplemental or enhanced training during an outbreak or seasonal peaks such as flu season.

Personnel training includes standard or universal precautions, proper hand washing technique, the use and disposal of personal protective equipment and supplies, the use of alternative cleansing solutions, and the use of aseptic techniques.

Posted signs, items in a newsletter, or other means could be used to educate family members, volunteers, and other visitors about precautions and preventing the spread of infections and communicable diseases.

Applicable Standards

Standard 1.H.13. 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. **13. 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 vehicle(s).**
- **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 vehicle(s) owned or operated by the organization according to manufacturers' recommendations.

l. If services are contracted, a documented review of the contract at least annually 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.

13.j. First aid supplies are checked for expiration and availability of adequate supply through a systematic process and replenished and replaced as needed.

13.l. See the Glossary for the definition of *contract*.

Examples

This standard is not applied to public transportation services that the person served may use; for example, city taxis, Uber, Lyft, Para-transport from the city, city buses, etc. The organization may have a phone available for people to arrange these types of services to facilitate their transportation needs.

If persons served pay the program seeking accreditation for the transportation service (either as a fee for service or as part of their agreement for services) this standard applies. If persons served pay a driver or transportation company directly, this standard is not applicable to the program seeking accreditation.

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

13.d.–e. The intent of these standards includes the use of age-appropriate restraining devices to be secured in the vehicles. Height, weight, cognition, etc., need to be taken into consideration.

Road hazard equipment is secured in a specific location in the vehicle. The equipment might include a flashing light, portable red/yellow reflector warning device, or road signs that can be placed outside the vehicle.

13.g. Drivers are trained in assisting passengers who have a variety of needs in order to make the vehicles accessible to them. This may include training in wheelchair management, providing seating assistance, and securing passengers once in the vehicle.

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

13.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.

A standard first aid kit is on board. A routine check of the supplies in the kit is done and recorded so that the kit always contains the necessary items.

1.H. **14. Comprehensive health and safety self-inspections:**

a. Are conducted:

(1) At least semiannually.

(2) 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. Many organizations have an ongoing review of their environment for safety. The standard is a minimum threshold.

These reviews, as well as the external review, are addressed in the organization's performance improvement activities if performance issues are identified. If something is found to be in need of correction, an action plan is developed, implemented, and then reviewed for accomplishment of the stated target. Personnel conducting self-inspections should have appropriate safety knowledge and be provided with a checklist or some other means of identifying which locations, equipment, and supplies have been inspected, along with supporting documentation of the results of the inspection.

Programs that have individual units which they equip with emergency call or monitoring systems, such as a pull cord system, pendant system, or a system in which a phone is knocked off the hook and automatically alerts a call center, may include in their self-inspections a process to ensure that such systems are in working order.

1.H. **15. 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

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

15.a.(1) 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.

Examples

A written report identifies what was inspected, issues that were discovered during the inspection, and an action plan that supports improvement. If the programs and services are part of a larger entity, inspectors may already be inspecting the facility. The organization's safety personnel should be advised of what needs to be inspected so that it can be part of all the safety inspections that the overall organization completes.

When the program is provided by a unit of a larger entity, such as a health system, parent corporation, management contract, or CCRC, the larger entity's safety engineers or other personnel are not considered external authorities. External authorities may include, but are not limited to:

- A licensed or registered safety engineer.
- A representative of an agency that provides an OSHA-type inspection.
- An engineer involved in industrial operations.
- A plant engineer familiar with the types of programs being provided.
- A safety specialist familiar with the types of programs being provided.
- An architect familiar with the types of programs being provided.
- A safety consultant who represents the organization's fire insurance carrier.
- A safety consultant who represents the organization's workers' compensation carrier.
- A safety consultant who is in private practice.
- An industrial health specialist.
- A representative of the state/provincial fire marshal's office.
- A local fire control authority.
- A technical assistance consultant in safety. In Canada, this could include a representative from a provincial or territorial body designated under legislation related to workplace safety.
- A technical assistance consultant in health.
- A risk management specialist.

Areas covered in these inspections relate to the types of programs and services that the organization provides.

15.b. The report may be a single consolidated document or it may consist of multiple documents that each clearly identify the areas inspected, recommendations for improvement, and actions to be taken. An organization may have inspections performed by several outside authorities.

1.H. **16. The organization implements written procedures concerning hazardous materials that provide for safe:**

a. Handling.

b. Storage.

c. Disposal.

Examples

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

Written procedures may include appropriate labeling of containers to promote safe handling, storage, and disposal of hazardous materials.

I. Workforce Development and Management

Description

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

1.I. **1. The organization documents the composition of its workforce, including all human resources involved in the delivery, oversight, and support of the programs/services seeking accreditation.**

Intent Statements

A written description of the composition of the workforce informs the application of subsequent standards in this section as well as related standards throughout this manual. It is not expected that the organization provide specific numbers or percentages, but rather a general description of the groups that comprise its workforce. Such groups include full-time employees, part-time employees, contractors, independent contractors, per diem workers, remote workers, volunteers, peer support specialists, students, and any other groups or categories of workers involved in the delivery, oversight, and support of the programs/services seeking accreditation.

1.I. **2. Based on the composition of its workforce, the organization demonstrates a systematic approach to workforce development and management activities and practices.**

Intent Statements

The organization demonstrates an approach to workforce development and management that minimizes risk and protects safety and quality for the persons served. Expectations of individuals or groups comprising the workforce may vary based on legal and regulatory requirements, roles and responsibilities of the individuals or groups, the scope of their involvement with persons served and the service delivery team, and other factors.

The organization complies with requirements for independent contractors, as defined by the Internal Revenue Service (**www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee**), the Canada Revenue Agency (**www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4110/employee-self-employed.html**), or similar entities in other countries.

Examples

An organization's practices and procedures related to activities such as credentials verification, onboarding, performance appraisal, and education and training may vary for members of the workforce who are employed by the organization, independent contractors, volunteers, and students. The extent and duration of involvement with the persons served and team may also result in variation (e.g., training and education expected of a provider who is a consistent member of the interdisciplinary team for persons served versus a provider who provides weekend or vacation coverage; performance appraisal of employees versus volunteers and students; onboarding requirements for employees versus consulting or contracted providers such as agency staff or a medical director/advisor).

1.I. **3. Workforce development and management practices reflect the organization's:**

a. Mission.
b. Culture.
c. Person-centered philosophy.
d. Performance measurement and management system.
e. Risk management plan.
f. Strategic plan.

Intent Statements

A strategic approach to workforce development and management contributes to organizational effectiveness. For an organization to implement its mission, strategy, and philosophies, as well as practice within its culture, it requires a workforce that is committed to these concepts. Selection and orientation of the workforce and its development and management are all critical to the overall success of the organization.

This standard relates to others in Section 1 including, but not limited to, Standard 1.A.2. on person-centered philosophy; 1.A.3.a. on establishment of the organization's mission and direction; 1.C.1.–3. on strategic planning; 1.G.1.–5. on risk management; and 1.L.1.–10. and 1.M.1.–3. on performance measurement, management, and improvement.

3.b. Culture relates to the diversity of the workforce and the culture of the organization as a whole.

Examples

Discussions of the organization's mission, culture, philosophy, and plans are embedded throughout its workforce development and management practices. As important cornerstones of the organization, these topics are reinforced throughout:

- Recruitment, selection, orientation, and ongoing training and development activities.
- Written and verbal communications.
- Efforts to seek input and feedback from persons served, the workforce, and other stakeholders for planning and improvement purposes.

- Knowledge of how each individual contributes to decreasing risks, increasing the value of the services delivered, and advancing the organization's strategic direction.

1.I. **4. Ongoing workforce planning includes:**

a. Workforce analysis.

b. Written job descriptions.

c. Review and update of written job descriptions in accordance with organizational needs and/or the requirements of external entities.

d. Recruitment.

e. Selection.

f. Retention.

g. Succession planning.

Intent Statements

Workforce planning is the strategic alignment of an organization's workforce with its goals and operational plans. Regardless of the size of the organization, the purpose of workforce planning is to ensure that the organization has the right people with the right skills at the right time.

4.a. Workforce analysis is the process of analyzing the current workforce: determining future workforce needs: identifying the gaps between the present and the future; and implementing solutions that will allow the organization to accomplish its mission, goals, and objectives.

4.b. Job descriptions outline duties, responsibilities, competencies, and requirements of a particular job. They are essential in the development of programs to recruit, select, compensate, train, and assess the performance of current and future members of the workforce.

4.c. The organization determines the frequency at which job descriptions are reviewed and updated based on the needs of the organization or other external requirements. Members of the workforce are aware of their job descriptions and may provide input into changes.

4.d. Recruitment is the activity of identifying and soliciting individuals, either from within or outside of the organization, to fill current vacancies or areas of anticipated growth. Individuals with knowledge of the position(s) being recruited for have input into recruitment plans and activities. Often considered part of recruitment, sourcing is proactive searching for qualified job candidates for current or planned open positions at an organization. Sourcing may identify and collect relevant information on candidates who are actively searching for jobs (active job seekers) and candidates who are not actively looking for job opportunities (passive job seekers).

4.e. Selection involves activities related to choosing people who have the right qualifications to fill a current or future job opening.

4.f. Retaining a qualified and engaged workforce has a direct impact on the organization's ability to achieve its mission. Retention programs play an important role in attracting and retaining key members of the workforce and in reducing turnover and its related costs.

4.g. Succession planning identifies actions to be taken by the organization should key members of the workforce be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization.

Examples

Efforts to recruit, select, retain, and promote members of the workforce may consider the diversity of the persons and communities served.

4.d. Job seekers might be located by sourcing job boards, social media sites, and alumni associations and through all types of networking; e.g., relationships with high schools, colleges, and professional associations.

4.f. Retention strategies may include a culture that values the workforce; competitive wages; career ladders; opportunities to participate in special projects; offering activities and resources that are meaningful to the workforce, such as wellness programs, child care, elder care, and continuing education/tuition support; flexible scheduling; and telecommuting.

1.I. **5. The organization implements written procedures that address:**

- **a. Verification of:**
  - **(1) Backgrounds of the workforce in the following areas, if required:**
    - **(a) Criminal checks.**
    - **(b) Immunizations.**
    - **(c) Fingerprinting.**
    - **(d) Drug testing.**
    - **(e) Vulnerable population checks.**
    - **(f) Driving records.**
  - **(2) The credentials of all applicable workforce (including licensure, certification, registration, and education):**
    - **(a) With primary sources.**
    - **(b) In all states/provinces or other jurisdictions where the workforce will deliver services.**
  - **(3) Fitness for duty, if required.**
- **b. Actions to be taken in response to the information received concerning:**
  - **(1) Background checks.**
  - **(2) Credentials verification.**
  - **(3) Fitness for duty.**
- **c. Timeframes for verification of backgrounds, credentials, and fitness for duty, including:**
  - **(1) Prior to the delivery of services to the persons served or to the organization.**
  - **(2) Throughout employment.**

Intent Statements

The organization is prepared to demonstrate how each of the areas listed is verified. CARF expects that the organization will follow all of the procedures and timeframes that the organization has established and that it will comply with all applicable legal requirements in determining its procedures.

5.a.(1) The organization is aware of and adheres to any external requirements (e.g., of funders, regulatory entities, contractual agreements, etc.) for background checks of its workforce and any requirements it may have established internally. The organization determines whether it will conduct background checks in more than one state/province or jurisdiction for all or select members of the workforce.

Related to background checks for organizations in the U.S. that receive federal funding, Standard 1.A.7.b. addresses implementation of a procedure to identify exclusion of individuals and entities from federally funded healthcare programs.

5.a.(2)(a) Primary source verification can occur when credentials are initially earned; at the time of hire; or, for existing members of the workforce, prior to an accreditation survey. Verbal, written, or electronic confirmation of credentials (including degrees) from state/provincial or other jurisdictional boards, schools or institutions, and/or trade associations or verification through a credentials verification organization is required. Copies of credentials provided directly by personnel do not meet the primary source verification requirement.

High school diplomas do not need primary source verification, but college degrees, when required for the position, would need to be verified with primary sources. When a 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.

5.a.(2)(b) If services are delivered in more than one state/province or jurisdiction, the organization is knowledgeable about reciprocity of credentials such as licensure, certification, or registration; how credentialing requirements may differ from one state/province or jurisdiction to another; and how this would impact in-person service delivery or service delivery via information and communication technologies.

5.a.(3) A fitness-for-duty exam is a medical examination used to determine whether a worker is physically or psychologically able to perform the essential functions of the job.

5.b. The organization has procedures in place in the event that backgrounds, credentials, or fitness for duty cannot be verified.

5.c. Timeframes are established by external authorities or, in their absence, by the organization.

Examples

5.a.(1)(e) Vulnerable population checks might include verifications through an elder abuse database, adult protective services, child protective services, or a sex offender registry.

5.a.(1)(f) Verification might address:

- Whether a driver's license is current.
- Whether a driver's license is the right classification for the vehicle and type of driving the person will be doing for the organization; e.g., transporting persons served, driving to deliver services in the homes of persons served or in the community or to meet stakeholders, and driving the organization's vehicle or the person's own vehicle.
- Whether there are violations on the driving record.
- Proof of insurance.

5.a.(2) Procedures may include use of a standard form or checklist to document verification of credentials and other relevant information about an individual. Documentation obtained by the organization may include:

- An original letter or copy of a letter from the appropriate credentialing, licensing, or certification board.
- 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.
- A copy of a webpage listing (for situations where verification is completed online by checking a listing of licensed/certified personnel).

5.c.(2) The organization may conduct verifications throughout employment at times such as transfer to a new position, the addition of new job responsibilities, pending expiration of a current license or certification, newly acquired credentials, or return to work after an injury or illness.

1.I. **6. Onboarding and engagement activities include:**

a. Orientation that addresses the organization's:

(1) Mission.

(2) Culture.

(3) Person-centered philosophy.

(4) Performance measurement and management system.

(5) Risk management plan.

(6) Strategic plan.

(7) Other organizational planning efforts.

(8) Workforce policies and procedures.

b. On-the-job training.

c. Position roles and responsibilities.

d. Position performance expectations.

e. Communication systems and expectations.

Intent Statements

6.a. This standard addresses organization-level orientation topics, which are typically supplemented by program/service and/or position-specific topics addressed in other sections of the standards manual.

Examples

6.a. The organization's awareness of and attention to the diversity of the people with whom it interacts—persons served, families/support systems, personnel, and other stakeholders—is reflected in attitudes, organizational structures, policies, procedures, plans, and services. Orientation addresses how the organization responds to the diversity of its stakeholders and reinforces its commitment to a culture that fosters acceptance and respect for diversity in all forms. Specific topics could include internal and external bias; cultural humility, which includes both knowledge about various cultures and self-reflection to discover how one's own biases and perceptions may affect interpersonal relationships; and intersectionality, which speaks to the overlap or combination of social factors to create disadvantages or advantages for people.

6.a.(4) Orientation to performance measurement and management might address:

- The terminology of performance measurement and management.
- Roles and responsibilities in implementing the performance measurement and management system, 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.
- How performance information is used by the organization, including to review implementation of its mission and core values, improve the quality of its programs and services, facilitate organizational decision making, review and update its strategic plan, and communicate business and service results to stakeholders.

6.a.(7) To the extent that the organization expects workforce engagement in various organization-wide planning and implementation efforts, orientation may also address topics such as accessibility; finance; technology; and succession.

6.b. On-the-job training may include mentoring for individuals who have limited or no experience in a program area by more experienced individuals. Such collaboration focuses on activities designed to facilitate learning of the required competencies. Consideration is given to the intensity of the collaboration (e.g., side-by-side collaboration, on-site collaboration, collaboration via telephone), the length of the collaboration (e.g., one week, one month, several months), and whether it is necessary to have the collaboration conducted by an individual of a specific discipline.

6.d. Position performance expectations could relate to the competencies required of the position; scheduling expectations, such as working weekends or rotating shifts; supervision of others, such as new team members, students, or volunteers; business travel; or use of technology.

6.e. Communication systems and expectations might address:

- Mechanisms used throughout an organization, such as an intranet system used to communicate policies, procedures, and job aids; personal use of organizational email; appropriate use of the organization's social media channels; and use of personal devices to access organizational information and resources.
- Mechanisms used to communicate information about the persons served. Refer to Standard 2.A.6.
- Expectations for maintaining confidentiality and privacy.
- Expectations for maintaining current personal and emergency contact information.

1.I. **7. The organization promotes engagement through respect for all individuals in the workforce, including:**

- **a. Open communication.**
- **b. A value-driven focus.**
- **c. Initiatives that address:**
  - **(1) Recognition.**
  - **(2) Compensation.**
  - **(3) Benefits.**
  - **(4) Well-being.**
- **d. Policies and written procedures that:**
  - **(1) Address, at a minimum:**
    - **(a) Mechanism(s) to provide favorable and constructive feedback.**
    - **(b) Mechanism(s) to address concerns.**
    - **(c) Job postings.**
    - **(d) Promotion.**
    - **(e) Disciplinary action.**
    - **(f) Separation.**
    - **(g) Labor relations, if applicable.**
    - **(h) Prevention of harassment.**
  - **(2) Are accessible to the workforce.**

Intent Statements

Workforce engagement refers to the level of an individual's commitment and connection to an organization. High levels of engagement promote workforce retention, foster loyalty, and improve organizational performance and value.

7.a. Open communication is characterized by a mutual exchange of information and ideas, transparency, and access to people and information.

7.b. Refer to the Glossary for a definition of *value*.

7.d. This standard does not require that each individual be given a copy of the policies and written procedures, but it does require that each individual has access to the policies and written procedures and that there is notification of when there are changes to policies and procedures that the workforce should be aware of. Evidence that the policies and written procedures are provided or available does not have to be in writing.

Review of the workforce policies is part of the review of the organization's policies addressed in Standard 1.A.3.k.

7.d.(1)(b) The intent of this standard is that all individuals in the workforce have access to an identified mechanism through which they may express concerns.

7.d.(1)(c)–(d) When a job is available, individuals in the workforce know where it will be posted and are clear on whether there is a possibility of promotion from within the organization.

Examples

7.a. Open communication in an organization may be demonstrated through regular meetings at which important topics and updates are shared, newsletters, suggestion boxes, management rounds, open-door policies, and opportunities to provide input into the plans and activities of the organization.

7.c.(1) Examples of recognition initiatives include employee of the month or year awards, opportunities to earn additional time off or entry into a gift drawing as incentives to complete certain activities, participation in special projects, career ladders, goal-sharing programs, and personal recognitions on anniversaries or for a job well done.

7.c.(3) An organization might also consider benefits that address the unique and diverse characteristics of its workforce, such as floating holidays that personnel may use as they choose.

7.c.(4) Initiatives that address the well-being of the workforce may vary based on the scope of programs/services or the size of the organization. Examples could include hosting employee educational programs that focus on health/wellness topics or personal financial management, accessing resources through professional associations, inclusion of well-being-related information in an employee newsletter, or providing access to an Employee Assistance Program (EAP).

The organization may maintain a directory of resources in the community that support the non-work needs of workers such as child care, transportation, financial assistance with bills or consolidating debt, food stamps or similar assistance, and free or low-cost legal assistance.

7.d.(1) Policies and written procedures might address:

- Mechanisms to provide feedback, such as a suggestion box, forums with leadership, an open-door policy of leadership, or an annual workforce satisfaction survey.
- Workforce grievance procedures; how to deal with allegations of violations of ethical codes (related to Standard 1.A.6.b.); and how to deal with allegations of waste, fraud, abuse, and other wrongdoing (related to Standard 1.A.7.d.).
- Conflict resolution, mediation, and collective bargaining agreements.

7.d.(1)(h) Harassment in the workplace might include unwelcome physical or verbal behavior such as offensive jokes, belittling comments, slurs, epithets, name calling, physical threats or assaults, ridicule or mockery, insults, offensive objects or pictures, or other interference with work performance that creates an intimidating or hostile work environment. Harassment can also include sexual harassment such as unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature.

7.d.(2) When there are new policies and written procedures, or changes to existing policies and procedures, the workforce might be notified via departmental, team, or one-on-one meetings; posting notices in a common area of the building; email; the organization's intranet system; or dissemination of a form requesting verification by individuals that they have completed a regular review of specified documents.

1.I. **8. Workforce development activities include:**

- **a. Documentation of competencies:**
  - **(1) To support the organization in the accomplishment of its mission and goals.**
  - **(2) To meet the needs of the persons served.**
- **b. Documented assessment of competencies.**
- **c. Documentation of timeframes/frequencies related to the competency assessment process.**
- **d. Competency development, including the provision of resources.**
- **e. Performance appraisal.**
- **f. Education and training.**

Intent Statements

Refer to the Glossary for a definition of *competency*.

Examples

8.a. This may include competencies specific to a position, such as service delivery or clinical competencies, and competencies related to customer service, person-centered approaches to service delivery, communication with stakeholders, etc.

8.d. Competency development may occur through opportunities on the job and externally. Resources to develop competencies might include journal subscriptions, online access to learning opportunities and reference materials or journals, access to evidence-based practice databases and reviews, guest speakers, sponsoring educational events at the organization, in-service programs, journal clubs, collaborative resource or education efforts with other area providers of services, and financial support and/or time off to participate in special interest groups or to attend courses or conferences.

1.I. **9. The organization implements written procedures for performance appraisal that address:**

- **a. The identified workforce.**
- **b. The criteria against which people are being appraised.**
- **c. Involvement of the person being appraised.**
- **d. Documentation requirements.**
- **e. Timeframes/frequencies related to the performance appraisal process.**
- **f. Measurable goals.**
- **g. Sources of input.**
- **h. Opportunities for development.**

Intent Statements

Organizations vary in their preferences and approaches to performance appraisal. For some, a traditional approach suits their needs, while others are evolving to a more fluid process that may look different for different members of the same workforce. To meet this standard the organization demonstrates implementation of a performance appraisal process that includes all of the elements of the standard as they apply to the groups that comprise its workforce (as documented in Standard 1. in this section). This allows the organization flexibility to determine what meets its needs relative to appraisal of employees, contractors, students, volunteers, etc.

If the organization's workforce includes contract workers, refer to Standard 1.G.5. on documented reviews of contract services.

Examples

9.b. Criteria might be included in a performance appraisal tool, job description, behavior attributes, expectations established through goal setting, or employee handbook.

9.d. This refers to documentation requirements of the performance appraisal process, such as whether a certain form is to be used, what elements are to be addressed, where documentation of performance appraisals is maintained, and at what intervals documentation is required.

9.f. A measurable goal describes an expected outcome, result, or output, which could be qualitative or quantitative, and has a timeline associated with reaching it. In addition, effective goals may be characterized as participative; reasonable; specific; challenging but attainable; flexible; easily monitored for progress; and in alignment with an organization's mission, strategy, and goals. They may be individual, team-based, or project-based.

One approach to establishing goals is SMART goals—goals that are specific (simple, sensible, significant), measurable (meaningful, motivating), achievable (agreed, attainable), relevant (reasonable, realistic, and resourced, results based), and time bound (time based, time limited, time/cost limited, timely, time sensitive). For more information, visit **www.mindtools.com/pages/article/smart-goals.htm**.

9.g. Sources of input to the performance appraisal might include the person being appraised, supervisors, peers, persons served, families/support systems, external stakeholders, etc.

9.h. Opportunities for development may include supervisory/management training; clinical training to develop expertise in a particular practice, technique, or piece of equipment; training to move into another area of a continuum of services; and precepting students or responsibility for a student internship program.

1.I. **10. There is an adequate workforce to:**

- **a. Implement the plans of the persons served.**
- **b. Ensure the safety of persons served.**
- **c. Manage unplanned absences.**
- **d. Meet the performance expectations of the organization.**

Intent Statements

This standard relates to the organization's performance measurement and management; i.e., the collection, analysis, and use of data in areas such as finance, risk management, human resources, health and safety, service delivery, etc. Whether or not performance targets are met in these areas may reflect the adequacy of the workforce to meet the needs of the organization and the persons served.

No ratios are established by CARF for the number of persons served to the number of personnel. During a survey, the organization is able to articulate its strategy to determine what workforce is necessary to meet ongoing needs and to minimize the impact of absences and vacancies in its workforce.

Examples

10.a. Indications that the workforce is not adequate to implement the plans of the persons served may include wait lists or delays for specific services the program indicates in its scope that it can provide, turning potential persons served away, lacking specific types of providers to fulfill individual plans, inconsistent assignment of individuals in the workforce, and persons served not accomplishing their goals or the expected outcomes established by the team.

1.I. **11. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant:**

- **a. Regulatory requirements.**
- **b. Licensure requirements.**
- **c. Registration requirements.**
- **d. Certification requirements.**
- **e. Professional degrees.**
- **f. Training to maintain established competency levels.**
- **g. On-the-job training requirements.**

Intent Statements

The organization is knowledgeable about and ensures that services are provided in accordance with external and internal requirements and education relevant to its workforce.

Examples

11.a. Regulatory requirements may specify a certain credential for a position or a number of hours of service delivery or in-service training.

1.I. **12. The organization's succession planning addresses, at a minimum:**

- **a. Its future workforce needs.**
- **b. Identification of key positions.**
- **c. Identification of the competencies required by key positions.**
- **d. Review of talent in the current workforce.**
- **e. Identification of workforce readiness.**
- **f. Gap analysis.**
- **g. Strategic development.**

Intent Statements

This standard relates to Standards 1.A.3.m. and 1.B.5. on succession planning.

An organization relies on its workforce to carry out its mission, provide programs and services, and meet organizational goals. Important to any size organization, succession planning helps an organization prepare to support program and service continuity when key individuals leave, either planned or unexpectedly.

12.b. Key positions include those requiring specialized skills or levels of experience and those that may be difficult to replace.

12.d. A review of talent involves assessment of the current workforce with the goal of identifying those who have the skills and knowledge or the potential along with the desire to be promoted to existing and new positions.

12.e. Identification of workforce readiness considers the skills and knowledge already present in members of the workforce who have been identified for promotion to existing or new positions and the skills and knowledge that may need development.

12.f. Once an organization has identified positions that may be vacated due to retirements, are difficult for which to recruit, or require extended training, etc., it assesses the current workforce to determine whether there are candidates with the skills, knowledge, and potential to fill those positions or whether it needs to recruit and/or train candidates for those positions. Gap analysis identifies disparities between what is needed in the workforce and what is available.

Examples

Succession planning considers planned and unplanned departures from key positions in the organization.

An organization determines whether it will fill a position on an interim basis until it can be filled on a permanent basis.

In its succession planning an organization may identify whether internal candidates or external candidates are more suitable to fill specific roles.

Succession planning that includes identification of internal candidates and the provision of development opportunities considers the candidates' expectations regarding guaranteed advancement into the positions for which they are being prepared.

1.I. **13. The organization provides documented training to personnel:**

- **a. On cybersecurity.**
- **b. On the technology used in performance of their job duties.**
- **c. Including:**
  - **(1) Initial training.**
  - **(2) Ongoing training.**

Examples

13.a. This training will help ensure that personnel are familiar with the organization's information security procedures, understand what information is sensitive and vulnerable, and are trained on steps to take to protect data assets.

13.b. A colleague does a side-by-side monitoring of how a staff person records attendance data in the billing database to provide tips on how it may be done with a higher level of accuracy.

The education coordinator observes personnel recording blood pressure on a digital monitor and provides feedback to them.

The program may implement a process for ordering supplies or food through an automated system. Existing personnel participate in training at the time of implementation. This training is then incorporated in the new hire orientation for all new dining service employees.

J. 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.J. **1. 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.**
  - **(6) Discrimination.**
- **d. Access to:**
  - **(1) Information pertinent to the person served in sufficient time to facilitate the person's decision making.**
  - **(2) Their own records.**
- **e. Informed consent or refusal or expression of choice and withdrawal of consent 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

When consent is required, there is also discussion of informed refusal. A person served may refuse to sign a consent form, but with that refusal, the organization is committed to explaining the risks and adverse consequences of the refusal.

During the survey, the survey team will interview persons, observe activities, and look at some records for the issues surrounding rights.

1.J. **2. 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) At least 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

Copies of resident rights should be provided to persons served at all levels of the program; this includes the independent living area of a continuing care retirement community. Organizations might consider resident handbooks, meetings, in-house television, flyers, or providing information to residents at an annual flu shot clinic as mechanisms to accomplish this.

This could include large print, translations into different languages, audio and video recordings, an orientation handbook, and one-on-one verbal communication.

1.J. **3. The organization:**

- **a. Implements a policy and written procedure by which persons served may formally complain to the organization that specify:**
  - **(1) Its definition of a formal complaint.**
  - **(2) That the action will not result in retaliation or barriers to services.**
  - **(3) How efforts will be made to resolve the complaint.**
  - **(4) Levels of review, which include availability of external review.**
  - **(5) Timeframes that:**
    - **(a) Are adequate for prompt consideration.**
    - **(b) Result in timely decisions for the person served.**
  - **(6) Procedures for written notification to persons served regarding the actions to be taken to address the complaint.**
  - **(7) The rights of each party.**
  - **(8) The responsibilities of each party.**
  - **(9) 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, as defined by the organization.

Examples

3.b.(1) Complaint procedures and forms (if used) could be provided to the persons served in information or orientation packets, posted on an organization's website, or made available at a central office or upon request to personnel.

1.J. **4. An analysis of all formal complaints:**

- **a. Is conducted at least annually.**
- **b. Is documented, including:**
  - **(1) Whether formal complaints were received.**
  - **(2) Trends.**
  - **(3) Areas needing performance improvement.**
  - **(4) Actions to address the improvements needed.**
  - **(5) Implementation of the actions.**
  - **(6) Whether the actions taken accomplished the intended results.**

Intent Statements

An analysis of formal complaints can give the organization valuable information to facilitate change that results in better customer service and results for the persons served.

Examples

As complaints may, in some organizations, be part of risk management, this information may be documented in a variety of reports and used for a variety of different purposes. Trends or analysis reports may be shared with boards, leadership, personnel, etc.

K. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

1.K. **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 to consider barriers in each of 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 demonstrates a commitment to accessibility and the removal of barriers. Organizations address barriers to accessibility in order to:

- Foster a person-centered approach to service delivery, facilitate inclusion, and 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 barriers include the following:

- Architecture: width of doors, steps without ramps, narrow doorways, multilevel buildings without elevators, historic buildings, or carpet that aggravates allergies. High ceilings with poor acoustics may also be a barrier for those with hearing loss.
- Environment: poor signage; low lighting; a noisy environment; or lack of understanding regarding how to use emergency response systems, such as pull cords, pendants, and other similar systems.
- Attitude: assumptions based on age, ethnic background, or socioeconomic status.
- Finances: limited payment for needed services, lack of additional resources in a community to offset additional needs, financial fees.
- Employment: personnel are from other countries and their spoken language differs from the primary language used by the organization, shortages in critical areas (e.g., nursing, RNs, CNAs, PSWs), or the location of the organization makes it difficult for employees who use public transportation.
- Communication: lack of translation of materials into formats that are appropriate for stakeholders to understand, insufficient training for personnel on diversity issues, lack of assistive technology to augment communication, lack of hearing amplification equipment and assistive listening systems (e.g., a hearing loop) in community settings that the persons served use (e.g., theaters, activity rooms, worship spaces, etc.).

  In addition to barriers resulting from design and attitudinal and competency barriers, many people experience barriers of inaccessible diagnostic, therapeutic, procedural,

rehabilitation, and exercise equipment, such as examination and treatment tables and chairs, weight scales, x-ray equipment, glucometers, blood pressure cuffs, and treadmills and other exercise equipment.

- Transportation: limited accessible public transportation, increasing number of persons served with no transportation available to them, limited vehicles that deal with various physical impairments (height, weight, mobility), price of gasoline.
- Community integration: lack of opportunities to engage with community organizations such as those pertaining to religious, educational, social, and volunteer issues.

1.b.(9) Barriers to community integration may 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, or accommodations may be needed for the persons served to return to previous volunteer activities with the community food bank. Another barrier to community integration might be involvement of the persons served in the criminal justice system, which could impact employment, housing, etc.

1.K. **2. The organization implements an accessibility plan that:**

a. Reflects the diversity of:

(1) Persons served.

(2) Personnel.

(3) Other stakeholders.

b. Includes, for identified barriers:

(1) Actions to be taken.

(2) Timelines.

c. Is reviewed at least annually for relevance, including:

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

(2) Areas needing improvement.

d. 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.

2.a. Through an understanding of the diversity of its stakeholders, the organization may reduce barriers to accessibility and enhance outcomes for the persons served.

2.b. "Identified barriers" refers to the barriers identified in Standard 1.K.1.

Examples

Examples of conformance may be found in minutes of meetings where analysis, action planning, and goals are established; conversations with stakeholders; focus groups and council meetings; community events; surveys; etc.

At a minimum, the planning addresses:

- The barriers that limit access to programs and services.
- A detailed outline of the methods to be used in removing barriers and making programs accessible.
- A schedule for taking necessary steps to decrease or remove the identified barriers. If the time period for achieving conformance is to be longer than one year, the plan should identify the interim steps to be taken to achieve program access.

Barrier removal that is not readily achievable at first might be achievable later when the organization has more resources available. An organization must continually monitor its accessibility, as well as its financial and other resources, and remove barriers as new measures become readily achievable. The organization's plan may have options for the use of and referral to other services that may be more accessible.

In order to develop an accessibility plan, an organization first identifies barriers. When identifying potential barriers to services, the organization looks at barriers within the organization itself and in the community. In the U.S., an ADA checklist may be helpful in conducting this evaluation. For organizations in Canada,

accessibility issues are addressed by federal and provincial acts on accessibility, human rights, and employment.

2.a. Diversity may be considered in terms of culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status, language, race, and other factors that are relevant to persons served, personnel, and other stakeholders and that affect the work of the organization.

For example, an organization that serves a culturally diverse population may not only address communication barriers, e.g., through the use of translators and provision of information and materials in different languages, but also consider how those cultures view health and disability to understand and address potential attitudinal barriers to accessing services. Similarly, an organization's understanding of the socioeconomic diversity of the community it serves may lead it to explore resources for transportation, childcare, or supplemental assistance programs that would support persons served in attending the programs/services to which they are referred.

An organization that serves diverse groups such as veterans or active duty military, persons who are involved in the criminal justice system, or persons who are part of the deaf community may incorporate information on these groups into personnel training on cultural competency and diversity.

1.K. **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.

Please see the Glossary for a definition of *reasonable accommodations*.

Examples

According to certain regulatory requirements, organizations may need to have procedures and a point of contact in place regarding requests for reasonable accommodations. Information regarding how to request reasonable accommodations may be in employee handbooks, or they may be identified in public information postings related to employee rights throughout the organization.

A request for a reasonable accommodation does not automatically require that the organization meet the request. There should be an investigation 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 to use other resources that are accessible.

Review Results

L. Performance Measurement and Management

Description

CARF-accredited organizations demonstrate a culture of accountability by developing and implementing performance measurement and management plans that produce information an organization can act on to improve results for the persons served, other stakeholders, and the organization itself.

The foundation for successful performance measurement and management includes:

- Leadership accountability and support.
- Mission-driven measurement.
- A focus on results achieved for the persons served.
- Meaningful engagement of stakeholders.
- An understanding of extenuating and influencing factors that may impact performance.
- A workforce that is knowledgeable about and engaged in performance measurement and management.
- An investment in resources to implement performance measurement and management.
- Measurement and management of business functions to sustain and enhance the organization.

NOTE: *Please refer to the Glossary for definitions of the following terms used throughout this section: person served, family/support system, stakeholders, performance indicator, performance target, effectiveness, efficiency, service access, validity, reliability, and value.*

1.L. **1. The leadership demonstrates accountability for performance measurement and management in:**

a. Service delivery.

b. Business functions.

Intent Statements

To survive and thrive in today's environment, health and human services providers must produce value. Through service delivery and business practices that are ethical, state of the art, and durable, organizations strive to meet the needs of their stakeholders, sustain their programs/services, and support growth. Leadership accountability is demonstrated through engagement in and support of the organization's performance measurement and management activities and effective utilization of the information produced to improve the quality of programs/services; make decisions; uphold the organization's mission; and objectively demonstrate value to persons served and their families/support systems, other stakeholders, and the organization itself.

Examples

The leadership may review established objectives, performance indicators, and measures to confirm that the information being gathered can be used to answer questions from a variety of stakeholders, guide the organization, and identify areas for improvement.

There may be leadership representation on quality committees, performance improvement teams, and in meetings with stakeholders to gather input and suggestions about the organization's performance management activities and plans.

The leadership may hold forums to seek input and insight into topics that could be incorporated into and addressed in the performance measurement and management plan.

There may be an ongoing, open exchange with internal stakeholders via an intranet to ensure that items measured are addressing areas that are critical to the organization and meeting stakeholder needs.

There may be a variety of mechanisms used to exchange information with stakeholders, such as town hall meetings; on-line surveys; members of the leadership team meeting with small groups of persons served, personnel, or other stakeholders; etc.

The leadership supports and may participate with personnel in training on assessment tools being used and methods to ensure data integrity.

The governance board may establish a quality committee that reviews performance reports on a regular basis.

1.L. **2. The organization identifies gaps and opportunities in preparation for the development or review of a performance measurement and management plan, including consideration of:**

- **a. Input from:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **b. The characteristics of the persons served.**
- **c. Expected results.**
- **d. Extenuating and influencing factors that may impact results.**
- **e. The comparative data available.**
- **f. Communication of performance information.**
- **g. Technology to support implementation of the performance measurement and management plan.**

Intent Statements

An analysis of gaps and opportunities provides an organization with essential information in preparation for developing a performance measurement and management plan for the first time or reviewing it for continued relevance and/or necessary changes. Input from persons served, personnel, and other stakeholders about what they want to know about the organization and its programs/services guides the selection of objectives, performance indicators, and measures and positions the organization to later share performance information that meets stakeholder needs. A meaningful performance measurement and management plan elevates an organization's accountability for and knowledge and understanding of the results of its service delivery and business practices.

Through the analysis of gaps and opportunities it may be determined that changes are indicated not only in the performance measurement and management plan but also in areas such as strategic planning, person-centered practices, advocacy for persons served, corporate responsibilities, etc.

Examples

2.b. Characteristics include a wide variety of data that reflect relevant information about the persons served, such as age, gender, ethnicity, race, education levels, living arrangements, primary language, impairment, and activity limitation. In the context of performance management this information can be used to analyze performance relative to specific groups of persons served who share similar characteristics.

Similarly, there are characteristics or conditions in the environment that may be shared by a group of persons or a population served. These are referred to as social determinants of health (SDOH)—conditions in the environments in which people are born, live, learn, work, play, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH such as income and social status, employment and working conditions, education and literacy, physical environments, social supports and coping skills, health behaviors, and access to health services may also impact the results that can be achieved for the persons served by a program. For example, in an area where the unemployment rate is high, job placement for persons served may be more challenging or return-to-work rates may be lower; in an area where there is limited public transportation, persons served may have difficulty attending the program or following through with transition/discharge recommendations; in an area where there is limited affordable housing, the discharge

or placement options for persons served may be limited. All of these SDOH may impact the results the program can achieve for the persons served and may also be considered in establishing the program's performance targets.

2.d. Examples of extenuating or influencing factors that could impact performance include a change in leadership, relocation of an organization or program, reductions in budget, personnel shortages, new regulations, changes in the geographic area where services are offered such as a housing shortage, financial challenges in the community such as high unemployment, poor public transportation, a natural disaster such as a hurricane or earthquake, and individuals entering the programs/services with more co-morbidities or co-occurring conditions.

1.L. **3. The organization implements a performance measurement and management plan that:**

- **a. Addresses:**
  - **(1) Collection of relevant data on the characteristics of the persons served.**
  - **(2) For each program/service seeking accreditation, identification of measures for service delivery objectives, including, at a minimum:**
    - **(a) Results achieved for the persons served (effectiveness).**
    - **(b) Experience of services received and other feedback from the persons served.**
    - **(c) Experience of services and other feedback from other stakeholders.**
    - **(d) Resources used to achieve results for the persons served (efficiency).**
    - **(e) Service access.**
  - **(3) The collection of 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.**
  - **(4) Identification of priority measures determined by the organization for business function objectives.**
  - **(5) The extent to which the data collected measure what they are intended to measure (validity).**
  - **(6) The process for obtaining data:**
    - **(a) In a consistent manner (reliability).**
    - **(b) That will be complete.**
    - **(c) That will be accurate.**
  - **(7) Extenuating and influencing factors that may impact results.**
  - **(8) Timeframes for the:**
    - **(a) Analysis of data.**
    - **(b) Communication of results.**
  - **(9) How:**
    - **(a) Data are collected.**
    - **(b) Data are analyzed.**
    - **(c) Performance improvement plans are developed.**
    - **(d) Performance improvement plans are implemented.**
    - **(e) Performance information is communicated.**
- **b. Is reviewed at least annually for relevance.**
- **c. Is updated as needed.**

Intent Statements

3.a.(1) Characteristics include a wide variety of data that reflect relevant information about the persons served. As data are collected and aggregated at the level of each program/service seeking accreditation, the identification and analysis of any significant performance differences of the program/service in serving relevant groups ties into later being able to target specific program improvements.

3.a.(4) Measurement of business functions is addressed in related standards throughout Section 1, including, but not limited to, 1.F.3. and 1.F.4. on the analysis of financial performance,

1.H.7. on the testing of emergency procedures, 1.H.11. on the analysis of critical incidents, and 1.J.4. on the analysis of formal complaints. The organization might identify these and/or other priority areas for business function measurement.

3.a.(5)–(6) It is not required that the organization subscribe to a proprietary data vendor in order to achieve data integrity.

Examples

3.a.(3)(d) Data may be collected at point(s) in time following services through use of a survey that is mailed or emailed to persons served, phone calls to persons served, or in-person at a follow-up visit to the program/service or to another provider to which the person was referred at transition/discharge.

When the reason for transition/discharge from the program/service is that the person served has died, or this is discovered after the person has left the program/service, follow-up efforts may focus on the family/support system; e.g., whether they were satisfied with the services the person served received, whether they received the support they desired from the program, resources the program can offer to support the family/support system in their grieving process, etc.

3.a.(4) An organization may identify priority business areas based on input from stakeholders or circumstances such as implementation of new program/service, opening of a new location, turnover in key leadership or management positions, or recent history of a natural disaster.

3.a.(5) The organization chooses indicators, measures, and data elements that measure what it intends to measure.

The analysis of gaps and opportunities addressed in Standard 1.L.2. may identify changes in measures for service delivery objectives that may need to occur because of changes in the environment, legislative or regulatory changes, societal or financial changes, or development or revision of programs/services.

3.a.(5)–(6) There are a variety of ways an organization can demonstrate that it addresses the integrity of the data it uses for performance measurement, management, and improvement and management decision making. These approaches can range from simple to sophisticated.

3.a.(6)(a) 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, and measures or codes are explained and periodically reviewed.
- Inter-rater reliability assessments can be conducted in which different personnel record measures for the same persons served and data are compared statistically to assess whether different personnel arrive at the same ratings for a given individual.
- A potential training opportunity might be for a multi-site organization to have personnel from one location conduct screenings/assessments at other locations to help to increase the reliability of the screening/assessment process.

3.a.(6)(b) 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 managers 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 organization-wide 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.
- Personnel training for data-recording activities includes attention to the importance of recording each data field for every person served.

- Complete information on the characteristics of the persons served, for example, is critical to being able to analyze performance related to specific groups or populations served by a program.
- The data manager routinely cross checks the number of records of persons served 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.

3.a.(6)(c) 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 entered into the database.
- The data manager routinely reviews the distribution of values in test data runs and asks the direct care personnel 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.L. **4. To measure its results achieved for the persons served (effectiveness), each program/service seeking accreditation documents:**

a. An objective(s).

b. A performance indicator(s), including:

(1) To whom the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

In accordance with the performance measurement and management plan, each program/service seeking accreditation measures results achieved for the persons served (effectiveness).

4.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

4.b.(4) Measuring change over time is inherent in the measurement of results achieved for the persons served. Data collected at the beginning of services, at specific intervals during services, at the end of services, and/or at a point(s) in time

following services allow the program/service to measure change over time. Examples of effectiveness measures include:

- Increased or continued independence in instrumental activities of daily living (IADL) and activities of daily living (ADL).
- Increase in community/social engagement.
- Decrease in social isolation.
- Reduction in caregiver burden.
- Reduction in falls.
- Sense of safety and security.
- Reduction in emergency room visits or rehospitalizations.
- Wound/skin care.
- Management of chronic diseases.
- Health promotion and wellness.
- Quality of life.
- Positive health behaviors.
- Decrease in depression.
- Reduction in use of restraints, both physical and chemical.
- Use of psychotropic medications.
- Medication management.
- Engagement in activity programming.
- If services were provided through the use of information and communications technology (ICT), participation in virtual support groups.

1.L. **5. To measure experience of services received and other feedback from the persons served, each program/service seeking accreditation documents:**

a. An objective(s).

b. A performance indicator(s), including:

(1) To whom the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

In accordance with the performance measurement and management plan, each program/service seeking accreditation measures the experience of services received and other feedback from the persons served.

5.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

The perception of the persons served regarding their experience with the program/service provides valuable feedback on how well the program/service is meeting or met their expectations in areas such as service responsiveness, respect, informed choice, participation, and overall value. For example:

- Was the person served treated with dignity and respect?
- Did the program focus on the needs of the person served and the family?
- Were grievances or concerns addressed?
- Overall feelings of satisfaction.
- Use of informed choices about modes of treatment, medications, etc.
- Use of informed choices about services/supports.
- Satisfaction with physical facilities, fees, access, and results achieved.
- I would move into this community if I were to do it again.
- I am satisfied with the quality of food that is available.
- The transportation provided/arranged is convenient.
- The program demonstrated respect for and understanding of my culture.
- If services were provided through the use of information and communications technology (ICT):
  - Satisfaction with connectivity/quality of platform.
  - Convenience of days and times that services/appointments were available.
  - The services I received through the use of ICT met my needs.

The tools used to measure the experience of services received and other feedback are appropriate for the population served in terms of age, developmental level, language, and culture.

1.L. **6. To measure experience of services and other feedback from other stakeholders, each program/service seeking accreditation documents:**

a. An objective(s).

b. A performance indicator(s), including:

(1) To whom the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

In accordance with the performance measurement and management plan, each program/service seeking accreditation measures the experience of services and other feedback from other stakeholders.

6.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance

target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

The perception of stakeholders regarding their experience with the program/service provides valuable feedback on how well the program/service is meeting or met their expectations. For example:

- The information I received from the program met my needs.
- The information I received from the program was useful in my decision making.
- I received information from the program in a timeframe that met my needs.
- I am satisfied with the opportunities available to interact with the team serving my family member.
- I am satisfied with the services/care my family member received from the program.
- I would recommend this program to others.
- I would refer again to this program.
- I am satisfied with the timeframe for admission to services for persons referred.
- I am satisfied with the communication mechanisms to coordinate care for persons served.
- If services were provided through the use of information and communications technology (ICT):
  - I am satisfied with the options offered by the organization for service delivery through the use of ICT.
  - The services delivered by the organization through the use of ICT will positively impact the lives of the persons served.

1.L. **7. To measure the resources used to achieve results for the persons served (efficiency), each program/service seeking accreditation documents:**

a. An objective(s).

b. A performance indicator(s), including:

(1) To whom or what the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

In accordance with the performance measurement and management plan, each program/service seeking accreditation measures the resources used to achieve results for the persons served (efficiency).

7.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance

target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

7.b. Efficiency measures address the relationship between resources used and results achieved. Resources may include time, money, personnel, etc. For example:

- Service delivery cost per service unit.
- Staffing ratios and consistency in staff.
- Utilization of staffing agency for coverage.
- Time to fulfill maintenance requests.
- Direct service hours of clinical staff or other personnel.
- If services were provided through the use of information and communications technology (ICT):
  - Number or percentage of sessions that started on time, were completed as scheduled, were delayed/cancelled/rescheduled due to technical issues.
  - Retention in services was the same or better than in-person services.
  - The cost of service delivery compared to in-person services.
  - The cost of service delivery versus reimbursement compared to in-person services.

1.L. **8. To measure service access, each program/service seeking accreditation documents:**

a. An objective(s).

b. A performance indicator(s), including:

(1) To whom or what the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or is based on an industry benchmark.

Intent Statements

In accordance with the performance measurement and management plan, each program/service seeking accreditation measures service access.

8.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

8.b. Service access addresses the organization's capacity to provide services to those who desire or are in need of receiving services. For example:

- Convenience of service hours and locations.
- Waiting time for routine or emergency care.
- Time taken to set a first or subsequent appointment.
- Waiting list information on persons found ineligible for services.
- Telephone response time.
- The success of formal referral mechanisms.
- Impact of funding or resources available.
- Response times to resident calls for assistance.
- Time to fill a vacant apartment/unit.
- Access to transportation.
- Information and materials available to persons served in their preferred language and through their preferred mode.
- If services were provided through the use of information and communications technology (ICT):
  - Increased engagement of families/support systems in services/decision making/education.
  - Increased availability/convenience of appointments for the persons served.
  - Service delivery via the use of ICT resulted in additional convenience to the persons served, e.g., fewer missed appointments, missed episodes of service provision, less time away from work/school.

1.L. **9. To measure its business function, the organization documents:**

a. Objectives in priority areas determined by the organization.

b. For each objective, a performance indicator(s), including:

(1) To what the indicator(s) will be applied.

(2) The person(s)/position(s) responsible for collecting the data.

(3) The source(s) from which data will be collected.

(4) Identification of relevant timeframes for collection of data.

(5) A performance target that is based on the organization's performance history or established by the organization or a stakeholder or that is based on an industry benchmark.

Intent Statements

Measurement of business functions is addressed in related standards throughout Section 1, including but not limited to, 1.F.4. on the analysis of financial performance, 1.H.7. on the testing of emergency procedures, 1.H.11. on the analysis of critical incidents, and 1.J.4. on the analysis of formal complaints. The organization might identify these and/or other priority areas for business function measurement.

9.b.(5) The establishment of a performance target of a level to be achieved is critical. Some organizations develop their own targets by reviewing their historical performance in an identified indicator while other organizations may use standardized tools that already have an established benchmark. A review of the literature and published practices is helpful in this process. The development of a performance target ensures that there will be action for improvement if the target is not met.

When an organization first implements a performance indicator, it may not have a performance history upon which to base a performance target. It may also lack an industry benchmark or a performance target established by a stakeholder. In this case, the organization establishes its own performance target and measures over time to

establish its history. Typically, the performance target established is maintained for a period of time in order to establish a foundation rather than changing it each cycle of analysis.

Through its performance measurement and management activities, an organization gains an accurate and complete picture of its performance in critical areas. If it is meeting all of its performance targets over a period of time the organization will want to consider whether the targets should be adjusted as well as whether there are other indicators that would be meaningful to measure.

Examples

In the area of financial planning and management, the organization might identify indicators related to expenses, revenues, or other budgetary information; financial reliance on related entities; its review of billing against records of the persons served; collections on bills for services rendered; or denial rates for billed services.

In the area of accessibility status reports, the organization might identify an indicator related to implementation of its accessibility plan and progress made in the removal of barriers.

In the area of risk management, an indicator might be identified related to the organization's actions to reduce risks, success of a fall prevention program, remediation plans addressing financial stability, complaints received, or medication errors.

Human resource indicators might be identified for recruitment, retention, or personnel turnover or the provision of training to personnel.

Health and safety indicators might relate to the analysis of unannounced tests of emergency procedures, critical incidents, infection control, or timeliness of response to maintenance requests for repairs found during external or internal inspections.

If services were provided through the use of information and communications technology (ICT), indicators might address additional hours of technical support needed, expenses related to the purchase or upgrade of software and/or hardware, or changes in staffing to support service delivery related to the revenue generated.

1.L. **10. Personnel are provided with documented education and training in accordance with their roles and responsibilities for performance measurement and management.**

Examples

Personnel may have a variety of roles and responsibilities in implementing the organization's performance measurement and management plan, including:

- Completing assessment tools from which data are gathered.
- Collecting data.
- Analyzing data.
- Participating on performance improvement teams or committees.
- Identifying or revising objectives, performance indicators, and performance targets.
- Establishing methods to communicate performance information to persons served, personnel, and other stakeholders.
- Training and/or mentoring peers on the importance of using performance information.
- Working in a quality department that has overall responsibility for performance management and quality.

M. Performance Improvement

Description

CARF-accredited organizations demonstrate a culture of performance improvement through their commitment to proactive and ongoing review, analysis, reflection on their results in both service delivery and business functions, and transparency. The results of performance analysis are used to identify and implement data-driven actions to improve the quality of programs and services and to inform decision making. Performance information that is accurate and understandable to the target audience is shared with persons served, personnel, and other stakeholders in accordance with their interests and needs.

1.M. **1. The analysis of service delivery performance:**

- **a. Is documented.**
- **b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan.**
- **c. Addresses service delivery indicators for each program/service seeking accreditation, including, at a minimum:**
  - **(1) Results achieved for the persons served (effectiveness).**
  - **(2) Experience of services received and other feedback from the persons served.**
  - **(3) Experience of services and other feedback from other stakeholders.**
  - **(4) Resources used to achieve results for the persons served (efficiency).**
  - **(5) Service access.**
- **d. If applicable, addresses service delivery indicators at the level of each specialty program, specialty designation, or special population for which the organization is seeking accreditation, including at a minimum:**
  - **(1) Results achieved for the persons served (effectiveness).**
  - **(2) Experience of services received and other feedback from the persons served.**
  - **(3) Experience of services and other feedback from other stakeholders.**
  - **(4) Resources used to achieve results for the persons served (efficiency).**
  - **(5) Service access.**
- **e. Incorporates the:**
  - **(1) Characteristics of the persons served.**
  - **(2) Impact of extenuating or influencing factors.**
- **f. Includes:**
  - **(1) Comparative analysis.**
  - **(2) Identification of trends.**
  - **(3) Identification of causes.**
- **g. Is used to:**
  - **(1) Identify areas needing performance improvement.**
  - **(2) Develop an action plan(s) to address the improvements needed.**

(3) Implement the action plan(s).

(4) Determine whether the actions taken accomplished the intended results.

Intent Statements

Through implementation of the standards in Section 1.L. Performance Measurement and Management, the organization establishes its framework for performance measurement and management, including the identification of objectives, performance indicators, and performance targets related to service delivery. Analyzing each performance indicator in relation to its target, including consideration of the characteristics of the persons served and extenuating or influencing factors that may impact performance, provides the organization with information on areas meeting or exceeding targets and areas in need of improvement. An action plan for improvement can then be developed in accordance with the organization's priorities, resources, and other considerations.

The analysis of performance at least annually provides information on value and satisfaction to the persons served and other stakeholders.

The performance analysis reviews data aggregated at a program/service level for each program/service seeking accreditation in order that the action plan(s) can target improvements at the individual program/service level.

1.d. When a program/service seeks accreditation in combination with any of the specialty programs in Section 4 of the Aging Services, Continuing Care Retirement Community, or Medical Rehabilitation Standards Manuals; specialty designations in Section 5 of the Behavioral Health, Child and Youth Services, or Opioid Treatment Program Standards Manual; or specific population designations/enhancements in Section 5 of the Employment and Community Services Standards Manual, it is expected that the analysis of service delivery indicators be conducted at the level of those designations.

1.M. **2. The analysis of business function performance:**

a. Is documented.

b. Is completed at least annually and in accordance with the timeframes outlined in the performance measurement and management plan.

c. Addresses priority business function indicators determined by the organization.

d. Incorporates the:

(1) Characteristics of the persons served, if applicable.

(2) Impact of extenuating or influencing factors.

e. Includes:

(1) Comparative analysis.

(2) Identification of trends.

(3) Identification of causes.

f. Is used to:

(1) Identify areas needing performance improvement.

(2) Develop an action plan(s) to address the improvements needed.

(3) Implement the action plan(s).

(4) Determine whether the actions taken accomplished the intended results.

Intent Statements

Through implementation of the standards in Section 1.L. the organization establishes its framework for performance measurement and management, including the identification of objectives, performance indicators, and performance targets related to business functions. Analyzing each performance indicator in relation to its target, including consideration of extenuating or influencing factors that may impact performance and, if applicable, the characteristics of the persons served, provides the organization with information on areas meeting or exceeding targets and areas in need of improvement. An action plan for improvement can then be developed in accordance with the organization's priorities, resources, and other considerations.

The analysis of performance at least annually provides information to aid in the strategic positioning of the organization and builds a stronger business foundation and engaged workforce.

1.M. **3. The results of performance analysis are used to:**

a. Improve the quality of programs and services.

b. Facilitate organizational decision making regarding:

(1) Service delivery.

(2) Business functions.

c. Guide changes to the performance measurement and management plan.

Intent Statements

CARF-accredited organizations use a fact-based decision-making process to identify and respond to organizational and stakeholder needs. Although not every performance indicator that is measured and analyzed may be acted on, the information gleaned from the analysis allows for a fact-based approach to decision making, planning, and performance improvement.

Examples

The organization demonstrates:

- 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 makes decisions to expand, remodel, open new sites, develop new services, modify a treatment or service approach, or change staffing patterns.
- How it responds to or prepares for changes in regulations, reimbursement, or corporate structure.
- Methods for reaching these decisions, which may include reviews of information, performance management reports, budgets, strategic plans, input forums, gap analyses, and satisfaction surveys.

1.M. **4. In accordance with the performance measurement and management plan, the organization communicates accurate performance information:**

a. To:

(1) Persons served.

(2) Personnel.

(3) Other stakeholders.

b. According to the needs of the specific group, including:

(1) Content.

(2) Format.

(3) Timing.

Intent Statements

Sharing performance information with internal and external stakeholders is a vital aspect of continuously improving the programs/services of the organization. CARF-accredited organizations realize the importance of transparency and sharing performance information that is relevant and accurate with the persons served, personnel, and other stakeholders. Stakeholder input guides the content, format, and timing of the information shared so that it meets the needs of stakeholders both internal and external to the organization.

Examples

The content of the information shared is tailored to the needs of the audience and what the specific stakeholder group would like to know about the programs/services. The information is presented in a format and language that is understandable to those with whom it is shared. Format may vary for different stakeholder groups. For example, performance information could be communicated through:

- Annual reports.
- Press releases.
- Newsletters.
- Narrative reports.
- Bulleted summaries or fact sheets.
- Pie charts.
- Bar graphs.
- Balanced scorecards.

Information could be mailed, emailed, posted on the organization's website, displayed in a

reception area, audio or video recorded, or presented in person. To further meet the needs of stakeholders, information may be provided in a large font size, using more graphics than text, in various languages, in Braille, or utilizing captioning or interpreters.

SECTION 2

Care Process for the Persons Served

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.

Applicable Standards

Please refer to the following grid to determine the standards in Section 2 that are applicable to the programs in Section 3 for which your organization is seeking accreditation. Additional information regarding applicable standards is included with each program in Section 3 and each specialty program designation in Section 4.

Program Seeking Accreditation	2.A. Program/Service Structure	2.B. Residential Communities	2.C. Care Process for Specific Diagnostic Categories	2.D. Skin Integrity and Wound Care Standards	2.E. Care Process for Personal Support Services	2.F. Service Delivery Using Information and Communication Technologies
Section 3. Program Specific Standards						
3.A. Adult Day Services	Apply all	Not applicable	Apply as applicable	Not applicable	Not applicable	Apply all*
3.B. Assisted Living	Apply all	Apply all	Apply as applicable	Apply all	Not applicable	Apply all*
3.C. Person-Centered Long-Term Care Community	Apply all	Apply all	Apply as applicable	Apply all	Not applicable	Apply all*
3.D. Home and Community Services	Apply all	Not applicable	Apply as applicable	Apply all if Standards 3.D.16.–18. are applicable	Not applicable	Apply all*
3.E. Case Management	Apply 2.A.1.–9.	Not applicable	Not applicable	Not applicable	Not applicable	Apply all*
3.F. Independent Senior Living	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Apply all*
3.G. Personal Supports Services	Apply 2.A.1.–9.	Not applicable	Not applicable	Not applicable	Apply all	Apply all*
3.H. Continuing Care Retirement Community	Apply all	Apply all	Apply as applicable	Apply all	Not applicable	Apply all*
Section 4. Specialty Program Designation Standards						
4.A. Dementia Care Specialty Programs	Apply as applicable	Apply as applicable	Not applicable	Apply as applicable	Apply as applicable	Apply all*
4.B. Palliative and End-of-Life Care Specialty Program	Apply as applicable	Apply as applicable	Apply as applicable	Apply as applicable	Apply as applicable	Apply all*

*Section 2.F. applies if the program delivers services using information and communication technologies.

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.

Applicable Standards

For information about the applicability of the standards in this section to the services for which your organization is seeking accreditation, please refer to the Applicable Standards statements in the individual services or to the grid at the beginning of this section.

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) Payers and funding sources.

(7) Fees.

(8) Referral sources.

(9) The specific services offered, including whether the services are provided directly, by contract, or by referral.

(10) If the program delivers services via information and communication technologies:

(a) Geographic areas served.

(b) The communication technology used to deliver services.

b. Shares relevant 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.

d. Updates the scope as necessary.

Intent Statements

The scope is defined at the level of the program/service. It is not expected that the program/service shares all information listed in 1.a. with every stakeholder, but that it provides the persons served, families/support systems, referral sources, payers and funding sources, and other stakeholders with relevant 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.

1.a.(10) Service delivery using information and communication technologies is addressed in Section 2.F. of this manual.

Examples

The scope may be defined in written entry criteria, a written program description, an outcomes system description, or a policy and procedure.

An organization advertises that it has a certain program. It has the appropriate equipment and space and personnel who possess the competencies to meet the needs of persons served.

An organization is sponsored by a religious organization, but takes persons served of all faiths. It provides access to spiritual services that meet the needs and interests of all participants.

1.a.(7) The program may identify that certain services are provided through a contractual relationship with another provider in the community. There may be fees associated with

services such as beauty services, massage, transportation, personal companion, and art lessons.

1.a.(10) A program/service that uses information and communication technologies (ICT) to deliver services, whether for selected services or exclusively, includes this information in the documentation of its scope.

1.a.(10)(a) The program documents and shares information on the geographic areas it serves at the level of detail needed by stakeholders to consider whether the program can meet their needs. This may be locale or states/provinces or other jurisdictions related to access/convenience by persons served, credentialing of providers, or billing for services.

1.a.(10)(b) The communication technology used to deliver services may be described in terms such as phone call, live chat, text, Zoom, video conference, and platforms.

1.b. Information about the scope of the program may be shared a variety of ways to raise awareness about the program to a variety of audiences. The ways to share information may include in writing, via video or audio recordings, on an organization's website, one on one or to groups, or with the assistance of an interpreter.

Examples of efforts to share information about the scope of the program could include invitations sent to regulatory officials to attend an open house at the organization; letters and marketing materials mailed to the local chapters of the office on aging, Alzheimer's Association or Society, and stroke association; an email blast to members of the local case management association, or a public mailing to residents in the surrounding zip codes.

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

Resources may include, but are not limited to, personnel; finance; leadership; space, materials, and equipment; continuing education for personnel; and education for the persons served, families/support systems, and the community.

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

When establishing the criteria for entry, transition, and exit, the capability of the program to provide the needed services is considered.

While a program/service may use terms that are different than those above, the concepts are the same.

3.a. Entry criteria may also be called admission criteria, enrollment criteria, or move-in criteria.

3.b. Transition criteria may also be called transfer guidelines. These guidelines address transitions to other levels of care as well as transitions within a program/service.

3.c. Exit criteria may also be called agreement termination criteria, contract termination criteria, discharge criteria, or move-out criteria.

2.A. **4. When a person is found ineligible for services:**

a. The person is informed as to the reasons.

b. In accordance with the choice of the person:

(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

4.a. Informing persons as to why they are ineligible helps them to locate and access appropriate services to meet their needs.

4.c. The person may verbally be given information about alternative services, or this information may be provided in writing for later use. In some cases, the referral source may be the more appropriate source for information about alternative services.

2.A. **5. 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

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 care paths or treatment guidelines, etc. Resources used in this process might 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 resources, or education efforts with other area providers of services.

2.A. **6. 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 that services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples

Communication and collaboration may occur in the program/service through written or oral communication, such as electronic formats, log books, face-to-face meetings, progress notes, specialized communication devices, facilitative communication, handheld devices and computers, video or audio recordings, and one-on-one teaching.

6.a.(2) The organization may utilize identifiers that preserve dignity to assist with communication, such as color coding or thoughtful graphic symbols to identify those at risk of falling.

2.A. **7. 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 persons served may not have the capacity or be of the age to make decisions in their 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 jurisdiction to jurisdiction; e.g., 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.

7.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 family/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.

Examples

7.a. The legal decision-making authority of the persons served may be addressed by someone in the organization who has expertise in competency determination, through a screening process, in team conferences, etc. A provider could demonstrate knowledge of legal decision-making authority through a discussion with the surveyor of legal decision-making authority issues pertinent to existing state or provincial law, policies that outline levels of legal autonomy, in-services on issues of legal decision-making authority, and materials for personnel and the persons served that explain legal decision-making authority.

2.A. **8. If the program holds funds for the persons served, it implements written procedures that address:**

a. How the persons served can access their funds.

b. Safeguards in place to:

(1) Segregate funds for individual persons served.

(2) Ensure that funds are used for the designated purposes.

c. The provision of information to persons served on the status of their funds:

(1) At a frequency determined by the program.

(2) Including:

(a) Funds spent.

(b) Funds remaining.

d. How funds will be returned to the persons served upon transition/exit from the program.

e. Communication of these procedures to the persons served.

Intent Statements

If a program holds funds such as cash; checks; or credit, debit, or gift cards as a courtesy to persons served for their personal use during the program, it has a system in place to safeguard those funds and make them available to the persons served for the intended purposes.

2.A. **9. If the organization has related entities, it:**

a. Documents the types of relationships.

b. Makes information regarding its relationships with related entities available to:

(1) Persons served.

(2) Families/support systems.

(3) Other relevant stakeholders.

Intent Statements

Disclosure of relationships demonstrates an organization's commitment to transparency. Information is made available to support decision making on the part of persons served,

families/support systems, and other stakeholders regarding entry, transition, or exit from a program.

Examples

Examples of relationships include:

- Parent-subsidiary structures.
- Affiliations.
- Alliances.
- Guarantees.
- Joint ventures.
- Limited partnerships.
- Management agreements.
- Other third-party operating support.
- Financial support from related foundations.

There are a variety of ways that information regarding relationships with related entities may be shared with different stakeholders. Websites, videos, informational brochures, or facility tours may be used to communicate this information with persons served and families/support systems, while marketing efforts, in-person business forums, or educational events may be used to share information with other stakeholders such as referral sources and business partners.

2.A. **10. 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 timeframes 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.

Examples

A funding issue might result from a change in a contract for services; e.g., if the total amount of a contract decreases, there is a change in the funding model, eligibility criteria are revised, or the scope of services approved under a contract changes. Other resource issues might include the unavailability of staffing due to an unexpected illness or inability of the person served to attend the program/services because a family member who usually provides transportation suffers an illness or injury that prohibits the person from driving.

2.A. **11. Based on the scope of services, there is a written agreement:**

- **a. That is presented in an understandable format.**
- **b. Of which a copy is provided to the person served:**
  - **(1) For review prior to entry to the program.**
  - **(2) After it is signed by all appropriate parties.**
- **c. That is available at all times for review by the person served.**
- **d. That is signed by:**
  - **(1) The person served.**
  - **(2) The program's representative.**
- **e. That contains information regarding:**
  - **(1) Entry:**
    - **(a) Criteria.**
    - **(b) Procedures.**
  - **(2) Transition:**
    - **(a) Criteria.**
    - **(b) Procedures.**
  - **(3) Exit:**
    - **(a) Criteria.**
    - **(b) Procedures.**
  - **(4) Scope of services that will be provided.**
  - **(5) Fee schedule.**
  - **(6) Responsibility for payment of fees.**
  - **(7) Refund policies.**
  - **(8) Resources to address program or payer limitations.**

Intent Statements

Information exchange promotes an understanding between the program and persons served regarding critical components of how service

delivery is conducted. Information is shared at appropriate times to support transparency and knowledgeable decision-making.

Examples

Written agreements may be referred to as admission agreements, contracts, residence and care agreements, life leases, or participant agreements.

11.b. Written agreements may be shared a variety of ways at different points in time:

- In an admissions packet
- During a person-centered planning meeting
- During a transition planning or move-out discussion with the person served
- At any time if a person served requests to review it

11.e.(2) Transitions may be voluntary or involuntary and may be between levels of care such as assisted living and long-term care within the same organization or transition from assisted living to a memory care neighborhood in the community. Under certain circumstances, transitions may also include movement between one apartment or cottage to another or one room to another. Transitions may also be within an adult day program regarding level of care; e.g., from basic ADL support to a level requiring more nursing services during participation hours.

11.e.(8) Limitations of the program could include space availability (e.g., a participant wishes to attend five days a week and space is available only for three days a week) or limited hours of operation (e.g., program closes at 5:00 p.m., but family would prefer to pick up the person served at 6:00 p.m.).

Resources to address payer limitations could include a benevolent fund or a scholarship fund that can be accessed by persons served under certain circumstances.

2.A. **12. The program provides opportunities to orient potential persons served and their families/support systems about the program in order to:**

- **a. Familiarize them with the:**
  - **(1) Mission of the program.**
  - **(2) Personnel.**
- **b. Determine their expectations.**
- **c. Provide information on:**
  - **(1) The fee schedule.**
  - **(2) Accepted payer sources.**
  - **(3) Levels of assistance provided.**

Intent Statements

In many cases, initial interactions may be a deciding factor in whether or not individuals seek services from a provider. Processes are helpful in ensuring that there is consistency in how interactions with those who may seek services from the program occur.

Examples

Opportunities to learn about the program could include visiting the program, a video tour, providing printed materials via mail or in person, reviewing information available on the organization's website, having telephone calls between program personnel and the person served, and supplying audio recordings about the program.

- A couple stops by the program for information late in the afternoon. The receptionist, a new volunteer, refers to a handbook that includes a one-page guide on how to greet visitors, areas of the program to highlight, materials to provide to individuals making inquiries, and follow-up steps.
- The marketing or admissions staff of a program provides a "Welcome Visitor" workshop as part of new hire orientation and annually for all personnel who may be involved in visits of potential persons served.

2.A. **13. Based on the scope of services, written screenings/assessments are conducted:**

- **a. Prior to the initiation of services.**
- **b. At a frequency that is consistent with the needs of the persons served.**
- **c. In response to changes in care needs.**
- **d. In response to changes in preferences of the persons served.**

Intent Statements

Communication between persons served and personnel in a program contributes to effective service planning. Information gained from the various screenings/assessments filters into the

person-centered plan as it evolves over time based on the changing needs and preferences of the person served.

Examples

In Canada, external public sector/health authority case managers may provide an initial and ongoing assessments (e.g., RAI) for publicly funded/subsidized services to contracted service providers.

Examples of screenings/assessments might include:

- Physical examination conducted by the personal physician of the person served.
- Annual wellness assessment conducted by a wellness professional.
- Interdisciplinary team observation system that includes forms used by dining and housekeeping to identify unique needs of persons served.
- A record of a conversation that program personnel have with the family/support system of a person served addressing information such as medication needs, transportation, dietary preferences, and changes in participation hours.

2.A. **14. Based on the scope of services of the program, initial and ongoing written screenings/assessments:**

a. Address the following areas:

(1) Behavior.
(2) Cognition.
(3) Communication.
(4) Dental.
(5) Function.
(6) Grief and loss.
(7) Health.
(8) Legal involvement.
(9) Medications.
(10) Nutritional.
(11) Pain management.
(12) Physical.
(13) Psychological.
(14) Relationships.
(15) Recreation and leisure.
(16) Risk.
(17) Sexuality.
(18) Social.
(19) Spiritual.
(20) Trauma.
(21) Others, as appropriate to the needs of the person served.

b. Identify:

(1) Prior daily routines.
(2) The preferences of the persons served.
(3) The choices of the persons served.
(4) The personal goals of the persons served.

c. Are used to develop person-centered plans for the persons served.

Intent Statements

To ensure that the needs of all persons served are adequately identified, screenings/assessments consider the areas listed based on the scope of services of the program. The extensiveness of the assessment in each of these areas varies for individuals based on their unique needs.

14.a.(17) The assessment of sexuality, including any forms used, is conducted in such a way as to encourage persons served to share information as they are comfortable and willing.

14.b.(2)–(3) Choices are limited by what is available and preferences are what a person served would have or do if there were no limits on available choices.

Examples

14.a. Screening and assessment tools may cover more than one area. For example, assessment related to a palliative approach to care might address legal involvement, pain management, spiritual, and other areas in addition to grief and loss.

14.a.(5) Examples of function could be maintaining balance during mobility or the level of continence of the individual and how these impact participation in activities. Function may also include activities of daily living and instrumental activities of daily living such as paying bills, shopping, housekeeping, and laundry.

14.a.(7) Examples of health-related information may include allergies, smoking cessation and weight maintenance, arthritis, heart health, diabetes, podiatry, ophthalmology, stroke recovery, hearing loss, vision loss, and oncology.

14.a.(8) Legal involvement may include if the person served is listed as a sex offender, convicted of assault or theft, restraining orders, or has a record of other serious offenses that may pose a risk to others. This type of information can be essential in developing an appropriate person-centered plan for the person served that considers situations that may pose a risk to that individual or others.

14.a.(11) Assessment of pain in individuals with dementia may require observations of behavior consistent with the presence of pain, as well as the use of tools such as the Pain Assessment in Advanced Dementia Scale (PAINAD) or the Discomfort Scale for Dementia of the Alzheimer's Type (DS-DAT).

14.a.(12) An example of physical assessment might be regular skin checks or routine dermal inspection conducted by an appropriate practitioner who can identify potentially dangerous skin changes that require treatment.

14.a.(14) Examples of relationships may include a variety of interactions including those that are platonic friendships and those involving sexual intimacy.

14.a.(16) Risk assessment may address areas such as driving; falls; depression, anxiety, or suicide; pain management; poor diet; loss of vision, hearing, or mobility; skin integrity; or other areas that impact routine function and independence.

For Person-Centered Long-Term Care Community programs seeking accreditation, Standard 3.C.7. addresses risk assessment and reduction.

14.a.(17) Assessment of sexuality may encompass gender identity and expression, identification of preferred pronouns, chosen versus biological family, sexual orientation, intimacy needs, sexual function, or other areas as appropriate.

14.a.(19) An assessment in this area may consider culture, religion, and religious beliefs and practices.

14.a.(20) It is important to recognize that persons served may have a past traumatic experience that might impact their quality of life and the care provided. Trauma survivors, including veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors, and survivors of abuse are among those who may be receiving services. Any experience that threatened death or harm may be considered trauma, and witnessing of trauma events should also be considered. Knowledge of this trauma can then allow care to be provided in a manner that minimizes the risk of re-traumatization and facilitates quality delivery of care.

14.a.(21) Examples of other information may include vocational capacity for persons served who are still working or seeking to return to work.

14.b.(2)–(3) A person served might prefer mint ice cream, but might be given a choice between chocolate and vanilla. A person served may prefer a private room, but if not available, the person served may have a choice of roommate.

2.A. **15. Based on scope and identified needs, person-centered plans are implemented for the persons served:**

- **a. That are based on:**
  - **(1) Initial and ongoing screenings/assessments.**
  - **(2) Observations of the person served.**
  - **(3) Choices of the person served.**
  - **(4) Preferences of the person served.**
- **b. That address:**
  - **(1) Identified service needs.**
  - **(2) Necessary:**
    - **(a) Interventions.**
    - **(b) Approaches.**
    - **(c) Supports.**
  - **(3) The types of services to be provided.**
  - **(4) The intensity of services to be provided.**
  - **(5) The frequency of services to be provided.**

(6) The goals of the person served.

(7) Persons responsible for facilitating each goal.

(8) The integration of available resources.

(9) The choices and behaviors of the person served that pose a risk to the person's health or safety.

(10) Transition/exit plans, as appropriate.

(11) Identification of the preferences of the person served for involvement of members of the family/support system.

(12) The changing lifespan issues of the person served.

c. That are monitored for progress toward accomplishment of the goals identified.

d. That are shared in an understandable manner with:

(1) The persons served.

(2) Other persons identified by the persons served.

(3) Appropriate personnel.

Intent Statements

Person-centered plans will vary from simple to complex depending upon the needs of the person served, the level of activity, health concerns, etc. The concept of person-centered plans is to increase the integration of information about the person served into a centralized system. To foster efficiency and effectiveness of service delivery, personnel are able to access current information about persons served from a variety of sources that feed into a central system.

Plans evolve over time as the individual changes. The program has a method for collecting information about each person's preferences, choices, and needs through a variety of sources that include observations of and interactions with the persons served, as well as initial and ongoing screenings/assessments. The plans are documented, monitored for progress, and revised as the needs or preferences of the person served change.

Examples

15.a.(3)–(4) Examples of preferences vs. choices may include:

- A person served may prefer to take a walk every day at 8:00 a.m. but that may not be possible in the setting, so the program offers the choice to walk every day later in the morning or in the early afternoon when a volunteer is available to accompany the person served.
- A person served prefers to have pancakes every day for breakfast. Since pancakes are not on the menu every day, the program offers the person served the choice of having pancakes whenever they are on the menu.
- A person served prefers to sleep in until 11:00 a.m. every day. The program offers the choice to wake at whatever time the person wants to wake. In this case, the preference and the choice may align.

15.b.(1)–(2) For individuals that have urinary incontinence, the program might identify if bladder control training, medications, or other nonsurgical approaches can help manage the condition.

For individuals with common skin problems, which could include excessive dry skin, eczema, increased fragility, and reduced sensation, the program might foster regular observation practices to identify skin changes, encourage use of appropriate lotions, or implement gentle hygiene techniques like patting rather than rubbing delicate areas when washing in order to promote skin integrity. If the skin integrity issues exceed the scope of the program, a referral may be made to a dermatologist or other professional to review the condition and perhaps prescribe a topical treatment.

15.b.(3)–(5) The program identifies the type, amount, and duration of needed services chosen by the person served such as fitness, nutrition, social opportunities, home-making assistance, pastoral, or nursing/medical support services.

Person-centered plans might be called resident files or participant files.

The identification of needs starts with the application which is filled out by the prospective person served or with the assistance of a family member, admission coordinator, or marketing representative and may include lifestyle preferences, financial resources and basic healthcare information.

Lifestyle preferences may include desire to participate in various activities, dining options, transportation needs, an individual's rhythm of the day, and religious or spiritual preferences and choices.

The changes that any personnel, including those from activities, transportation, and dining, observe may be included in the person-centered plan. A program may also have members of the interdisciplinary team who identify and address concerns within their area of responsibility in order to be aware of changes in the needs of the persons served. This information may be helpful in developing and maintaining the person-centered plan.

2.A. **16. Based on the scope of the program, when a need for assistance is identified for a person served, the program offers assistance for activities of daily living in a manner that promotes:**

- **a. Independence.**
- **b. Safety.**
- **c. Dignity and self-worth.**

2.A. **17. Based on the scope of the program, the service delivery team:**

- **a. Is determined by the:**
  - **(1) Screening/assessment process.**
  - **(2) Person-centered planning process.**
  - **(3) Goals of the person served.**
  - **(4) Strategies utilized to achieve the goals.**
- **b. Includes:**
  - **(1) The person served.**
  - **(2) Members of the family/support system, in accordance with the preference and choice of the person served.**
  - **(3) Personnel with the competencies necessary to evaluate the person served and facilitate the achievement of goals of the following types:**
    - **(a) Behavior.**
    - **(b) Cognition.**
    - **(c) Communication.**
    - **(d) Dental.**
    - **(e) Function.**
    - **(f) Grief and Loss.**
    - **(g) Health.**
    - **(h) Legal involvement.**
    - **(i) Medications.**
    - **(j) Nutritional.**
    - **(k) Pain management.**
    - **(l) Physical.**
    - **(m) Psychological.**
    - **(n) Relationships.**
    - **(o) Recreation and leisure.**
    - **(p) Risk.**
    - **(q) Sexuality.**
    - **(r) Social.**
    - **(s) Spiritual.**
    - **(t) Trauma.**
    - **(u) Others, as appropriate to the needs of the person served.**
  - **(4) Other stakeholders, as appropriate.**

Intent Statements

The composition of each person's team is determined through the screening/assessment and person-centered planning processes. The scope of the program guides the type of competencies needed by personnel since programs vary regarding the services offered. The team is a dynamic group of individuals that may change during the person's participation in the program. Some personnel may be active team members for the entire length of a person's participation in the program while others may become active members of the team as the need for services or

expertise is identified. Frontline caregivers are included as integral members of the team and provide input to the person-centered plan and services to be provided.

Examples

17.b.(3) The areas listed in this standard align with standard 2.A.14. on ongoing screenings/assessments of the persons served. Members of the service delivery team may have specific competencies based on their clinical expertise. Team members may also build their competencies through additional training and educational opportunities such as attending courses on trauma-informed care, mental health and substance use concerns in older adults, or palliative approaches to service delivery.

17.b.(3)(e) Examples of personnel able to assess function might include a physical therapist, occupational therapist, social worker, or nurse.

17.b.(3)(l) Physical goals might be addressed by personnel who are knowledgeable about skin integrity risk factors and interventions to promote skin health and minimize wounds. Personnel might include, but are not limited to, direct care personnel, nurses, or other clinical personnel.

17.b.(4) If input from a particular discipline is required for the person served to achieve identified goals in areas such as dental, legal, etc., and that discipline is not already part of the team, arrangements might be made to seek input from an external provider to participate on the team when needed.

2.A. **18. Based on the scope of the program, to ensure achievement of the goals of the person served, the personnel who coordinate services for each person served:**

- **a. Demonstrate appropriate competencies as defined by the program.**
- **b. Are identified to:**
  - **(1) The person served.**
  - **(2) The family/support system, in accordance with the preference and choice of the person served.**
- **c. Have the authority to coordinate the provision of services.**
- **d. Are knowledgeable about the person's preferences, choices, and personal goals.**
- **e. Are available to interact with:**
  - **(1) The person served.**
  - **(2) The family/support system, in accordance with the preference and choice of the person served.**
  - **(3) Other relevant stakeholders.**
- **f. Provide appropriate orientation to:**
  - **(1) The person served.**
  - **(2) The family/support system, in accordance with the preference and choice of the person served.**
- **g. Ensure communication with:**
  - **(1) External sources.**
  - **(2) Internal sources.**
- **h. Integrate the available financial information into decision making about the provision of services.**
- **i. Facilitate the involvement of the person served throughout the service delivery process.**
- **j. Ensure that transition/agreement termination arrangements are completed.**
- **k. Ensure that transition/agreement termination recommendations are communicated to appropriate stakeholders.**
- **l. Facilitate the implementation of transition/agreement termination recommendations when appropriate.**

Intent Statements

The program determines the individuals who will fulfill these responsibilities. If responsibilities are shared by multiple persons for a person served, the program identifies who has ultimate responsibility for the shared areas and how efforts will be coordinated on behalf of the person served. Persons served and the family/support systems know who is coordinating services for the person served.

Examples

Personnel in this role might be called coordinators, case managers, or resident services coordinators.

18.g. Service delivery personnel may identify a skin integrity risk for a person served and report this information to a clinical expert who can review and treat the issue to prevent skin breakdown or infection.

The activities coordinator notices a resident is becoming less engaged in groups and events that the person previously enjoyed and communicates this to the team to discuss whether further assessment or referral is indicated.

2.A. **19. Based on scope, the responsibilities of the service delivery team include:**

- **a. Reviewing relevant reports to facilitate initial and ongoing screenings/assessments.**
- **b. Conducting initial and ongoing screenings/assessments.**
- **c. Assisting persons served to set personal goals.**
- **d. Identifying resources.**
- **e. Integrating information on resources into program planning.**
- **f. Establishing the person-centered plan.**
- **g. Integrating information on resources into program implementation.**
- **h. Implementing the person-centered plan.**
- **i. Providing education and training.**
- **j. Modifying the person-centered plan.**
- **k. Ensuring that team members change based on the needs of the person served.**
- **l. Partnering with the person served to achieve that person's goals.**
- **m. Establishing the transition plan.**
- **n. Establishing the agreement termination plan.**
- **o. Transitioning the persons served to other levels of care and/or other services/programs, as needed.**
- **p. Referring the persons served to other services/programs, as needed.**
- **q. Communicating with relevant stakeholders.**
- **r. Participating in performance improvement.**

Intent Statements

The responsibilities of the team are determined through the screening/assessment and person-centered planning processes. Members of the team are based on the needs of each person served and may change when needed during the person's participation in the program.

2.A. **20. In order to communicate and facilitate an integrated approach, the interdisciplinary team members, including team members working on all shifts and days, as well as the person served:**

- **a. Are aware of the person-centered plan for the person served.**
- **b. Implement the person-centered plan for the person served.**
- **c. Modify the person-centered plan as the status of the person served changes.**
- **d. Participate in making decisions concerning the person served.**
- **e. Ensure that decisions are communicated to the entire team.**
- **f. Store information utilizing a system that is accessible to the team.**
- **g. Consider the impact of the team's decisions on:**
  - **(1) The person-centered plan for the person served.**
  - **(2) The entire service delivery team.**

Examples

Examples of communication and collaboration by program personnel might include written communication, log books, face-to-face meetings, morning rounds, huddles, or in-services.

- The personnel working at night observe that a person served consistently tries to exit the program around 11:00 p.m. In discussions with family members, it is discovered that the

individual used to work nights as a security guard. The personnel working at night take the person served on rounds with them and have the person "check" things on the unit. Personnel communicate this to colleagues working days who better understand the need for the person to sleep during the day.

- The primary caregiver for the person served informs program personnel about a contingency plan for alternative transportation so the person served can still attend the program in the event of an emergency.

2.A. **21. As much notice as possible regarding transition or exit is provided to:**

a. The person served.

b. The family/support system, in accordance with the preference and choice of the person served.

c. Personnel.

d. Other relevant stakeholders.

2.A. **22. At the time of transition or exit the program communicates information to relevant stakeholders related to the person's participation in the program, including:**

a. Advance directives.

b. Assistance needed with activities of daily living.

c. Behavioral interventions.

d. Family/system support.

e. Healthcare information.

f. Medications.

g. Personal preferences.

Intent Statements

Communicating essential information is important to the continuity of services when a person served transitions within the program or to another setting.

Examples

Examples of relevant stakeholders may include payer, another program, and family/support system.

- To facilitate a smooth transition to the hospital for a surgical procedure, the program personnel prepare a written summary that accompanies the person served. Information important to continuity of care and an understanding of the needs and daily routine of the person served is included.
- Following a month's stay for rehabilitation for a hip replacement, the program prepares a summary that it provides to the person served to take home. This summary is then given to the adult day program where the person served participates.

22.e. Examples of health information may include allergies, past medical history, and diagnosis.

22.g. Examples of personal preferences may include favorite foods, waking time, and meaningful friendships that have developed.

2.A. **23. Family/support system discussions, when appropriate:**

a. Are arranged.

b. Are documented.

c. Are held at a frequency consistent with the needs and choices of:

(1) The person served.

(2) The family/support system.

d. Are scheduled at a time that is convenient for:

(1) The person served.

(2) The family/support system.

e. Include those team members who are necessary to discuss issues of importance to:

(1) The person served.

(2) The family/support system.

(3) The service delivery team.

Examples

Family/support system discussions may be conducted on site or through other mechanisms such as conference calls.

Program personnel observe changes in the behavior or routine of persons served and might contact family/support systems to discuss the observations.

- Between scheduled care planning meetings, a family member may request a meeting to discuss a change in the condition of the person served. Program personnel responsible for the person served might schedule a time to meet when the individual and key personnel are available.
- A person served may be admitted to the program because the primary caregiver's new job no longer allows for care in the home. The person served may not be participating in activities. The primary caregiver may be called to discuss how to help with adjustment.

2.A. **24. In accordance with the choice of the person served, the program partners with the family/support system throughout the service delivery process, including:**

a. Ongoing consideration of the family's/support system's:

(1) Ability and willingness to support and participate in the person-centered 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 program.

(8) Educational needs.

(9) Responsibilities, including decision making regarding:

(a) Healthcare of the person served.

(b) Finances of the person served.

(c) Lifestyle of the person served.

(d) Other, as appropriate.

(10) Geographic proximity to the person served.

(11) Preferred method of communication.

(12) Preferred timing of communication.

b. Financial, social, or cultural factors that might influence the person-centered plan.

c. Well-being of the family/support system.

Intent Statements

Trust and collaboration between families and personnel develop when the complexities of the family/support system are understood. All parties can more effectively work together to support the dignity of the person served.

Examples

Assessments may consider:

- Family/support system's ability to provide transportation.
- Family/support system's ability to provide clothing that supports self-care.
- Interactions between the person served and the spouse/significant other of the person served, caregivers, friends, peers and community.
- Composition such as the nuclear family, extended family with multiple children, grandchildren, blended families, friends, and neighbors.

24.c. The well-being of the family/support system may include multiple domains such as physical and emotional health, stress management and resilience, social connectedness, or lifestyle behaviors.

2.A. **25. Safety and security measures:**

- **a. Are consistent with:**
  - **(1) The behavioral needs of the persons served.**
  - **(2) The cognitive needs of the persons served.**
  - **(3) The physical needs of the persons served.**
- **b. Promote:**
  - **(1) Socialization.**
  - **(2) Interaction with the environment.**
- **c. Address:**
  - **(1) Chemical use, abuse, or dependency.**
  - **(2) Elopement risks.**
  - **(3) Equipment safety.**
  - **(4) Late pick up or no pick up.**
  - **(5) Mental health issues.**
  - **(6) Physical hazards.**
  - **(7) Physically aggressive behaviors.**
  - **(8) Self-injurious behaviors.**
  - **(9) Sexually-inappropriate behaviors.**
  - **(10) Suicidal ideation.**
  - **(11) Suspected neglect.**
  - **(12) Suspected abuse.**
- **d. Are addressed in personnel training at least annually.**

Intent Statements

It is important for all persons served to feel safe and secure in the program but not feel restricted. Persons served should also feel that they have choices. Individuals who wander or exhibit various behaviors still need to socialize as an important aspect of daily life, and there should be options for how and where that can safely occur.

Examples

Outdoor areas could be available and usable for persons served desiring to spend time outside. They are safe for persons served and promote interaction with each other and with nature.

Safety and security measures could be addressed architecturally when designing new areas or remodeling and when thinking about where and when to schedule activities.

Safety and security measures may be included as part of personnel training on related health and safety practices, as well as other personnel training that is conducted at least annually. For example, training may address what to do when a person served expresses thoughts of suicide, wanting to end one's life (even without a specific plan) or other self-harm, or is experiencing severe anxiety, panic attacks, or agitation.

25.c.(6) Physical hazards might include risk of falls due to physical limitations such as weight, lack of balance, or limited vision, and factors in the environment such as poor lighting or uneven floor coverings.

2.A. **26. When there is a need to address behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of personnel.**
  - **(3) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the appropriate approach, treatment, and/or supports necessary.**
- **f. Ensure the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
- **g. Implement the appropriate interventions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other appropriate personnel.**

(3) The family/support system, in accordance with the preference and choice of the person served.

Intent Statements

Persons served may do things that personnel might not always fully understand, yet all behavior has meaning. When personnel seek to understand what causes these behaviors, they can more effectively support the person served.

When caring for a person served who is living with dementia, behavior or nonverbal communication may be a sign of distress. Therefore, it is particularly important to take time to observe and seek to understand.

2.A. **27. The program implements a policy regarding the use of chemical or physical restraints that addresses whether and under what circumstances:**

a. Chemical restraints will be used.

b. Physical restraints will be used.

2.A. **28. The program implements written procedures regarding the use of chemical or physical restraints that address:**

a. Prevention of unsafe behaviors.

b. Alternative interventions used in an effort to avoid the use of chemical or physical restraints.

c. If the program uses chemical or physical restraints:

(1) The use of chemical or physical restraints only after nonpharmacological approaches have been exhausted.

(2) The use of chemical or physical restraints only temporarily in an emergency to protect the person served or others from injury or serious harm.

(3) Who is responsible for authorizing the use of chemical or physical restraints.

(4) Time-limited use.

(5) Disclosure when used.

(6) Strategies for discontinuation.

(7) Reviews for discontinuation.

(8) Documentation in the records of the persons served.

Intent Statements

To respond to behaviors, programs should seek therapeutic approaches that minimize the use of chemical or physical restraints. Chemical or physical restraints are not used for discipline or convenience. They are considered only temporarily in an emergency to protect the person served or others from injury or serious harm.

28.b. For programs that are restraint free, the expectation is that the program implements written procedures that identify the strategies implemented in lieu of the use of chemical or physical restraints and the approaches used in situations in which persons served might put others at risk of injury or serious harm.

Examples

28.c.(6) If a program has used chemical or physical restraints, strategies for discontinuation may be a process of multiple phases or steps involving reduction leading to discontinuation over a period of time.

2.A. **29. The program implements written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances, including:**

a. Medication storage.

b. Medication administration.

c. Timing of administration.

d. Location of administration.

e. Self-administration.

f. Medication management/assistance.

g. Medication reconciliation.

h. Medication disposal.

i. Over-the-counter:

(1) Medications.

(2) Supplements.

(3) Vitamins.

Intent Statements

Because laws and regulations vary tremendously on these topics, the program must not only have

written procedures in place regarding medications and controlled substances, it should also be able to explain to surveyors how these procedures are kept current with applicable requirements.

Examples

If a state/province or other jurisdiction has legalized marijuana use, written procedures may address whether a physician order is required, marijuana tracking and storage, and ingestion methods acceptable for the service delivery setting.

29.d. Location refers to the geographic location such as whether medication can be administered in the apartment of the person served or in the health clinic.

29.g. Medication reconciliation is a formal process in which healthcare providers partner with persons served and families/support systems to ensure that accurate and complete medication information is shared at transitions of care and at other points in time such as when new medications are being prescribed to the person served.

2.A. **30. Personnel responsible for medications receive competency-based training on medication:**

- **a. Upon hire.**
- **b. Annually.**
- **c. That includes:**
  - **(1) Written procedures that address medications.**
  - **(2) Actions to take in case of an emergency.**
  - **(3) Administration/assistance.**
  - **(4) Medication reconciliation.**
  - **(5) Dispensing.**
  - **(6) Disposal.**
  - **(7) Documentation.**
  - **(8) Errors.**
  - **(9) Implications of abrupt discontinuation.**
  - **(10) Implications for management of multiple medications.**
  - **(11) Indications and contraindications.**
  - **(12) Obtaining medication.**
  - **(13) Written procedures for handling controlled substances.**
  - **(14) Side effects.**
  - **(15) Storage.**
- **d. That addresses compliance with all applicable laws and regulations pertaining to:**
  - **(1) Medications.**
  - **(2) Controlled substances.**

Examples

30.d.(2) Training may address how personnel could comply with applicable laws and regulations pertaining to controlled substances such as medical marijuana (cannabis).

2.A. **31. The following are addressed in policy:**

- **a. Advance directives.**
- **b. Resuscitation, including:**
  - **(1) Provision of information for making a decision.**
  - **(2) The right to refuse resuscitation.**
- **c. Any legal requirements related to:**
  - **(1) Advance directives.**
  - **(2) Resuscitation.**
- **d. Provision of information on the organization's procedures concerning advance directives to:**
  - **(1) The persons served.**
  - **(2) The families, support systems, or caregivers of the persons served.**

Intent Statements

This standard may vary according to the level of care of the person served or existing state or provincial/territorial regulations.

This standard addresses the ultimate choice that a person served will make; that about the end of their life. To address the choices of persons served, there is a policy and written procedures describing how and when the organization obtains this information.

Examples

As in the exchange of all information, surveyors are interested in how an organization accounts for impairments, different education levels,

languages, and other aspects of the person's background.

An organization has policies and procedures in place to ensure that all personnel caring for persons served are aware of their desires for end-of-life decisions and care.

2.A. **32. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the program, on an ongoing basis:**

- **a. Determines that the technology and/or equipment:**
  - **(1) Functions properly.**
  - **(2) Achieves the intended purpose.**
- **b. Notifies the appropriate designee, as needed.**
- **c. In accordance with the person-centered plan, incorporates the technology and/or equipment into service delivery.**

Intent Statements

It is important that personnel are attuned to the ever-increasing role and impact of technology on the lives of the persons served. The extent to which a 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 at 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 technical difficulty with it, it would be the driver's responsibility to notify the appropriate person who could assist the person served.

"Smart homes" utilize information and communication technologies that assist with daily living activities, safety, falls, health monitoring, and environmental control. Smart homes allow and provide a way to record the activity or inactivity of an individual in their residence 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 personal care assistant that a video camera is not working. The personal care assistant notifies the appropriate personnel, who then follow up with the appropriate family member or vendor.

2.A. **33. The physical plant of the program:**

- **a. Has equipment available to meet the individual needs of the persons served.**
- **b. Facilitates the appropriate use of therapeutic equipment.**
- **c. Maintains safe environmental conditions.**

Intent Statements

The physical environment facilitates the accomplishment of the individual plans and predicted outcomes of the persons served; promotes their dignity, self-worth, privacy, and quality of life; and supports their ability to make choices in their daily routines.

Examples

The patio area accommodates those with mobility issues. It has been designed for usability, with protection from the elements.

In all reading areas, there is sufficient lighting for persons with low vision.

There is space for parties to celebrate holidays, birthdays, anniversaries, and events of family importance.

The bathrooms are designed to accommodate the use of wheelchairs.

The beds provide for the safety and comfort of persons served.

33.c. Environmental conditions such as temperature, air quality, and noise can impact not only the comfort of the persons served but their health and safety. For example:

- A comfortable temperature is maintained in the physical plant, including individual units, through central air conditioning, fans, portable cooling systems, programmable thermostats, and/or window treatments that protect from heat and direct sun.
- Ventilation systems are installed to maintain or enhance air quality and reduce transmission of infections and illnesses.
- In new construction or renovation attention is given to mitigating noise from outside the building generated by traffic and inside the building from hallways and activity in common areas.

2.A. **34. Based on its scope of services, the program implements a written philosophy of health and well-being for the persons served that:**

a. Addresses:

(1) Function.

(2) Quality of life.

(3) Aging in place.

b. Promotes healthy aging and well-being.

c. Is shared with:

(1) The persons served.

(2) Families/support systems.

(3) Personnel.

Examples

Well-rounded programming may address various aspects of well-being such as physical, social, spiritual, emotional, occupational, and intellectual.

A program's philosophy may be documented separately or included in other documents such as a vision and values statement, mission statement, or marketing materials.

An emphasis might be placed on the following:

- Maximizing or maintaining independence of persons served.
- How changing acuity needs will be addressed, such as whether hospice services will be offered in all units or in a specialized unit or a local hospice.

2.A. **35. Well-being for the persons served is promoted through activities that:**

a. Are based on input from the persons served.

b. Consider input from families/support systems.

c. Are purposeful.

d. Provide for daily structured and unstructured activities.

e. Promote healthy behavior.

f. Meet their interests.

g. Align with their cognitive capabilities.

h. Align with their communication capabilities.

i. Reflect their choices.

j. Promote their personal growth.

k. Enhance their self-image.

l. Improve or maintain their functional levels whenever possible.

m. Allow for social interaction.

n. Allow for autonomy.

o. Include opportunities for community integration.

p. Are documented in the individual plan for each person served.

Examples

Part of well-being might include identification and celebration of lifecycle events that are important and meaningful to the persons served, families and support systems, and personnel who provide care and services to these individuals.

Well-being may also include, based on the interests of the person served, opportunities to share talents and skills, mentor, or teach others.

35.d. Examples of unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to engage with online learning or social media.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large print books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
- Meditation, journaling, breathing techniques, and other self-directed mindfulness activities.

35.e. Regular exercise reduces the risk of developing dementia by improving overall brain health and managing risk factors like high blood pressure and high cholesterol. Even light physical activity is associated with a lower dementia risk compared to being inactive.

2.A. **36. When the program provides scheduled activities, information regarding the activities is:**

a. Communicated in a way that is understandable to the persons served.

b. Accessible to:

(1) The persons served.

(2) Their families/support systems.

2.A. **37. Based on the program's scope of services and on an assessment/screening of the learning needs and preferences of the persons served, the program provides or arranges for:**

a. Formal and informal educational opportunities.

b. Access to:

(1) Information of interest.

(2) Health information.

(3) Other media.

Examples

The program supports group learning activities such as current events discussion and might invite local experts or persons served to provide presentations on art, history, music, political science, or other topics of interest to persons served.

The program might schedule outings or notify persons served of events at the local community college including movies, art, music, and education.

Information on health-related issues and topics of interest might be available online or through books, pamphlets, or presentations, a health fair hosted by the program, or by attending a community health fair.

2.A. **38. The program makes available:**

a. Access to:

(1) Wi-Fi.

(2) Technology that:

(a) Promotes engagement in meaningful activity.

(b) Enhances quality of life.

b. Resources for the use of technology.

Intent Statements

38.a.(1) Across aging services providers, Wi-Fi access is becoming a vital component of service delivery, enhancing social connection and engagement for persons served and enabling communication between programs, persons served, families/support systems, and other stakeholders.

It is not required that Wi-Fi access be provided throughout an entire building or campus but that the program identify where service is available and may be used by persons served and others.

38.a.(2) It is the choice of the person served to use technology and in what way.

Examples

38.a.(1) Wired Internet, cellular network hotspots, and satellite Internet could be used to provide Wi-Fi internet access. If there are barriers to providing Wi-Fi internet access an organization may include this in its technology and accessibility planning.

38.a.(2) The variety of technology, devices, and applications used by older adults is continuously growing and varies from simple to sophisticated. Some may be owned by persons served and some by the program. Examples range from smart-home technology to robotic pets and meal delivery to iPads, smartphones, and virtual assistants that support older adults in engaging in meaningful activity.

38.b. The resources offered to support the use of technology might be individualized or offered to a group, accessed via community programs at a library or senior center, or provided via online tutorials or printed materials.

Examples could include a speaker to talk about internet security, e.g., how to connect one's personal technology (phone, laptop, iPad) to the internet and how to select and safeguard passwords; local high school volunteers that partner with persons served to learn about smart phone technologies and apps; and providing information on courses offered at a nearby library on how to avoid online fraud and scams targeting older adults.

2.A. **39. When the program provides dining services, it:**

- **a. Seeks input from the persons served regarding its dining services.**
- **b. Uses the information to improve its dining services.**
- **c. Promotes access, in accordance with the written agreements of persons served, to:**
  - **(1) Nutritious meals.**
  - **(2) Snacks.**
- **d. Allows persons served to:**
  - **(1) Select what they want to eat.**
  - **(2) Dine with:**
    - **(a) Members of their families/support systems.**
    - **(b) Friends of their choosing.**
- **e. Has sufficient capacity to:**
  - **(1) Prepare appropriate food.**
  - **(2) Deliver appropriate food.**
  - **(3) Arrange for appropriate food.**
- **f. Prepares food in a manner that is:**
  - **(1) Sanitary.**
  - **(2) Safe.**
- **g. Considers dietary requests.**
- **h. Upon request, provides nutritional information about items on the menu.**

Examples

A committee of persons served may work with the dining services department to provide suggestions regarding menu planning.

A committee of persons served that is planning social events for a holiday may offer suggestions to personnel regarding snacks that would be preferred by event participants.

The program engages a dietician or other qualified person to review the nutritional content of menus, meals, and snacks available to the persons served.

Snacks may be obtained through a marketplace, a café, or other venue.

The program may implement a take-out or delivery service for persons served that allows participants to pre-order meals.

Local or state/provincial inspection reports and dietician reports might be useful to determine how the program addresses food preparation.

Alternate selections to the daily menu, in line with preferences of persons served, might be available.

Vegetarian options are indicated on the menu.

Nutrition information such as caloric content, dairy-free, gluten-free, or nut-free could be listed on the meal schedule or menu.

A whiteboard is posted in the dining room and personnel write nutritional information about the specific meal being served that afternoon.

When serving a meal, personnel are able to describe nutritional details when individuals with specific dietary needs or questions ask about the food being served.

2.A. **40. If the program serves any persons who require respiratory management, it demonstrates:**

- **a. The establishment of personnel competencies.**
- **b. A mechanism to demonstrate the level of competency achieved.**
- **c. The availability of appropriate equipment and supplies, including:**
  - **(1) Cough assistance devices.**
  - **(2) Suctioning equipment.**
  - **(3) CPAP/BIPAP.**
  - **(4) Oxygen.**
- **d. The utilization of appropriate equipment.**
- **e. The maintenance of appropriate equipment.**
- **f. The availability of a pulmonologist.**
- **g. The availability of respiratory services 24 hours a day, 7 days a week.**
- **h. Training for:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **i. Emergency plans that take into consideration the unique needs of persons who require respiratory management.**
- **j. If ventilator dependent:**
  - **(1) Availability of portable ventilators.**
  - **(2) Ongoing assessment of the need for ventilatory support.**
  - **(3) Ventilator weaning protocols.**

Intent Statements

Interventions may range from noninvasive respiratory management through ventilator dependence. Persons served who have respiratory insufficiency are vulnerable and present unique needs. Respiratory management might be needed by persons with impairments of the lung, respiratory muscle, or swallow function who would benefit from interventions to improve or manage their respiratory conditions.

Examples

Respiratory management may be required for persons served due to premorbid conditions such as asthma or COPD, as well as those persons served whose respiratory function has been affected by their admission diagnosis; e.g., spinal cord dysfunction, stroke, or brain injury, or those who have a tracheostomy. Other conditions that might require respiratory management include dysphagia, sleep apnea, pneumonia, lung cancer, pneumothorax, or respiratory failure.

40.g. In addition to a respiratory therapist, respiratory services could be provided by a nurse, a therapist, or another professional with a health-related degree who demonstrates competency in the respiratory services needed by the person served.

2.A. **41. When a person served or someone who is of significance to a person served dies, opportunities to express grief and remembrance are provided to:**

- **a. Persons served.**
- **b. The family/support system.**
- **c. Personnel.**
- **d. Other stakeholders.**

2.A. **42. The records of the persons served include, when applicable:**

- **a. Identification data.**
- **b. Advance directives.**
- **c. Emergency contact information.**
- **d. Substitute decision maker who has been appointed for the person served, including:**
  - **(1) Name.**
  - **(2) Contact information.**
  - **(3) Verification of the appointment.**
- **e. Medication information.**
- **f. Healthcare providers involved in the care of the person served, including:**
  - **(1) Name.**
  - **(2) Contact information.**
- **g. Medical information.**

h. Reports for initial assessments.
i. Reports for ongoing assessments.
j. Reports from referral sources.
k. Reports of service referrals by the program.
l. Reports from outside consultants.
m. The person-centered plan of the person served.
n. Clinical entries related to the services received, as appropriate.
o. Release forms.
p. Discharge/transition summaries, as appropriate.

2.A. **43. The program works with local community resources on emergency preparedness concerning the unique needs of persons served to address:**

a. Emergency preparedness.
b. Power restoration.
c. Evacuation.
d. Transportation.
e. Shelter.
f. Recovery.
g. Public health concerns.

Intent Statements

The program works with community resources (e.g., first responders, civil defense, homeland security, Red Cross) to educate them about the unique needs of persons served, including persons with dementia if applicable to the program, and how to ensure that those needs can be met in the event of an emergency.

43.f. Recovery after a disaster means the return of the person served to the home or community setting.

Examples

Programs could communicate about the unique needs of the population served with local community leaders who work in fire departments, hospitals, pharmacies, first responder organizations, public health organizations, or other community organizations. "Work with" could be that aging services providers are involved in local meetings, serve on a local committee, share information via email with a local agency or organization to strategize regarding emergency preparedness topics and the unique mobility, cognitive or other issues that might be useful for community leaders to be aware of regarding the population served by the aging services provider.

43.f. Recovery might include transportation from the recovery center; home repairs needed due to damage from fire, water, or wind; utility recovery; or public health assessment for safe/healthy living conditions.

43.g. Public health concerns might include infections such as influenza, COVID-19, and monkey pox; air quality and weather-related conditions; fraud and scams that target older adults; gun violence; and rising rates of suicide.

2.A. **44. The program identifies:**

a. The individuals who have the responsibility and authority to manage key components of the program.
b. The skills and competencies required to perform as a program manager.

Examples

A program may have more than one position identified as leadership. There may be job descriptions that identify responsibilities and competencies for the leadership. Requirements may include previous experience working with person-centered care and in person-centered homes.

2.A. **45. Personnel are consistently assigned to each person served to meet the person's needs.**

Intent Statements

Strong relationships are central to quality care for persons served and families/support systems. Consistent assignment, which may also be called primary assignment, means that persons served see the same caregivers almost every time the caregiver is on duty. While not excluding a system of rotation, consistent assignment benefits both the persons served and the caregiver in the following ways:

- Prevents confusion of the persons served about the identity of their caregivers

- Builds and maintain relationships
- Decreases stress
- Increases caregiver retention
- Enhances caregiver knowledge

Examples

A full-time caregiver may be assigned the same group of persons served for the five days the caregiver is scheduled to work. The two days of the week that person is not scheduled, the same part-time caregiver works with that group of persons served. By implementing this approach, the persons served have relationships with two caregivers who know them well, rather than having multiple caregivers who may rotate daily and not know their preferences. Each quarter these two caregivers may be given the opportunity to work with a different group of residents in order to gain additional insights and knowledge.

In a small program, all personnel may consistently work with all persons served through daily interactions.

During the initial orientation and training period, personnel work on a variety of assignments in order to meet each person served as well as other personnel. After the initial rotation, the new personnel are given a regular assignment.

Dining personnel may serve the same group of tables for the days they are scheduled to work. They become familiar with the preferences and dietary needs of the persons served.

Each discipline may have a system whereby assignments of individual personnel are rotated to enhance the expertise of personnel in all the areas. If such a system is used, the persons served are notified before a rotation ends and are introduced and oriented to any new personnel assigned to care for them.

When scheduling does not permit consistent assignments, caregivers demonstrate to the persons served that they have knowledge of other team members' work in a coordinated fashion. If a program utilizes temporary, contract, or per diem personnel, it strives for maximum consistency and continuity of care through personnel assignments and scheduling.

2.A. **46. To fulfill the program's commitment to respond to the changing needs of the persons served, education is provided:**

- **a. To:**
  - **(1) Personnel.**
  - **(2) Volunteers.**
- **b. On:**
  - **(1) Indications that the status of the person served has changed.**
  - **(2) How to respond to information about persons served that may be reported by other sources.**
  - **(3) How to protect the privacy of the persons served.**
  - **(4) How to protect the dignity of the persons served.**
  - **(5) How to, on an ongoing basis:**
    - **(a) Observe for changes in persons served.**
    - **(b) Communicate observed or reported changes.**

Examples

46.b.(1) Persons served in an adult day services or home and community services program might not be able to communicate their needs as clearly during programming or may have more difficulty completing activities of daily living. In a residential setting, security personnel may have had to respond frequently to the fire alarm sounding in an apartment due to the oven being left on and burning food. Housekeeping might notice that a person served is no longer able to care for a pet and the pet is soiling the apartment to the point that there is odor in the common areas. Dining personnel may observe that a person served is having more difficulty with feeding and safely swallowing solid foods at meals in the dining room.

46.b.(2)–(3) Education might address if personnel involved in activities or caregiving notice a significant change in a person served, they know to share that information with their manager, who then shares it with an administrator. The education might also address key privacy considerations such as how such information is shared with the manager and not shared with other employees.

2.A. **47. Leadership fosters a continuous learning environment for personnel that:**

- **a. Recognizes and respects individual:**
  - **(1) Learning styles.**
  - **(2) Needs.**
  - **(3) Strengths.**
- **b. Provides and evaluates:**
  - **(1) Teaching.**
  - **(2) Coaching.**
  - **(3) Modeling.**
  - **(4) Supervision.**
  - **(5) Feedback.**
- **c. Measures the effectiveness of the techniques used in the learning environment against a performance target.**
- **d. Supports the implementation of innovative ideas and practices.**

Intent Statements

Education of personnel who care for the persons served is a key component of quality service delivery. Leadership ensures that the program has processes in place for initial and ongoing education designed to meet the needs of each staff member.

The program identifies the best way for each of its staff members to learn. For some it is in a classroom; for others it is a hands-on approach with a return demonstration; for others it is self-directed, online learning; and for others, it is a group discussion. Leadership ensures that personnel receive the education they need in the style best suited to their needs.

Examples

There may be opportunities for personnel to evaluate the program's teaching mechanisms, how they have been coached, and the feedback they have received from their supervisors. Leadership models the desired behaviors for personnel.

Direct care personnel might need to make on-the-spot decisions that have traditionally been first cleared with their supervisor. Supervisors might need ongoing coaching to help them empower and support the direct care personnel to be decision makers.

Persons served, families/support systems, and personnel may be involved in the creation of a curriculum as well as in the initial and ongoing educational initiatives. Direct care personnel might have a more in-depth curriculum than other personnel who work in the program.

47.c. Potential measures of the effectiveness of learning techniques include:

- Assessment of learning styles, needs, and strengths.
- Success of coaching.
- Appropriateness of level of supervision.
- Feedback regarding quality, quantity, or access to learning techniques.

2.A. **48. To enhance recruitment and retention of personnel, the program:**

- **a. Demonstrates outreach to expand its future workforce.**
- **b. Provides opportunities for career development.**
- **c. Provides mechanisms for personnel to:**
  - **(1) Recognize successes.**
  - **(2) Acknowledge challenges.**
  - **(3) Solve problems.**
  - **(4) Participate in the service delivery planning process.**
  - **(5) Participate in program development.**

Intent Statements

The field of aging services continues to face significant workforce challenges. This standard addresses how programs can proactively focus on finding talent within current personnel and also strategically thinking about nontraditional candidates. This standard relates to 1.I.6. that includes addressing the well-being of the workforce as it is increasingly becoming a factor in recruiting and retaining personnel.

Examples

To tap into potential sources for employees or volunteers, programs may have leaders attend functions, and the organization may advertise job opportunities to retired teachers, department of aging programs for retired workers, high school

student exchange programs, and international cultural exchange programs.

To attract workers the program may offer internship and apprenticeship opportunities.

It may modernize recruitment processes by using social media to advertise positions and technology to expedite its response to inquiries and applications.

2.A. **49. The program:**

a. Provides education, if needed, regarding end-of-life choices.

b. Honors the person's choices concerning end of life.

c. Initiates related services when appropriate.

d. Gives opportunities for expression of final choices concerning end of life to:

(1) The persons served.

(2) Families/support systems.

e. Provides opportunities to express grief and loss.

Intent Statements

It is important to support persons served in understanding and sharing their personal values, life goals, and preferences regarding future care. The goal of advance care planning is to help ensure that people receive care that is consistent with their values, goals, and preferences during serious and chronic illness.

Examples

Persons served may be interviewed about preferences regarding end of life (i.e., music, people, preparation and notification, comfort items, spiritual needs). The person-centered planning includes these preferences.

Information regarding advance directives is kept in an accessible location in a residential unit of the program.

Annually during the month of their birthday, persons served might have a physical exam from their primary care physician and meet with clinic staff to perform a medication review and update contact information and advance directives.

B. Residential Communities

Applicable Standards

The standards in this subsection apply to the following Aging Services residential programs:

- Assisted Living
- Person-Centered Long-Term Care Community
- Continuing Care Retirement Community

2.B. **1. Service delivery planning considers:**

a. The changing needs and expectations of current and prospective persons served, including:

(1) Dining.

(2) Healthcare.

(3) Housekeeping.

(4) Maintenance.

(5) Security.

(6) Social interaction.

(7) Transportation.

(8) Other services.

b. The changes in resources necessary to address those needs.

Intent Statements

As the population changes, services may be offered by program personnel that may not be included in the written agreement. Over time these individual situations may evolve into mainstream services that may impact resource utilization, budgeting, staffing, and expectations of persons served. When these services are unintentionally provided, this results in what may be referred to as service creep.

Examples

The department coordinator may initiate a planning discussion at a staff meeting regarding daily bed-making services. The objective of the discussion may be to determine how to fulfill this preference of the persons served without having to increase their fees or add personnel. The planning may include looking at numbers of requests and personnel statistics in order to assess the feasibility.

1.a.(6) Social interactions might include maintaining friendships using social media, accessing learning opportunities, or maintaining intimate relationships including sexual intimacy.

2.B. **2. The program implements policies and procedures regarding how it provides, arranges for or assists with arrangements for the following services:**

- **a. Health-related services.**
- **b. Rehabilitation services.**
- **c. Social services.**
- **d. Housekeeping services.**
- **e. Laundry services.**
- **f. Security services.**
- **g. Transportation services.**

Examples

Policies and procedures may address the following:

- Credentialing of physicians and other clinicians who provide services on site.
- Operations of the on-site medical clinic.
- Who provides medical services.
- What medical services are covered in the daily/contract/monthly fee.
- Services that are billed through governmental, private, or other funding.
- Services that are provided on site.
- Services that are provided by referral.
- Whether persons served may continue to see their own private physicians rather than the physician who comes on site.
- Facilitation and supervision of therapeutic recreation activities.

2.B. **3. Dependent on the needs of the persons served, the program provides, arranges for, or assists with arrangements for the following services:**

- **a. Health-related services:**
  - **(1) Nutrition.**
  - **(2) Medical care.**
  - **(3) Health promotion.**
  - **(4) Home health.**
  - **(5) Dental care.**
  - **(6) Nursing services.**
  - **(7) Mental health.**
- **b. Rehabilitation services:**
  - **(1) Physical therapy.**
  - **(2) Occupational therapy.**
  - **(3) Speech therapy.**
  - **(4) Creative arts therapy.**
  - **(5) Therapeutic recreation.**
  - **(6) Assistive technology.**
- **c. Social services:**
  - **(1) Counseling for the persons served.**
  - **(2) Counseling for members of their families/support systems.**
  - **(3) Support services.**
  - **(4) Education on community resources.**
- **d. Housekeeping services.**
- **e. Laundry services.**
- **f. Security services.**
- **g. Transportation services.**

Intent Statements

Ongoing screenings/assessments determine needs of persons served and identify services to address those needs. Based on the scope of services, the program determines how various services can be accessed by individuals.

Examples

A program may provide services through program personnel, arrange for services by contracting or establishing formal relationships with another company or individual to deliver services, or assist with arrangements such as scheduling appointments and providing transportation to providers in the community.

Arrangements are made by the program for persons served to have their hearing and vision tested during program hours by visiting professionals.

The program may offer regular classes for the persons served on prevention and well-being, holistic approaches to managing their health, and dealing with life transitions. The classes may be taught by faculty from the local community

college and are open to members of the community in addition to persons served and personnel.

A person served desires to visit the family dentist in the dental office. Personnel assist the person served to make the appointment and arrange transportation to the dentist's office.

The program might engage the care team and/or family members by providing supplemental training so that they are able to assist with implementing routine oral healthcare and related assessments for persons served that could then determine the need for care from a dental provider.

A person served has been a member of a recovery group and may desire to continue participation. An invitation is made to the group to meet at the program, or arrangements are made for one of the members to transport the person served to the meeting. A companion may be required, and these arrangements are made.

The spouse of a person served with Alzheimer's disease may be having a difficult time adjusting to the changes. The program provides information about the local chapter of the Alzheimer's Association or Alzheimer's Society.

Creative arts therapy could include art therapy, music therapy or dance therapy. In general, these are services provided by personnel who have received training in utilizing these forms of creative arts to address physical, emotional, cognitive and social needs of individuals of all ages.

A person served may desire to have certain articles of clothing dry cleaned. Arrangements may be made to have the clothes picked up by a dry cleaner and delivered back to the person served.

2.B. **4. The program provides or arranges for physician input, as appropriate, regarding:**

a. The adequacy of individual health services.

b. Transition decisions for the persons served.

Examples

Physician input may be sought from a medical director, physician who participates on a care planning committee, utilization review committee, or admissions/transitions committee.

A physician's assistant or nurse practitioner functioning as an extender of a physician may also provide input.

A physician might provide consultation for specific treatment such as wound care, diabetic foot care, significant weight loss or gain, cognitive impairments, or psychological issues.

2.B. **5. When the program provides medication management/assistance, the organization establishes a relationship with a pharmacist for persons served:**

a. To advise on an ongoing basis about medication management/assistance, including:

(1) Policies and procedures that address medication management/assistance.

(2) Actions to take in case of an emergency.

(3) Administration/assistance.

(4) Dispensing.

(5) Disposal.

(6) Documentation.

(7) Errors.

(8) Implications for management of multiple medications.

(9) Implications of abrupt discontinuation.

(10) Indications and contraindications.

(11) Obtaining medication.

(12) Procedures for handling controlled substances.

(13) Side effects.

(14) Storage.

b. To conduct drug regimen reviews for the persons served.

Intent Statements

A pharmacist consults with the program at a timeframe consistent with law and regulation in order to advise on medication management/assistance. This standard applies to all components of the program where medication management/assistance is provided. Ongoing communication with a professional helps to reduce medication errors for the persons served.

Examples

- The program schedules time in the meeting room quarterly for a pharmacist to meet with residents who receive medication management/assistance. Residents are encouraged to bring their medications, ask questions and obtain information.
- A consultant pharmacist visits assisted living or nursing care each month to provide guidance and conduct drug regime reviews for residents. Reports from the consulting pharmacist are reviewed by appropriate managers and provided to each of the prescribing physicians for review.
- A resident who is terminally ill is not experiencing adequate pain control. Personnel meet with the pharmacist who makes recommendations to the physician for better pain management.
- Residents of a memory care community are often groggy during breakfast. The pharmacist reviews the medications given to these persons served and suggests changes in dosage and frequency of administration.
- The pharmacist identifies persons served who need lab work done and this information is shared with nursing and medical personnel.
- When persons served are required to comply with medication formularies, the consultant pharmacist assists by suggesting alternative medications.

2.B. **6. The program provides information to persons served on contracting for outside services, including:**

a. Exploring services.

b. Hiring services.

c. Managing services.

d. Information exchange with program personnel.

e. Terminating services.

Intent Statements

When persons served hire their own services such as personal care attendants, companions, drivers, pet care, or other types of services, clarity regarding how such services are to be initiated, managed, and terminated are important to manage risk for all parties.

2.B. **7. Policies addressing the following are implemented:**

a. Requirements for services arranged by the person served.

b. Pets.

c. Service animals.

d. Upkeep and maintenance of individual residences.

e. Smoking.

f. Guests.

Examples

7.b. A policy regarding pets may address:

- Persons served who desire to have their pet live with them in the program may be allowed to do so.
- When the program invites family members and/or volunteers to bring pets for persons served to enjoy.
- Responsibilities for pet care, including feeding, walking, vaccinations, and vet care.
- The options available when persons served need assistance fulfilling pet-related responsibilities.

2.B. **8. The program provides, arranges or assists with arrangements for transportation services, including necessary assistance, for all persons served to participate in:**

a. Appointments.

b. External community events.

c. Outings sponsored by the program.

d. Recreational and leisure opportunities.

e. Religious services.

f. Shopping.

Intent Statements

See Standard 1.H.13. if the program provides or contracts transportation services for the persons served.

2.B. **9. Policies and written procedures allow the opportunity for the persons served to receive visitors 24 hours a day, if desired, and the visit does not infringe upon the health, safety, or rights of any persons served.**

2.B. **10. When available, persons served residing in assisted living or nursing care may choose to:**

a. Have a private or semiprivate living unit.

b. Have roommates.

Intent Statements

Persons served consider choice regarding living arrangements a key element of quality. Over time, the preferences of the persons served may change and should be honored by the program to the extent possible.

Examples

A couple that desires to live together may share a room.

After living in the program for several months, two persons served decide they would like to be roommates. Personnel assist them in making the necessary room changes when a room becomes available.

The program has a limited number of private rooms but maintains a wait list for persons served who desire to be in a private room.

During the initial visit to the program, the person served is shown all available rooms and identifies a preferred room.

An individual's roommate moves out of the program. The person served would like to move to the other side of the room, and personnel assist with the move.

2.B. **11. Individual units provide for:**

a. Personal choice about:

(1) Possessions.

(2) Décor.

b. Accessibility.

c. Healthcare needs of the persons served.

d. Personal security.

e. Privacy.

f. Safety.

g. Security of personal possessions.

Intent Statements

Home is a place where persons served are safe and their possessions are secure and accessible. The environment reflects their preferences, supports independence, and meets their needs.

Examples

11.a. Individual units may be decorated with different color schemes and contain personal possessions such as furniture, paintings, photographs, and linens.

The person served may have a grandfather clock or other large piece of furniture or art work that cannot fit in the individual unit, but, with permission of the person served, may be displayed in a common area.

11.b. Adaptations might be made in individual units including closets and bathrooms to facilitate independence in self-care and attending to the health needs of the person served.

A clothes bar may be lowered for an individual who uses a wheelchair.

11.e. Privacy might include accommodations for individuals to have confidential conversations or to have intimate interactions.

11.g. The program may provide a place for persons served to secure their valuables, such as a safe or locked closet.

2.B. **12. The program:**

a. Equips each individual unit with an emergency call or monitoring system.

b. Implements a system to summon emergency backup when needed.

Intent Statements

When maintaining an emergency monitoring system, providers should refer to Standard 1.H.3. to ensure that persons served are educated on use of the system, and to Standard 1.H.14. to verify, through the self-inspections process required in Standard 1.H.14., that the system is in working order.

Examples

12.a. In individual units, apartments, cottages, or other personal living spaces, this may be a pull cord system, pendant, or a system in which a phone that is knocked off the hook automatically alerts a call center.

12.b. Emergency backup may be to direct persons served or personnel to call emergency services.

2.B. **13. The program implements safety and security measures, including, but not limited to:**

a. Surveillance.

b. Entry to and exit from the property.

c. Entry to and exit from individual units.

d. What to do in case of an emergency.

e. Personal security options.

Intent Statements

This standard is focused on approaches, ways, or methods that the safety of the persons served, personnel, and other stakeholders is maintained on the premises of the organization. This includes the general campus or building, individual units, and measures that may be used by individuals. During a survey, the program is able to describe the techniques and approaches implemented to foster a safe environment.

Examples

13.a. Surveillance may include personnel who regularly or periodically check-in on persons served. It might also include cameras in areas such as parking lots, stairwells, and other parts of the physical plant. Because organizations have varying budgets and population needs, the term "surveillance" can mean people who do a walk-through of the physical plant, or it can mean an electronic system.

13.b. Measures that address entry and exit could include a gated community where individuals have to be buzzed in or use an access code to enter the property. Entry and exit might also be tracked by having visitors sign in at the front desk before visiting the person served.

13.c. Safety and security measures for individual units might include a locked door with a peephole or a door bell.

13.d. Measures related to what to do in case of an emergency might address how personnel are to respond if a person served or visitor is experiencing physical distress when they enter the premises. This includes specific measures to be taken if someone falls, chokes, or has some other emergency while on the premises of the organization.

Additionally, residential communities may need to address emergent situations such as what to do in the event of a theft or break-in or how to respond to and report an undesired or unknown visitor.

13.e. Personal security options might include a person served choosing to wear a medical alert bracelet or pendant due to a particular medical need, having a personal medical monitoring device in the individual unit, having a whistle alarm or flashlight on a key chain, or other personal security devices or techniques.

2.B. **14. The organization demonstrates efforts to maintain or improve the physical environment, including:**

a. Preventive maintenance.

b. Cleanliness.

c. Plans for capital improvements of property.

Intent Statements

14.c. If seeking accreditation for a Continuing Care Retirement Community, this standard relates to Standards 1.F.16.–18., which address a capital needs assessment and long-range financial plans.

Examples

14.c. Changes in weather patterns may indicate a future need for air conditioning or supplemental cooling. This relates to Standard 2.A.33.c. on the program's ongoing maintenance of safe environmental conditions.

2.B. **15. There are regular meetings between personnel and the persons served to discuss issues concerning the living environment.**

Intent Statements

See the Glossary for the definition of *regular*.

Examples

Meetings may be held monthly, quarterly, or annually and may include town-hall meetings with persons served to provide an overview of scheduled repairs or renovations, updated safety procedures, new laundry equipment and how it works, information about using updated thermostats in apartments, parking lot changes, or other topics regarding the living environment. Communications might also be through meetings with individual persons served or with groups of persons served such as individuals living on a certain floor of a building or neighborhood of a campus.

2.B. **16. The program demonstrates planning for sustained emergency conditions that includes:**

- **a. Contingency planning for workforce shortages.**
- **b. Expedited onboarding of personnel.**
- **c. Establishing priorities for service delivery.**
- **d. A policy that specifies whether the program allows essential caregivers during sustained emergency conditions.**
- **e. If the program allows essential caregivers:**
  - **(1) Identification of who may fulfill the role of an essential caregiver.**
  - **(2) Written procedures regarding the scope of their involvement with the persons served.**
- **f. Procurement of supplies.**
- **g. Communication that:**
  - **(1) Is timely.**
  - **(2) Is transparent.**
  - **(3) Includes:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) The workforce.**
    - **(d) Other stakeholders.**
- **h. Collaboration with community resources.**
- **i. A process for ethical decision-making.**

Intent Statements

An emergency situation that poses risk to health, property, and/or life requires immediate action to be taken. While many emergencies are resolved in a discrete timeframe, there are a growing number of situations (such as a pandemic or ongoing environmental concerns) that last for an extended period of time. Such circumstances may necessitate a change in priorities and routine practices. The purpose of this standard is to proactively consider what actions are needed to maintain service delivery during sustained emergency conditions.

16.a.–c. During periods of sustained emergency conditions significant workforce-related challenges may occur or intensify. Contingency planning for workforce shortages is intended to help programs prioritize needs, safeguard the health and safety of persons served, and continue to deliver essential services. In alignment with identified priorities, the program may implement an expedited onboarding process in which mission-critical topics are addressed and remaining subject areas are deferred to a later date.

16.d.–e. The concept of an essential caregiver emerged during the COVID-19 pandemic. Essential caregivers are not general visitors, nor are they considered members of the workforce; rather they are individuals designated by the person served who assist in meeting the person's needs with the goal of supporting and enhancing person-centered care. They may also be referred to as essential visitors, essential care partners, or other similar terms.

Residential programs are expected to indicate in policy whether they allow essential caregivers during periods of sustained emergency conditions, and, if they do, parameters for who may fulfill the role and what they may and may not do. Many states/provinces and other jurisdictions have enacted essential caregiver requirements.

When that is the case, an organization is expected to comply with any applicable licensing, regulatory, or insurance-related requirements.

16.g. During a sustained emergency situation, it is important that information be communicated in a transparent, accurate, and timely manner to all relevant stakeholders. Information is shared in a manner and format that is easily understood and reflective of the diversity of communication needs.

16.i. Within the context of residential programs, sustained emergency situations pose a number of unique ethical challenges. As part of an organization's ethical codes of conduct (related to Standard 1.A.5.), established ethical principles can be used as a guide for addressing complex dilemmas including those related to infection control and prevention.

Examples

16.a.–c. Contingency planning may include temporary use of administrative or corporate personnel in alternate service delivery roles, establishing relationships with local academic institutions to engage students/trainees, and use of staffing agencies.

16.e. If essential caregivers are allowed, procedures may cover topics such as visitation parameters, vaccine and screening requirements, the process and expectations for communication, training requirements, and the integration of essential caregivers into the person-centered plan.

16.f. The organization reviews its existing supply chain for essential goods and materials. Systems are in place that document existing and necessary stockpiles and processes outlined in order to ensure the ongoing adequacy of resources. Examples could include vertical collaboration, which would foster enhanced relationships between suppliers and customers, or horizontal collaboration, which would result in cooperation between similar providers to enhance supply chain access.

16.g. Using an online platform, the leadership team gathers daily to record brief updates that are then widely disseminated. Phone calls or one-on-one contacts are made to those who are unable to access the recordings. Once a week, interactive sessions are held offering all in attendance the opportunity to ask questions.

The organization's website serves as a valuable communication portal for internal and external stakeholders as well as the general public.

Automated calling or texting systems are deployed to ensure uniform and timely messaging. Individuals for whom translation or other individualized responses would be needed are proactively identified and their unique needs addressed.

To prevent duplication and possible miscommunication, individual leadership team members are assigned to serve as designated liaisons for key stakeholder groups, e.g., professional associations, local public health authorities, resident and family councils, and others.

16.i. Examples of ethical concerns could relate to supporting persons with memory loss during quarantine requirements, establishing care priorities during periods of workforce shortages, resident relocation and isolation, and implementation of requirements that vary across an organization's levels of care (e.g., independent living, assisted living, and person-centered long-term care community).

Learning circles are held to openly discuss and address vaccine hesitancy concerns amongst personnel in a confidential and supportive manner.

Ethics committees with diverse membership, including persons served, may be used to work through dilemmas in a constructive fashion.

C. Care Process for Specific Diagnostic Categories

Applicable Standards

The standards in this section are applicable if the program serves *any* persons with dementia and is not seeking accreditation as a Dementia Care Specialty Program.

2.C. **1. To empower the persons served with dementia to make decisions each day that are consistent with their abilities, the program, on an ongoing basis:**

- **a. Assesses the ability of the persons served with dementia to make decisions.**
- **b. Minimizes barriers to decision making by the persons served with dementia.**
- **c. Communicates with the persons served with dementia regarding the immediate consequences associated with choices and behaviors that pose a potential risk to their health or safety.**
- **d. Facilitates appropriate support for decision making by the persons served with dementia.**
- **e. Documents significant discussions and decisions made by the persons served with dementia in their records.**

Intent Statements

While complex decisions may not always be feasible, there are more simple decisions that a person served with dementia may be able to continue to make in order to maintain quality of life. The program personnel demonstrate approaches to communicating with the person served in a manner that clarifies the person's decision-making capacity because it can fluctuate over time, including at different times of the day.

Examples

1.a. Assessing the ability of the persons served to make decisions at different points in the day when they may be better able to interact with care providers may occur through careful observation, communication, and documentation to determine what cognitive patterns may be occurring.

1.e. This could include decisions that impact the person-centered plan of care, decisions that come up repeatedly, and high-level decisions. Significant discussions and decisions could also be related to nutrition, social interactions, or communications with family members. It may be important to document that discussions occurred with the person served and the nature of the discussion in order to be clear among caregivers why a specific decision was made.

2.C. **2. The ongoing screening/assessment process includes information about the person's:**

- **a. Life history.**
- **b. Important memories.**
- **c. Favorite stories.**
- **d. Daily routines.**
- **e. Comfort/reminiscence objects.**
- **f. People of importance.**

Intent Statements

This standard supplements Standard 2.A.14. on initial and ongoing written screenings/assessments of the persons served. By using a person-centered approach to screening/assessment the program gains an understanding of the person living with dementia, including the person's values, beliefs, interests, abilities, likes and dislikes, etc., and uses this information to inform the person-centered plan addressed in Standard 2.A.15. As a person's dementia progresses, an ongoing process for screening/assessment provides information on changing needs and preferences.

Examples

2.a. Life history may be gathered over time through a variety of techniques, including guided questions during a one-on-one conversation; observation; and information taken from group

activities using photographs, music, food, or other items that might spark conversation. Information gathered might include accomplishments, losses, significant experiences, hopes, dreams, preferences, important roles, and ways of dealing with previous challenges or stressful situations. Understanding the whole person in this way provides greater understanding and appreciation of the person served and the person's life experiences and promotes dignity and respect.

2.f. People of importance may include extended family such as nieces, nephews, grandchildren, and others such as friends, neighbors, and individuals from the person's spiritual community. People of importance may also include significant others/life partners as individuals may or may not wish to publicly identify as a member of the LGBTQ community.

2.C. **3. The program provides or arranges for education:**

- **a. To the persons served.**
- **b. To families/support systems.**
- **c. In accordance with identified needs that addresses, but is not limited to:**
  - **(1) Dementia, including:**
    - **(a) Signs and symptoms.**
    - **(b) Progression.**
    - **(c) Types of dementia.**
    - **(d) Coexisting conditions.**
    - **(e) Lived experience of dementia.**
  - **(2) Maintaining relationships.**
  - **(3) Skills training, including:**
    - **(a) Activities.**
    - **(b) Therapeutic approach to behavior.**
    - **(c) Communication skills, including communication with:**
      - **(i) Persons served.**
      - **(ii) Service providers.**
    - **(d) Caregiver self-care.**
  - **(4) Coping with changes.**
  - **(5) Driving.**
  - **(6) Falls.**
  - **(7) Incontinence.**
  - **(8) Loss and grief.**
  - **(9) Legal issues.**
  - **(10) Mobility.**
  - **(11) Palliative care.**
  - **(12) Planning for the future.**
  - **(13) Risk of elopement.**
  - **(14) Sexuality.**
  - **(15) Skin integrity.**
  - **(16) Community resources.**
  - **(17) Payer sources.**

Examples

3.b. Education is important to assist the family/support system in its understanding of the evolving needs of a person with dementia and to address concerns related to the role of being a caregiver.

3.c.(1)(e) "Lived" experience may refer to gaining a better understanding of how an individual with dementia might be perceiving surroundings and interactions with others as dementia progresses.

3.c.(3)(d) Examples of caregiver self-care may include counseling for caregiver stress reduction, online support groups to share experiences and gain insights, techniques for caregiver well-being and nutrition, respite care options, and other resources that may assist the caregiver to manage physical and mental fatigue and grief.

3.c.(5) Education related to driving may include identifying whether a person served is able to drive safely and awareness of how to access local resources for individuals who no longer drive, including volunteer driver programs and various forms of public transportation such as paratransit and other services.

3.c.(9) Legal issues may include education and information for persons served and their families/support systems for drafting and maintaining advance directives, do not resuscitate (DNR) orders, and powers of attorney so that the representative of the person served may facilitate service delivery in a way that reflects the wishes of the person served.

3.c.(16) Community resources might include respite care, volunteer drivers, friendly visitor programs, and pet therapy programs.

3.c.(17) Persons served and their families/support systems may not have knowledge of funding sources for various services, so the program might link individuals with local, state/provincial, or national information resources to help navigate the various funding sources for services, equipment, and specific types of care.

2.C. **4. Personnel implement a positive, therapeutic approach to behavior.**

Intent Statements

Responsive behaviors is a term that is used to describe the behaviors of people with dementia, such as agitation, wandering, or depression. The term shows how the actions, words, and gestures of people with dementia are a response to their current environment. When trying to understand the behaviors of a person served, it is important to employ a positive, therapeutic approach to respond to words, gestures, and actions that the person makes to communicate meanings, needs, and concerns. Positive therapeutic approaches are typically multidisciplinary and consider the following:

- What external factors may be influencing the behavior?
- Is the behavior a problem for the person served or for me?
- Will the "solution" cause more anxiety than the problem?

Ultimately, because a person with dementia cannot be expected to change, the idea is to accept the individuals as they are in this moment.

2.C. **5. As appropriate, the program incorporates into the person-centered plan:**

a. A palliative approach to care.

b. End-of-life care.

Intent Statements

Persons served, families/support systems, and personnel have opportunities to discuss end-of-life issues and participate in planning remembrance or memorial activities and creating end-of-life protocols.

Examples

Families/support systems are 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 person served so that the person does not die alone.

The person served and family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do not resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to a person's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or the family/support system.

Programs may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

2.C. **6. If the program utilizes volunteers, it provides documented, competency-based training to volunteers that addresses:**

a. Communication.

b. Dementia.

c. Post-incident debriefing opportunities.

d. Therapeutic approach to behavior.

Intent Statements

Volunteers can be valuable to a program, and it is important to have those individuals who interact with persons served and who impact service delivery receive competency-based training. This standard would not include a volunteer who assists with projects such as letter-stuffing for a one-time fundraising event.

Examples

Volunteers who assist with outings might receive training on emergency procedures, communication approaches, and how to maintain safety of individuals.

6.c. When incidents involving a person served occur during the volunteer engagement, the organization may find it helpful to debrief with the volunteer following an incident such as a person served beginning to cry during an art activity and/or yelling for help. Debriefs might be in a quiet location, shortly after the incident, and may provide an opportunity to explain potential causes, strategies that worked and did not work, and how to manage the stress or other emotions that may have resulted from the incident.

6.d. Volunteers might receive competency-based training regarding sexuality topics that are important to understand and respond to therapeutically if behaviors are exhibited by persons served.

2.C. **7. The organization provides documented competency-based training for personnel, as appropriate to their roles:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes:**
  - **(1) Dementia, including:**
    - **(a) Signs and symptoms.**
    - **(b) Progression.**
    - **(c) Types of dementia.**
    - **(d) Coexisting conditions.**
    - **(e) Lived experience of dementia.**
  - **(2) Delirium.**
  - **(3) Depression.**
  - **(4) Suicide risk assessment and prevention strategies.**
  - **(5) Identifying the personal preferences of the persons served.**
  - **(6) Loss and grief.**
  - **(7) Communication.**
  - **(8) Therapeutic approach to behavior.**
  - **(9) Observation skills.**
  - **(10) Sexuality.**
  - **(11) Skin integrity.**
  - **(12) Meaningful engagement of persons served on an ongoing basis.**
  - **(13) Therapeutic approach to activity development and implementation.**
  - **(14) Gathering information about the person served in the following areas:**
    - **(a) Life history.**
    - **(b) Important memories.**
    - **(c) Favorite stories.**
    - **(d) Daily routines.**
    - **(e) Comfort/reminiscence objects.**
    - **(f) People of importance.**

Intent Statements

7.b.(12) Almost every interaction in daily routines offers opportunities for meaningful engagement and activity-based care. Personnel are trained to actively seek opportunities, both planned and spontaneous, to engage in meaningful and purposeful interaction with the persons served.

Examples

7.b.(4) Identifying persons served in distress or exhibiting self-injurious behavior is part of ensuring that individuals receive the care and support needed to prevent suicide. Approaches might include teaching personnel about warning signs, screening protocols, and care approaches including assessing the environment to reduce access to means like balconies or windows.

7.b.(13) Therapeutic service delivery approaches might integrate favorite music, favorite foods, and other types of sensory engagement.

7.b.(14) Gathering information about the person served as part of the screening/assessment process may be enhanced by other conversation and observation approaches that may also be necessary to gather and maintain current information in light of frequent changes with the person served. It may be useful to have competency-based training focus on behavior versus asking questions about each area. Gathering informa-

tion using various approaches may be useful to understand the current reality of the person served and the communication level of the person served.

Practices might include observing and interpreting the meaning of behaviors and key words, phrases, or sounds used by the person served and what they indicate about the person. Strategies for understanding and responding to the information shared by the person served may include validation, mirroring, distraction, redirection, and cueing.

D. Skin Integrity and Wound Care Standards

Applicable Standards

Standards 2.D.1.–8. apply to the following programs:

- Assisted Living
- Person-Centered Long-Term Care Community
- Home and Community Services, if Standards 3.D.15.–17. apply (i.e., if specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need are provided)
- Continuing Care Retirement Community (assisted living and nursing care levels of the CCRC only)

2.D. **1. The program implements written procedures to address skin integrity and wound care, including:**

a. Initial and ongoing assessments of skin integrity.

b. Management of skin integrity issues.

c. Wound care.

d. Procedures for referral if assessment or management is outside the scope of the program.

Intent Statements

A range of skin integrity and wound care concerns may occur in any medical rehabilitation program, whether they are present at admission of the person served to the program or they arise during the course of the program. Programs that do not include skin integrity and/or wound care in their scope are expected to address the needs of persons served through linkage and/or referral to other resources.

Written procedures address the services the program provides directly and the referral process for assessment and management of skin integrity concerns outside its expertise, including the exchange of relevant information between the program and the referral resource.

Examples

Personnel in the outpatient medical rehabilitation program conduct assessments of skin integrity related to the use of orthotics they issue. The program has an established relationship with a nurse in the larger health system who is available to consult and provide guidance as needed.

The personal care assistant in the home and community services observes that the person served has areas of redness and swelling on her arms and reports it to the program manager. An appointment is made with the person's primary care provider for evaluation.

An outpatient cancer rehabilitation program provides speech-language therapy services to people immediately following surgery for head or neck cancer. In collaboration with the inpatient cancer rehabilitation program, the outpatient program develops protocols for skin assessment to detect burns resulting from radiation therapy. These persons served are referred to appropriate providers since treatment of these wounds is outside the scope of the program.

A residential rehabilitation program admits an individual with a spinal cord injury who has developed a pressure wound. Procedures outline the actions to be taken by program personnel to manage the wound, communication with the referring physician, and when to contact the referring physician if treatment of the pressure wound is outside the scope of the program.

2.D. **2. The interdisciplinary team demonstrates efforts to optimize outcomes through integration with other healthcare providers involved with the persons served, including, but not limited to:**

- **a. Exchange of information on factors facilitating skin integrity and wound management.**
- **b. Exchange of information on barriers to skin integrity and wound management.**
- **c. Collaboration with other healthcare providers on the timing of interventions.**
- **d. Arrangement of follow-up with other healthcare providers at the time of discharge/transition from the program to facilitate ongoing assessment and management of skin integrity and wound issues.**

Examples

2.c. Collaboration may be among providers on the program's service delivery team and with consulting, concurrent, or follow-up providers.

2.D. **3. Based on the scope of the program, initial and ongoing assessments of each person served:**

- **a. Document information about:**
  - **(1) Skin integrity, including.**
    - **(a) Edema.**
    - **(b) Pain.**
    - **(c) Pulses.**
    - **(d) Skin appearance.**
    - **(e) Skin turgor.**
  - **(2) Risks to skin integrity.**
  - **(3) Results of previous interventions, if applicable.**
- **b. Are addressed through referral or coordination with an appropriate healthcare professional if skin integrity assessment is outside the scope of the program.**

Intent Statements

3.a. If the program conducts assessments of skin integrity the areas listed are included.

3.a.(3) This includes interventions implemented by the team to address current skin integrity issues as well as interventions to address previous skin integrity issues.

Examples

The frequency of reassessment may be based on the needs of individual persons served, the program's written protocols, evidence-based practices, in accordance with regulatory requirements, or other considerations.

3.a. Assessments may be head to toe, e.g., if someone is diabetic, or focus on a body area, e.g., a person served who is wearing a splint following a wrist injury.

3.a.(1)(e) Skin turgor refers to the elasticity of the skin and may indicate dehydration in the person served.

2.D. **4. When skin integrity risks are identified through the assessment of the person served, the interdisciplinary team:**

- **a. Addresses identified needs that are within the scope of the program, including:**
  - **(1) Interventions to prevent or reduce the risk of a wound developing.**
  - **(2) Standards of practice.**
  - **(3) Nutritional needs.**
  - **(4) Equipment.**
  - **(5) Supplies.**
  - **(6) Education needs of:**
    - **(a) The person served.**
    - **(b) The family/support system.**
    - **(c) Personnel.**
- **b. Refers the person served to an appropriate healthcare professional to address identified needs that are outside the scope of program.**

Intent Statements

Measures to address the skin integrity risks of the person served are intended to prevent a wound from developing.

Examples

Evidence of the team addressing the skin integrity needs of the person served may be found in the individual plan of the person served; team or family conference summaries; and equipment, supply, or medication orders. The way that the team addresses the skin integrity needs is aligned with the scope of the program, meaning that some teams may address the needs directly, other teams may make referrals to clinicians, or there may be a combination of approaches depending on the skin integrity need.

4.a.(4) Equipment may include orthotics, prosthetics, seating cushions and supports, bed support surfaces, and wheelchairs.

2.D. **5. If a wound is present, the interdisciplinary team for each person served implements written protocols that address:**

- **a. When the wound care needed is within the scope of the program:**
  - **(1) Documented initial and ongoing assessments of wounds, including:**
    - **(a) Location.**
    - **(b) Description of base.**
    - **(c) Measurement.**
    - **(d) Exudates.**
    - **(e) Progression.**
    - **(f) Causes.**
  - **(2) Interventions to reduce and/or eliminate the wound.**
  - **(3) Standards of practice.**
  - **(4) Nutritional needs.**
  - **(5) Equipment.**
  - **(6) Supplies.**
  - **(7) Education needs of:**
    - **(a) The person served.**
    - **(b) The family/support system.**
    - **(c) Personnel.**
  - **(8) A plan for follow-up care.**
- **b. When the wound care needed is outside of the scope of the program, referrals to or coordination with appropriate wound care specialists.**

Examples

5.a.(1) This includes surgical and nonsurgical wounds, pressure sores, and other types of sores from injuries or other causes.

5.a.(1)(e) Progression may include staging of a pressure sore.

5.a.(1)(f) Causes of wounds may include infection; hematoma; co-morbid conditions such as diabetes or vascular disease; immobility; poor sensation; and external factors such as pressure, sheer, puncture, laceration or blunt force.

5.a.(2) Interventions may include, but are not limited to, the use of medications, recommendations for surgery, topical treatment, lifestyle change, shoe adaptation, seating and positioning, infection management, and the use of modalities such as negative pressure wound therapy.

2.D. **6. The program identifies and utilizes local, regional, provincial, national, or international resources to facilitate wound care.**

2.D. **7. Personnel who provide services related to skin integrity and wound management receive documented, competency-based training:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes, but is not limited to:**
  - **(1) Assessment protocols for skin integrity and wound management.**
  - **(2) Strategies and interventions for skin integrity and wound management 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.**
  - **(3) Education techniques to facilitate behavior change in persons served.**

Intent Statements

Personnel training is based on the program's scope and an individual provider's scope of practice and roles and responsibilities for skin integrity and wound management. The specific training provided may vary based on discipline, scope of practice, and/or experience level of the individual provider.

Examples

7.b.(2) This may include the use of evidence-based wound products and supplies.

2.D. **8. The program:**

- **a. Documents a service delivery indicator(s) to measure performance related to skin integrity.**
- **b. Establishes a performance target for each indicator identified.**
- **c. At least annually conducts a written analysis that includes:**
  - **(1) Performance in relationship to established targets in each area.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**
    - **(d) Other stakeholders.**

Intent Statements

This standard relates to the standards in Sections 1.L. Performance Measurement and Management and 1.M. Performance Improvement. Whether skin integrity concerns are managed by the program directly or by referral to or coordination with other resources, the program is expected to meet this standard and determines what information will be most valuable in connecting the persons served to the services and resources they need.

Examples

Depending on the scope of the program, indicators may address skin integrity and/or wound care. For example, indicators could address:

- How many referrals for wound care are made during a period of time or how long from referral to when the person served is seen by the wound care specialist.
- In accordance with the program's protocols, what percentage of family members and other caregivers receive training on the appropriate

use of orthotics and prosthetics, bed and wheelchair positioning to avoid pressure wounds, and other preventive measures to avoid skin integrity issues.

- Wounds present at admission to the program that improved during the program, wounds present at admission to the program that worsened during the program, or new wounds that developed during the program.

8.c.(5)(d) The program may use performance information to seek support from leadership to expand its scope of services related to skin integrity, pursue relevant training for personnel, or establish relationships with external resources. Likewise, the program may educate referral sources on the importance of early intervention when skin integrity risks are identified or when the diagnosis places persons served at higher risk for developing pressure wounds.

E. Care Process for Personal Supports Services

Applicable Standards

If the organization is seeking accreditation for personal supports services, Standards 2.A.1.–9. must be applied along with the standards in Section 3.G. Personal Supports Services.

2.E. **1. The program provides opportunities to orient potential persons served and their families/support systems about the program in order to:**

a. Familiarize them with the:

(1) Mission of the program.

(2) Personnel.

b. Determine their expectations.

c. Provide information on:

(1) The fee schedule.

(2) Accepted payer sources.

(3) Levels of assistance provided.

Intent Statements

In many cases, initial interactions may be a deciding factor in whether or not individuals seek services from a provider. Procedures may be helpful in ensuring that there is consistency in how interactions with those who may seek services from the program occur.

Examples

Opportunities to learn about the program could include providing printed materials by mail or in person, reviewing information available on the organization's website, having telephone calls between program personnel and the individual or a family member, and supplying audio recordings about the program.

- A couple stops by the administrative office for information late in the afternoon. The receptionist, a new volunteer, refers to a handbook that includes a one-page guide on how to greet visitors, aspects of the program to highlight, materials to provide to individuals making inquiries, and follow-up steps.

- The marketing or admissions staff of a program provides a "Welcome Visitor" workshop as part of new hire orientation and annually for relevant personnel.

2.E. **2. Based on the scope of services, information is gathered:**

a. Prior to the initiation of services.

b. At a frequency that is consistent with the needs of the persons served.

c. In response to changes in care needs.

d. In response to changes in preferences of the persons served.

Intent Statements

Communication between persons served and personnel in a program contributes to effective service planning. In addition to the persons served, information may be obtained from a variety of sources including families/support systems and referral sources, as appropriate.

Examples

In Canada, external public sector/health authority case managers may provide an initial and ongoing assessments (e.g., RAI) for publicly funded/subsidized services to contracted service providers.

Examples of external screenings/assessments might include:

- Physical examination conducted by a person's personal physician.
- Annual wellness assessment conducted by a wellness professional.
- A record of a conversation that program personnel have with the family/support system of a person served addressing information such as medication needs, transportation, and dietary preferences.

2.E. **3. Based on the scope of the program, when a need for assistance is identified for a person served, the program offers assistance in a manner that promotes:**

a. Independence.

b. Safety.

c. Dignity and self-worth.

Examples

The program may provide instrumental assistance with a variety of daily activities such as housekeeping, meal preparation, transportation, personal care, running errands, laundry, light exercise, hobbies, and pet care.

2.E. **4. As much notice as possible regarding transition or exit is provided to:**

a. The person served.

b. The family/support system, in accordance with the preference and choice of the person served.

c. Personnel.

d. Other relevant stakeholders.

2.E. **5. To facilitate the continuity of services, at the time of transition or exit the program communicates information related to the person's participation in the program to relevant stakeholders.**

Intent Statements

Communicating essential information is important when a person served transitions within the program or to another setting.

Examples

Relevant stakeholders may include payers, other programs or service providers, and families/support systems.

To facilitate transition to assisted living, program personnel might summarize information on personal preferences of the person served such as favorite foods, waking time, and meaningful friendships.

To facilitate a smooth transition to a hospital for a surgical procedure, personnel might prepare a written summary that accompanies the person served. Information important to continuity of care and an understanding of the needs, daily routine, and preferences of the person served may be included.

2.E. **6. Safety and security measures:**

- **a. Are consistent with:**
  - **(1) The behavioral needs of the persons served.**
  - **(2) The cognitive needs of the persons served.**
  - **(3) The physical needs of the persons served.**
- **b. Promote:**
  - **(1) Socialization.**
  - **(2) Interaction with the environment.**
- **c. Are addressed in personnel training at least annually.**

Intent Statements

It is important for all persons served to feel safe and secure but not feel restricted. Persons served should also feel that they have choices. Individuals who wander or exhibit various behaviors still need to socialize as an important aspect of daily life, and there should be options for how and where that can safely occur.

Examples

Safety and security measures may be included as part of personnel training on related health and safety practices or other types of personnel training that is conducted at least annually.

Persons served may benefit from the use of a personal emergency response system (PERS), medical alert, or technology-enabled in-home safety systems.

Physical hazards in the home environment might include risk of falls due to physical limitations such as weight, lack of balance, or limited vision, and factors in the environment such as poor lighting or uneven floor coverings.

2.E. **7. When there is a need to address behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of personnel.**
  - **(3) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the appropriate approach, treatment, and/or supports necessary.**
- **f. Ensure the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
- **g. Implement the appropriate interventions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other appropriate personnel.**
  - **(3) The family/support system, in accordance with the preference and choice of the person served.**

Intent Statements

Persons served may do things that personnel might not always fully understand, yet all behavior has meaning. When personnel seek to understand what causes these behaviors, they can more effectively support the person served. When trying to understand the behaviors of a person served, it is important to employ a positive, therapeutic approach in response to the actions, words, and gestures of the person to communicate meanings, needs, and concerns.

Examples

Persons served with dementia may express themselves through actions, words, and gestures that are a response to their current environment or conditions. For example, they may be experiencing pain due to a urinary tract infection, be hungry, or simply be frustrated because they are not being understood.

2.E. **8. The organization implements a policy that identifies its role related to medication management.**

Intent Statements

Refer to the Glossary for a definition of *medication management*. The organization clearly identifies whether or not it has any role in medications for persons served so that personnel, persons served, and other stakeholders understand and comply.

2.E. **9. If the program is involved in medication management, it implements written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances, including:**

- **a. Medication storage.**
- **b. Medication administration.**
- **c. Timing of administration.**
- **d. Location of administration.**
- **e. Self-administration.**
- **f. Medication management/assistance.**
- **g. Medication reconciliation.**
- **h. Medication disposal.**
- **i. Over-the-counter:**
  - **(1) Medications.**
  - **(2) Supplements.**
  - **(3) Vitamins.**

Intent Statements

Because laws and regulations vary tremendously on these topics, the program must not only have written procedures in place regarding medications and controlled substances, it should also be able to explain to surveyors how these procedures are kept current with applicable requirements.

Examples

If a state/province or other jurisdiction has legalized medical marijuana use, written procedures may address whether a physician order is required, marijuana tracking and storage, and ingestion methods acceptable for the service delivery setting.

9.g. Medication reconciliation is a formal process in which healthcare providers partner with persons served and families/support systems to ensure that accurate and complete medication information is shared at transitions of care and at other points in time such as when different medications are being prescribed to the person served.

2.E. **10. If the program is involved in medication management, personnel responsible for medications receive competency-based training on medication:**

- **a. Upon hire.**
- **b. Annually.**
- **c. That includes:**
  - **(1) Written procedures that address medications.**
  - **(2) Actions to take in case of an emergency.**
  - **(3) Administration/assistance.**
  - **(4) Medication reconciliation.**
  - **(5) Dispensing.**
  - **(6) Disposal.**
  - **(7) Documentation.**
  - **(8) Errors.**
  - **(9) Implications of abrupt discontinuation.**
  - **(10) Implications for management of multiple medications.**
  - **(11) Indications and contraindications.**
  - **(12) Obtaining medication.**
  - **(13) Written procedures for handling controlled substances.**
  - **(14) Side effects.**
  - **(15) Storage.**
- **d. That addresses compliance with all applicable laws and regulations pertaining to:**
  - **(1) Medications.**
  - **(2) Controlled substances.**

Examples

10.d. Training may address how personnel could comply with applicable laws and regulations pertaining to controlled substances such as medical marijuana.

2.E. **11. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the program, on an ongoing basis:**

- **a. Determines that the technology and/or equipment:**
  - **(1) Functions properly.**
  - **(2) Achieves the intended purpose.**
- **b. Notifies the appropriate designee, as needed.**
- **c. Incorporates the technology and/or equipment into service delivery as appropriate.**

Intent Statements

Technology has an ever-increasing presence in aging 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 persons served in their homes. However, if a person uses 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 is not able to use the PMD as intended or was having some mechanical difficulty with it, it would be the driver's responsibility to notify the appropriate person who could assist the person served.

"Smart homes" utilize information and communication technologies that assist with daily living activities, safety, falls, health monitoring, and environmental control. Smart homes provide a way to record the activities or inactivity of an individual in a home and can report events 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 personal support worker that a video camera is not working. The worker notifies the appropriate personnel, who then follow up with the appropriate family member or vendor.

2.E. **12. The records of the persons served include, when applicable:**

- **a. Identification data.**
- **b. Advance directives.**
- **c. Emergency contact information.**
- **d. Substitute decision maker who has been appointed for the person served, including:**
  - **(1) Name.**
  - **(2) Contact information.**
  - **(3) Verification of the appointment.**
- **e. Medication information.**
- **f. Healthcare providers involved in the care of the person served, including:**
  - **(1) Name.**
  - **(2) Contact information.**
- **g. Medical information.**
- **h. Release forms.**
- **i. Other information required by the program.**

Examples

12.i. Other information may include reports or assessments from referral sources, consultants, or other external sources; medication history; and summary information related to a person's participation in the program that is provided to stakeholders upon the person's transition or exit.

2.E. **13. The program identifies:**

- **a. The individual(s) who has the responsibility and authority to manage key components of the program.**
- **b. The skills and competencies required to perform as a program manager.**

Examples

A program may have more than one position identified as leadership. There may be job descriptions that identify responsibilities and competencies for the leadership.

2.E. **14. The organization:**

a. Considers the individual preferences of those served when selecting direct care personnel.

b. Addresses the input of persons served on an ongoing basis.

Intent Statements

Striving to address the preferences of the persons served is key to person-centered care.

Examples

The program may consider individual preferences in the assignment of caregivers; e.g., a female person served may prefer a female caregiver.

The person served may provide favorable feedback on a new caregiver and request that caregiver as many days during the week as possible. Similarly, the person served may provide input about replacing a caregiver that has been assigned.

2.E. **15. Personnel are consistently assigned to the persons served to meet their needs.**

Intent Statements

Strong relationships are central to quality care for persons served and families/support systems. Consistent assignment, which may also be called primary assignment, means that persons served see the same caregivers almost every time the caregiver is on duty. While not excluding a system of rotation, consistent assignment benefits both the persons served and personnel in the following ways:

- Prevents confusion of the persons served about the identity of their caregivers.
- Builds and maintain relationships.
- Decreases stress.
- Increases caregiver retention.
- Enhances caregiver knowledge.

Examples

A full-time caregiver may be assigned the same persons served for the five days the caregiver is scheduled to work. If supports are also provided on the two days of the week that caregiver is not scheduled, the same part-time caregiver works with those persons served. By implementing this approach, the persons served have relationships with two caregivers who know them well rather than having multiple caregivers who may rotate daily and not know their preferences.

In a small program all personnel may consistently work with all persons served through daily interactions.

During the initial orientation and training period, personnel work on a variety of assignments in order to meet each person served as well as other personnel. After the initial rotation, the new personnel are assigned to support the same persons served.

Programs may have a system whereby assignments of individual personnel are rotated to enhance the expertise of personnel in all areas. If such a system is used, the persons served are notified before a rotation ends and are introduced and oriented to any new personnel assigned to provide support.

When scheduling does not permit consistent assignments, caregivers demonstrate to the persons served that they have knowledge of other team members' work in a coordinated fashion. If a program utilizes temporary, contract, or per diem personnel, it strives for maximum consistency and continuity of care through personnel assignments and scheduling.

2.E. **16. To fulfill the program's commitment to respond to the changing needs of the persons served, education is provided:**

- **a. To:**
  - **(1) Personnel.**
  - **(2) Volunteers.**
- **b. On:**
  - **(1) Indications that the status of the person served has changed.**
  - **(2) How to respond to information about persons served that may be reported by other sources.**
  - **(3) How to protect the privacy of the persons served.**
  - **(4) How to protect the dignity of the persons served.**
  - **(5) How to, on an ongoing basis:**
    - **(a) Observe for changes in persons served.**
    - **(b) Communicate observed or reported changes.**

Examples

16.b.(1) Examples of indications that the status of the person served may have changed include:

- A person served might not be able to communicate needs as clearly or may have more difficulty completing activities of daily living.
- It may be reported that 911 was called to respond to the smoke detector/fire alarm sounding in an apartment due to the oven being left on and burning food.
- Personnel might notice that a person served is no longer able to care for a pet and the pet is soiling the home to the point that there is significant odor.
- Personnel may observe that a person served is having more difficulty eating and safely swallowing solid foods.

16.b.(2)–(3) Education might address if caregivers notice a significant change in a person served, they know to share that information with their manager. The education might also address key privacy considerations such as how such information is shared with the manager and not shared with other personnel.

2.E. **17. When a person served:**

- **a. Exhibits early signs of aging-related decline or dementia, the program makes recommendations for further evaluation to the case manager responsible for the person's healthcare.**
- **b. Has a confirmed diagnosis:**
  - **(1) If the scope of the program can support the person to remain and age in place, the individualized planning process incorporates any new needs identified.**
  - **(2) If the scope of the program cannot support the new needs:**
    - **(a) Appropriate transition planning is initiated.**
    - **(b) Transfer of information occurs to support successful transition.**

Examples

Alzheimer's disease and related dementias are debilitating conditions that impair memory, thought processes, and functioning, primarily among middle-aged and older adults.

F. Service Delivery Using Information and Communication Technologies

Description

Based on the individual plan for the person served, the use of information and communication technologies (ICT) allows personnel to see, hear, and/or interact with persons served, family/support system members, and other organizations in or from remote settings (i.e., the person served and personnel are not in the same physical location). 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, virtual meeting, virtual services, remote monitoring, etc.).

The provision of services via information and communication technologies may:

- Include services such as assessment, individual planning, monitoring, prevention, intervention, family services, transition planning, follow-up, supervision, education, consultation, and counseling.
- Involve a variety of personnel such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, dieticians, employment specialists, direct support professionals, peer support specialists, rehabilitation engineers, assistive technologists, teachers, and other personnel providing services and/or supports to persons served.
- 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.
- Be provided via fully virtual platforms.

The quality and integrity of services delivered via ICT should be comparable to services provided face to face.

The use of technology for strictly informational purposes (such as having a website that provides information about the programs and services available, meeting reminders, or service delivery scheduling) or the use of self-directed apps is not considered providing services via the use of information and communication technologies.

Applicable Standards

If the program uses information and communication technologies (ICT) to deliver services, Standards 2.F.1.–7. apply.

2.F. **1. The program 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 the use of information and communication technologies versus in-person services:**
    - **(a) At the beginning of services.**
    - **(b) Throughout the course of services.**
- **b. To confirm that all necessary technology and/or equipment is available and functions:**
  - **(1) Prior to the start of service delivery.**
  - **(2) As needed throughout services.**
  - **(3) At the location of the:**
    - **(a) Person served.**
    - **(b) Provider.**
- **c. To verify at each encounter:**
  - **(1) The identity of the person served.**
  - **(2) The identity of the provider.**
  - **(3) The physical location of the person served.**

d. To maintain privacy during the delivery of services.

e. To respond to technology disruption that impacts the delivery of services.

Intent Statements

1.a.(1) The program implements written procedures that describe the method(s) used to obtain consent of the person served and that satisfy its regulatory and payment requirements. Although the program may have already obtained consent for service delivery, this standard is specifically about obtaining consent to participate in service delivery using information and communication technologies.

1.a.(3) Decision making about whether the use of information and communication technologies is appropriate for a person served considers the person's preferences, initial and ongoing assessments, including any risk assessments, under what circumstances it is safe and effective to deliver services at a distance, and reasonable expectation of the person benefiting from services delivered this way. While it may be determined that service delivery via information and communication technologies is appropriate at the beginning of services, it is important to revisit decision making throughout services to address changes in the condition or circumstances of the person served or the service delivery site and the need for in-person (i.e., the person served and provider are in the same physical location) contact.

1.c.(3) Identifying the physical location of the person served is critical should an urgent situation arise that requires response to that location. Based on the identified location of the person served, personnel may also assess whether the service can be delivered safely where the person served is located. The information may also be used in verifying the credentials of a provider to deliver services in the location of the person served and for billing purposes.

1.d. Maintaining privacy during the delivery of services includes the person served and the provider. If the person served is in a location where privacy may be compromised (e.g., a public library or community center, walking outside, on the job, at home with young children who require supervision), the program addresses the importance of privacy and makes an effort to help problem solve and identify alternatives with the person served. As personnel also could be providing services from locations that are susceptible to losses of privacy, they should take steps to protect the privacy of the persons served in their environment.

1.e. Identifying a back-up method for communication will reduce the impact of technology disruption such as hardware or software failure or environmental conditions on service delivery.

Examples

1.a.(1) The procedures may include obtaining consent to participate in service delivery via information and communication technologies in writing, obtaining consent from a parent or other legal representative, and obtaining consent via virtual platform when applicable.

1.a.(3) The procedures may include regular timeframes/intervals to consider decisions regarding service delivery via information and communication technologies or criteria that trigger reassessment under specific conditions.

Information and communication technologies may be used for remote monitoring of a person served. For example, the individual plan might include:

- Biometric monitoring of persons with chronic conditions, such as monitoring of weight, blood pressure, or heart rate, to allow assessment of stable health or the need for medical attention.
- Motion sensors in someone's home that indicate how much/when a person is up and about, may be in need of help, or may have left the home without the supervision necessary to be safe.
- Case management/service coordination visits via computer or other electronic device for routine communications.
- Interactive voice response, such as someone with diabetes or a heart condition who reports symptoms telephonically by responding to prerecorded questions. Certain answers prompt an alert to be sent to a service provider who can follow up with the person as needed.

- Personal emergency response systems, such as a pendant or bracelet worn by a person served. When the button is pushed or when the device senses a fall an emergency alert is transmitted to a predetermined contact to respond.

In addition to risks related to the status of the person served, the use of information and communication technologies may present risks such as access to or the reliability of technology, equipment, and the internet; receptivity and understanding of the person served regarding the use of technology and equipment; availability, support, and/or interference of members of the family/support system; or safety and/or privacy of the location of the person served during service delivery.

1.b.(2) There may be a need to confirm availability and/or function during the course of services if new technology or equipment is being implemented, there have been problems with the technology or equipment during prior encounters, or someone new will be responsible for operating the equipment or technology.

1.c.(1) Verification of the identity of the person served may be accomplished a variety of ways including asking the person's name, accessing a picture in the record of the person served for comparison, voice recognition from a prior encounter, or asking the person to show a picture ID that includes his or her name.

2.F. **2. As appropriate, personnel who deliver services via information and communication technologies receive documented competency-based training on:**

a. How to deliver services effectively via information and communication technologies, including:

(1) Human factors.

(2) Crisis response procedures.

(3) Assessment of risk factors in the environment of the person served.

(4) How to modify treatment techniques/interventions to deliver services virtually.

b. Equipment used in service delivery, including hardware and software:

(1) Features.

(2) Setup.

(3) Use.

(4) Maintenance.

(5) Safety considerations.

(6) Infection control.

(7) Troubleshooting.

Intent Statements

For service delivery to be effective, personnel are trained how to deliver or adapt services at a distance, how to use the equipment and technology needed to deliver those services, and how to guide persons served, members of the family/support system, and others in the location of the person served on their use.

2.a.(2) Responding to a crisis when the person served is in a different location requires a different skill set than responding in person. Regardless of the activity occurring, a person served could experience a medical emergency, a fall or other injury, a medication error, suicidal ideation, threat from another person at the location, or other crisis that requires immediate attention. Comprehensive training on crisis response procedures helps prepare personnel who provide services via information and communication technologies to effectively and efficiently respond to the needs of a person served who experiences a crisis during an encounter.

2.a.(4) Most providers have been trained to deliver services, treatment, and/or interventions in person. With the increasing and, in some cases, exclusive provision of services using information and communication technologies, providing personnel with training on how to modify and adapt treatment techniques/interventions is essential to effective service delivery. Depending upon the type of program being provided modifications may range from minor to more substantial.

Examples

2.a.(1) Training on human factors may address strategies for communication with persons served and, if applicable, members of the family/support system who are in a different location than the provider, understanding nonverbal communication, establishing rapport, maintaining eye contact, and providing a conducive environment including lighting, background, and staying framed in the field of the camera.

2.a.(2) Training on crisis response procedures may include how to identify a crisis situation, assessing the situation and the associated level of risk, identifying and implementing a response, and reporting and following up on the situation as appropriate.

2.a.(3) Personnel are trained to observe and assess risks in the environment of the person served, which will vary depending on the type of program and persons served. For example, a provider may observe:

- Someone in the environment of the person served who speaks or otherwise behaves in a way that seems threatening to the person served; nonverbal communication on the part of the person served signaling a threat; new bruising, cuts, or other signs of injury; etc.
- Trip hazards such as rugs, electrical cords, spills, or clutter for someone with balance, sensory, or ambulation concerns or who uses equipment such as a walker, cane, or wheelchair.
- Guns, knives, or other items that could cause harm to the person served.
- Medications that are not properly stored/secured.
- Lack of supervision for someone with cognitive impairment.

2.b.(6) Infection control addresses equipment used at the location of the person served and the provider. 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 handwashing 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.

2.F. **3. As appropriate, instruction and training are provided:**

a. To:

(1) Persons served.

(2) Members of the family/support system.

(3) Others.

b. On equipment used in service delivery, including:

(1) Features.

(2) Setup.

(3) Use.

(4) Maintenance.

(5) Safety considerations.

(6) Infection control.

(7) Troubleshooting.

c. On creating an appropriate environment to receive services.

Examples

3.c. Environmental considerations include:

- Being in a location that is safe, e.g., indoors if the weather is bad, parked if sitting in a car, in an area that is lit if outside and it is after dark.
- Being in a location that provides privacy, whether at home, work, or in a community setting such as a library, school, or community center.
- Access to the necessary technology, equipment, and internet service to successfully connect.
- Human factors as outlined in the example for Standard 2.a.(1).
- Expectations such as being on time and having equipment or materials prepared for sessions that are scheduled.

2.F. **4. Service delivery via information and communication technologies includes:**

- **a. The provision of information to the persons served on:**
  - **(1) How to contact the program.**
  - **(2) The expected timeframe for response.**
- **b. Personnel to provide technical assistance with accessing services provided by the program.**
- **c. Personnel to address questions related to service delivery.**
- **d. Based on identified need:**
  - **(1) An appropriate facilitator at the location of the person served.**
  - **(2) Modification to:**
    - **(a) Treatment techniques/ interventions.**
    - **(b) Equipment.**
    - **(c) Materials.**
    - **(d) Environment at the location of the person served, including:**
      - **(i) Accessibility.**
      - **(ii) Privacy.**
      - **(iii) Usability of equipment.**

Examples

4.a. The program provides information to the persons served on how to contact the program and when persons served may expect a response. This may be information on program hours of operation, methods persons should use to contact the program when they have specific needs, the typical timeframe in which the persons served can expect a response to inquiries, and whether contacts will returned in evenings or over weekends.

4.c. Between scheduled sessions persons served and others who may be assisting them might have questions related to their individual plans, e.g., regarding medication use; a home exercise program; assisting with transfers; or how to contact other providers, vendors, or support services.

4.d.(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. Use and selection of a facilitator also consider the preferences of the person served and who can provide appropriate support or may pose challenges to the delivery of services, e.g., a family member who tends to speak for the person served or is otherwise disruptive during service delivery.

4.d.(2) Examples of modifications include the use of assistive technology such as alternative keyboards and headphones, close-captioning software, a sign language interpreter, materials in large font or braille, the use of appropriate lighting and backgrounds so faces can be clearly seen, and the provision of printed materials and audio recordings to supplement information provided during an encounter.

4.d.(2)(d)(ii) Privacy considerations may include whether the environment where the person served is located provides for confidentiality during interactions between the provider and person served.

2.F. **5. Prior to the start of each session:**

- **a. Any participants in the session in addition to the person served are identified.**
- **b. The program provides information that is relevant to the session.**

Examples

5.a. In addition to the person served and provider, other participants in the session may include members of the family/support system, caregivers or others who are assisting the person served; other members of the service delivery team; a supervisor who is observing the provider; and students or other trainees.

5.b. Information may be shared on the credentials of the provider, structure and timing of services, recordkeeping, scheduling, contact between sessions, privacy and security, potential risks, safety considerations, confidentiality, billing, rights and responsibilities.

Service delivery using information and communication technologies may be ongoing rather than session-based, e.g., supporting persons served in their living environment through the

use of video, audio, or motion monitoring. In addition to sharing relevant information about the use of ICT at the initiation of services, the program may establish a minimum frequency, such as at least annually, to review that information; may review it based on need, such as when the person served or a member of the family/support system has questions; or may link it to other activities in the service process such as periodic review of the person's individual plan, goals, and preferences.

2.F. **6. The organization maintains equipment in accordance with manufacturers' recommendations.**

2.F. **7. Emergency procedures address the unique aspects of service delivery via information and communication technologies, including:**

a. Identification of an emergency contact for the person served, including phone number.

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

c. The provider becoming familiar with the emergency procedures at the location of the person served, if the procedures exist.

Intent Statements

In case of emergency, the provider has immediate access to emergency contact information for the person served and information on local emergency resources, including their phone numbers.

Examples

7.a.–b. Through the intake process the program gathers information from the person served on an emergency contact and local emergency resources such as emergency response systems and law enforcement.

7.c. 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.

If a person served who is at home utilizes a medical alert system such as Life Alert, the provider becomes familiar with how the system is activated in case of an emergency.

SECTION 3

Program Specific Standards

NOTE: *An organization seeking accreditation for a Continuing Care Retirement Community only or in combination with other programs in this section must use the Continuing Care Retirement Community Standards Manual. An organization that is not seeking accreditation for a Continuing Care Retirement Community must use the Aging Services Standards Manual.*

A. Adult Day Services

Description

An adult day services program is a nonresidential program that provides supervised care to adults of all ages in a supportive and safe setting during part of a day. Assessments of the persons served and their families/support systems and person-centered plans of care drive the delivery of services. An adult day services program provides or arranges for services that include, but are not limited to, therapeutic activities, nutrition, health and personal care, and transportation.

Adult day services programs typically deliver services through a social model and/or a medical model. Either of these might provide services to specialized populations of persons served.

By supporting family systems, an adult day services program enables the persons served to live and engage in the community and provides the family system with an opportunity to fulfill daily responsibilities and for respite. An adult day services program strives to optimize the dignity, choice, preferences, autonomy, and quality of life of the persons served.

Applicable Standards

An organization seeking accreditation for an Adult Day Services program must meet:

- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- All standards in Section 2.A.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.F. if the program delivers services using information and communication technologies.
- All standards in this Section 3.A.

3.A. **1. If the adult day services program is co-located in an organization housing other services, the adult day services program will have during its operational hours separate designated space.**

Examples

A residential program also operates an ADS program three days a week for community participants. On the days the ADS program operates, the activity space is only used for persons attending the ADS program and guests of program participants.

3.A. **2. The program's role in and use of a continuum of care that is responsive to the needs of the persons served are:**

a. Demonstrated.

b. Documented.

c. Utilized in establishing linkages with community agencies/institutions for coordination of services.

Intent Statements

Programs providing adult day services recognize that they are part of a larger network of available services within the community. Adult day services providers implement strategies for maintaining their connections with other parts of the continuum.

Examples

Programs may have a relationship with a case management group, or hospital or clinics in the area that refer individuals to the program. The program might also have relationships with other providers such as outpatient, home care, transportation, companion services, retirement communities, assisted living and nursing centers to which it refers persons served.

Relationships could be documented through philosophy statements, referral agreements, community collaborative agreements, communitywide health projects and documentation indicating participation in a local networking alliance.

3.A. **3. Documented unit cost data:**

a. Are calculated at least annually as part of the budgeting process.

b. Allow for comparative analysis.

c. Are shared with relevant stakeholders.

d. Are used for business/strategic planning.

Intent Statements

By understanding the actual cost per client day, a program is better prepared to conduct strategic planning, budgeting, contract negotiations, and advocacy efforts.

Examples

Sample Calculation:

Number of Days Open 250

Average Daily Census 14

Total Budget $160,000

Total Budget ÷ Number of Days Open x Average Daily Census = Unit Cost

$160,000 ÷ [250 x 14] = $45.71

An example of how an ADS program may use this information for planning might include examining the difference between reimbursements compared to the actual cost of providing services.

A program calculates unit cost per client day. The Medicaid contract pays less than the unit cost. The program uses this information to identify the amount of supplemental income needed to cover its costs. The program may also share this information with funding authorities, public officials, or other stakeholders to advocate for increased reimbursement.

3.A. **4. To ensure that the family/support system is involved as desired by the person served, the program provides, arranges, or assists with arrangements for services for each family/support system, as needed, including:**

a. Advocacy education.

b. Assistive technology.

c. Counseling/support services.

d. Education.

e. Reasonable accommodations.

f. Respite.

g. Support.

Intent Statements

The program recognizes that the family/support system is essential to enabling persons served to live in the community.

Examples

Services for family/support systems may be in areas of:

- Assistance for the person served with activities of daily living such as bathing.
- Education related to the use of communication technology with a person served who can no longer speak following a stroke.
- Education about managing specific conditions such as high blood pressure, diabetes, cholesterol, and/or dementia, as appropriate.
- Resources to support those with visual or hearing impairment.

3.A. **5. Based on need, the program makes current information available:**

- **a. To the persons served.**
- **b. To families/support systems.**
- **c. Regarding:**
  - **(1) Adult protective services.**
  - **(2) Alternative housing.**
  - **(3) Care management services.**
  - **(4) Community service organizations.**
  - **(5) Crisis intervention programs.**
  - **(6) In-home services, including:**
    - **(a) Home healthcare services.**
    - **(b) Homemaker services.**
  - **(7) Meal delivery services.**
  - **(8) Specialized services unique to the population served.**
  - **(9) Transportation options.**
  - **(10) Well-being and health promotion.**
  - **(11) Other services, as needed or required.**

Intent Statements

The program is aware of resources available in the community that may assist persons served and their families/support systems.

Examples

Programs may maintain a resource library, offer participant/family education, host family council meetings, conduct town hall meetings, post information on a website or in newsletters, and/or make referrals to local agencies.

5.c.(4) Support groups.

5.c.(6)(a) Home healthcare could include in-home services by healthcare professionals, such as nurses or therapists.

5.c.(6)(b) Homemaker services could include light housekeeping, meal preparation, shopping or companion services.

5.c.(8) Mental health, Alzheimer's Association, home safety evaluations, pharmacy delivery, home modification companies.

5.c.(9) Adult day personnel may have a list of available phone numbers for alternative transportation when a participant's regular transportation is not available.

5.c.(11) Hospice, durable medical equipment, hearing aids.

3.A. **6. The program provides education regarding the medications that are administered while the person served attends the program:**

- **a. To:**
  - **(1) The persons served.**
  - **(2) Their families/support systems.**
- **b. That addresses:**
  - **(1) Actions to take in case of an emergency.**
  - **(2) Administration/assistance.**
  - **(3) Dispensing.**
  - **(4) Documentation.**
  - **(5) Errors.**
  - **(6) Identification of medication, including why each medication is given.**
  - **(7) Implications of abrupt discontinuation.**
  - **(8) Implications for management of multiple medications.**
  - **(9) Indications and contraindications.**
  - **(10) Procedures for handling controlled substances.**
  - **(11) Side effects.**
  - **(12) Storage.**

3.A. **7. Current emergency information is available in writing for each person served that includes the person's:**

- **a. Advance directives.**
- **b. Allergies.**
- **c. Behavioral symptoms.**
- **d. Cognitive status.**
- **e. Current diagnoses/conditions and history.**

f. **Emergency contact information.**
g. **Equipment and devices.**
h. **Functional status.**
i. **Hospital preference.**
j. **Healthcare providers involved in care, including contact information.**
k. **Immunization status.**
l. **Insurance information.**
m. **Medications.**
n. **Mental health status.**
o. **Photograph (for identification of the person served).**
p. **Prosthetics and orthotics information.**
q. **Risk factors.**
r. **Vision and hearing.**

Intent Statements

Information that is portable is important in emergency situations. An individual's information may be available in paper or electronic format. The program should have a process to ensure that emergency information is updated as needed to remain current.

Examples

7.c. Behavioral symptoms may include a person with diabetes who demonstrates a more aggressive manner when blood sugar is low or a person who paces when frustrated with an activity. This information is helpful to personnel so that they may respond appropriately to emergencies.

3.A. **8. Policies addressing the following are implemented:**

a. **Requirements for services arranged by the person served.**
b. **Pets.**
c. **Service animals.**
d. **Smoking.**
e. **Guests.**

Examples

8.a. Persons served may have an individual attendant or other support provided during the hours they attend the adult day center. The policy may require that aides/attendants hired by the person served have background checks, while this may not be necessary for guests identified in element e.

8.b. A policy regarding pets may address:

- Whether or not the program allows persons served to bring their pets to the center.
- When the program invites family members and/or volunteers to bring pets for persons served to enjoy.
- Responsibilities for pet care, including feeding and walking while the person served attends the program, and options for assistance with those responsibilities if needed.
- Requirements for pet vaccinations and other vet care in order for the pet to be on-site at the program.

8.c. A policy regarding service animals may address which types of animals are allowed, if there are any distinctions between service animals and comfort animals, and other related considerations.

B. Assisted Living

Description

Assisted living is a residential program that provides meals, housing, and a range of hospitality and personal care services for adults of all ages in a supportive and safe home-like setting. Assisted living strives to optimize the dignity, choice, preferences, autonomy, engagement in life roles, and quality of life of the persons served. The program might provide services for specialized populations of persons served.

Assisted living offers a culture of customer service and hospitality as well as an environment of safety and security for persons served. A philosophy of independence, engagement, and wellness guides the communications between personnel and persons served in assisted living.

Assessments of the persons served and their person-centered plans drive service delivery. Coordination of care and care delivery are conducted in accordance with applicable regulations for the assisted living program. Staffing is provided 24 hours a day, 7 days a week. A variety of services ranging from minimal to intensive assistance with activities of daily living such as bathing, dressing, eating, grooming, mobility, toileting, and assistance with medications may be available, as well as referrals to external services. Assisted living programs may provide some health services and intermittent nursing care. Additionally, these programs may offer housekeeping, laundry services, medication management, recreation programs, and transportation.

Assisted living programs are provided in a variety of settings from a small home with just a few individuals to a high-rise building housing many individuals. Individual living accommodations can be private or shared and include a single room or a full-size apartment. Assisted living may have different names in different jurisdictions.

Applicable Standards

An organization seeking accreditation for an Assisted Living program must meet:

- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.D.
- All standards in Section 2.F. if the program delivers services using information and communication technologies.
- All standards in this Section 3.B.

3.B. **1. To help stakeholders determine whether, related to its scope of services, the program can meet the needs of the person served, the program documents information about the characteristics of the population it can effectively serve, including:**

a. Ages.
b. Activity limitations.
c. Behavioral status.
d. Cultural needs.
e. Medical conditions.
f. Participation restrictions.
g. Psychological status.

Intent Statements

This standard expands on Standard 2.A.1., which addresses the scope of the program. The assisted living program should document its scope regarding characteristics of the persons served and share this information with all groups identified in that standard.

3.B. **2. The program demonstrates the involvement of the following individuals in the person-centered plans of the persons served:**

a. The person served.
b. Treating physicians.

c. **Healthcare professionals.**
d. **Members of the family/support system, as appropriate.**
e. **Other stakeholders, as appropriate.**

Examples

In order to develop an integrated plan for the person served, the groups identified may be involved based on the choice of the person served. Involvement of physicians may mean that they are consulted by phone or in a meeting to provide important information to guide person-centered planning. Other professionals such as nutritionists or therapists may also be involved in planning meetings or they may be consulted for key information related to their work with the person served.

3.B. **3. The program addresses coordination of services for spouses/significant others, when appropriate.**

Examples

Services for spouses/significant others recognize the importance of these individuals in the life of the person served. Such services are directed toward spouses/significant others who are also being served in the program at another level of care or at the same level of care and could include opportunities for spouses to attend social events or trips with the person served. They may also include opportunities for both parties to dine together regularly, to participate in person-centered planning discussions, or to have private space for personal communication.

3.B. **4. The rhythm of daily life is directed by each person served, as demonstrated by:**

a. **Freedom to make choices regarding the cycle of each day, including:**
   (1) **Bathing.**
   (2) **Dressing.**
   (3) **Eating.**
   (4) **Hygiene.**
   (5) **Oral care.**
   (6) **Sleeping.**
   (7) **Waking.**
b. **Choice of clothing.**
c. **Choice of grooming style.**
d. **Each person's choice to participate in personally meaningful customary routines, including, but not limited to:**
   (1) **Cleaning.**
   (2) **Community activities.**
   (3) **Contact with pets.**
   (4) **Cooking.**
   (5) **Exercise/mobility activities.**
   (6) **Gardening.**
   (7) **Hobbies.**
   (8) **Intimacy.**
   (9) **Recreation.**
   (10) **Social interaction.**
   (11) **Spiritual/religious activities.**

Intent Statements

Individuals in assisted living direct the rhythm of their daily life. From rising in the morning to retiring in the evening, the choice of the daily routine is determined by the person served. It is not dictated by the convenience of the personnel or by a schedule designed to create efficiency. Being able to accommodate the person's rhythm of daily living is a hallmark of assisted living. Residents should not have to give up everything they are accustomed to when entering assisted living. Participating in the life of the community while maintaining their daily routine is crucial for their quality of life. Living in a community always includes the freedom to exercise individual rights and respect for the rights of others.

Examples

Persons served can be afforded opportunities to continue activities they enjoyed prior to moving to assisted living as well as to pursue activities that will support their growth and development. Some examples of these might include:

- Choosing when to wake up, nap and retire.
- Choosing the schedule for completing their ADLs.
- Participating in meal preparation.
- Creating a garden of flowers or vegetables for use in the community.
- Caring for or simply enjoying the companionship of pets.

- Continuing to participate in the Rotary, League of Women Voters, church clubs, etc.
- Tutoring students in English as a second language (ESL).
- Assisting personnel with tax preparation.
- Engaging in intimacy with a spouse or significant other.
- Enjoying familiar recreational activities.
- Learning a new hobby or skill.
- Encouraging opportunities for the resident to engage in meaningful work, if desired.
- Engaging in meaningful interactions with other residents, personnel, and members of the local community.

Persons served who wish to do so can be encouraged to participate in the daily routine of their community by continuing to do the things they did at home (e.g., setting the table, dusting, doing laundry, gardening, woodworking).

3.B. **5. The program addresses 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 specific age or developmental need.

d. Fatigue.

e. Signs and symptoms of emergent medical or psychological conditions.

f. Sleep.

Intent Statements

The service delivery team should be able to describe and provide examples of how they provide services to individuals based on consideration of these areas and be prepared to describe specific examples with individual persons served as well as more global examples regarding the population they serve in the assisted living program.

Examples

5.c. If a person served has Parkinson's disease, the program is knowledgeable about the anticipated course of this disease and how it might impact the way the assisted living program would provide services to the individual. If the individual has congestive heart failure, the course of this condition might prompt diet, medication monitoring, medical checkups, and other areas of service delivery.

5.e. Sometimes swelling can indicate a problem such as heart, liver, or kidney disease. Skipping meals or lack of participation in activity programs can be a symptom of depression. Getting lost within the campus on a regular basis or going to the wrong apartment or unit regularly might be a sign of dementia.

3.B. **6. The program implements policies and procedures that address PRN (as needed) medications, including:**

a. Identification of need.

b. Timely administration.

c. Follow up on effectiveness.

Intent Statements

Policies and procedures regarding medications taken on an "as needed" basis rather than on a regular schedule help organizations implement appropriate practices to identify when the medications should be given so that persons served may benefit from these medications.

3.B. **7. In collaboration with the person served, the team assesses options for:**

a. Medication storage.

b. Medication administration.

c. Timing of administration.

d. Location of administration.

e. Self-administration.

f. Over-the-counter medications.

g. Complementary health approaches.

Intent Statements

Within applicable law and regulation, persons served participate with personnel in decisions about self-medication including medication storage, timing, and location. Persons served wishing to continue their use of over-the-counter medications and herbal remedies are given the opportunity to do so after it has been determined it will not negatively affect prescribed medications.

Examples

7.f. Over-the-counter medications may include a daily dose of aspirin; supplements such as fish oil, lemon balm, echinacea; and vitamins such as vitamin C, calcium, or others in doses that can be purchased at a grocer.

7.g. Complementary health approaches may include the use of herbal remedies, essential oils, complementary therapies, and cultural practices. The use of complementary health approaches may be addressed between the person served and the person's physician. The program does not need to offer or provide complementary approaches; however, if the person served pursues such options, the program may work with the person to determine options for these approaches within the program.

3.B. **8. As indicated by the person-centered plan, the program implements a process for scheduled safety checks of the persons served.**

Intent Statements

Person-centered plans should identify service needs and necessary supports for persons served so that scheduled safety checks are used when needed for individuals. To this end, scheduled safety checks are implemented so that organizations may keep a "watchful eye" on behalf of persons served while continuing to respect their privacy and self-determination.

Examples

There are a growing number of technology-based solutions that support resident safety checks, including voice-activated assistance and passive monitoring systems such as motion detectors or pressure-activated devices that record when a person gets in and out of bed.

Visits to persons served might occur if they miss one or more scheduled meal times that they generally attend.

If a person does not leave for an appointment or other outing when scheduled to do so, personnel may stop by the individual's unit to make sure everything is all right.

3.B. **9. The program:**

a. Has written indicators to measure the following:

(1) Falls.

(2) Well-being.

b. At least annually addresses:

(1) Performance in relationship to established targets in the following areas:

(a) Falls.

(b) Well-being.

(2) Trends.

(3) Actions for improvement.

(4) Results of performance improvement plans.

(5) Necessary education and training of:

(a) Persons served.

(b) Families/support systems.

(c) Personnel.

Intent Statements

Programs can benefit from measuring falls and a well-being-related topic of their choosing. In order to use measurements for performance improvement, targets for falls prevention and enhancement of well-being can be established. This standard is focused on measurement for the program as a whole rather than for each individual person served.

3.B. **10. As appropriate to their roles, the program provides training for personnel:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes information on:**
  - **(1) Aging process.**
  - **(2) Dementia.**
  - **(3) Disease management.**
  - **(4) Fall prevention.**
  - **(5) Pain management.**
  - **(6) Safeguarding health records.**
  - **(7) Topics identified by:**
    - **(a) Persons served.**
    - **(b) Personnel.**
  - **(8) Work place violence.**
  - **(9) Working with external entities.**

Intent Statements

The organization determines which topics personnel need in accordance with their job responsibilities. Not all personnel may need to be educated on all topics.

3.B. **11. The program implements written procedures that address:**

- **a. Conducting criminal background checks of all personnel.**
- **b. Timeframes for criminal background check verification, including:**
  - **(1) Prior to the delivery of services to the persons served.**
  - **(2) Throughout employment.**
- **c. Actions to be taken in response to the information received.**

Intent Statements

This standard relates to Standard 1.I.5. 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 cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

3.B. **12. To advance the field of assisted living, leadership supports the program's participation in research opportunities.**

Intent Statements

It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc. Regional, state, and national provider associations often facilitate or share information about research opportunities.

3.B. **13. Current emergency information is readily available in writing for each person served that includes, as applicable:**

- **a. Advance directives or end-of-life issues.**
- **b. Allergies and sensitivities.**
- **c. Behavioral symptoms.**
- **d. Cognitive status.**
- **e. Current diagnoses/conditions and history.**
- **f. Emergency contact information.**
- **g. Equipment and devices.**
- **h. Functional status.**
- **i. Healthcare providers involved in care, including contact information.**
- **j. Communication needs.**
- **k. Hospital preference.**
- **l. Immunization status.**
- **m. Insurance information.**
- **n. Legally appointed decision maker(s), including contact information.**
- **o. Medications.**
- **p. Mental and behavioral healthcare providers involved in care, including contact information.**
- **q. Mental health status.**
- **r. Photograph (for identification of the person served).**
- **s. Prosthetics and orthotics information.**
- **t. Risk factors.**
- **u. Spiritual preferences.**
- **v. Vision.**

Intent Statements

Information that is portable is important in emergency situations. An individual's information may be available in paper or electronic format. The program should have a process to ensure that emergency information is updated as needed to remain current.

Examples

13.c. Behavioral symptoms may include a person with diabetes who demonstrates a more aggressive manner when blood sugar is low or a person who paces when frustrated with an activity. This information is helpful to personnel so that they may respond appropriately to emergencies.

C. Person-Centered Long-Term Care Community

Description

Person-centered long-term care communities, such as nursing homes or long-term care homes, may include freestanding homes, homes that are part of continuums of care, or homes that are part of health systems. Person-centered long-term care communities are residential programs that provide nursing and other services 24 hours a day, 7 days a week. Programs may offer long-term services, short-term services, or both to address a variety of needs.

Person-centered long-term care communities foster a holistic culture that focuses on:

- Autonomy, dignity, and individual choice of the persons served.
- Relationships among persons served, families/support systems, and personnel.
- Understanding what services persons served want, how the services should be delivered, and how the persons served can be engaged in the community.
- Persons served making decisions about the rhythm of their day, the services provided to them, and the issues that are important to them.
- Cultural competence, flexibility, and safety and security of the community.

Persons served are the experts regarding life in their home. Their voices are heard and their life stories, wishes, and needs drive service delivery. Persons served and personnel celebrate the cycles of life and connect to the local community to continue relationships that nurture the quality of everyday life.

Leadership commits to continuous learning and growth, teamwork, empowerment, responsiveness, and spontaneity. A person-centered long-term care community is a place where persons served want to live, people want to work, and both choose to stay.

Applicable Standards

An organization seeking accreditation for a Person-Centered Long-Term Care Community program must meet:

- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.D.
- All standards in Section 2.F. if the program delivers services using information and communication technologies.
- All standards in this Section 3.C.

3.C. **1. A person-centered philosophy:**

a. Is documented.

b. Addresses, at a minimum:

(1) Autonomy in decision making.

(2) Choice.

(3) Cultural competence.

(4) Flexibility.

(5) Holistic service delivery.

(6) Individuality.

c. Is modeled by:

(1) Leadership.

(2) Personnel.

(3) Persons served.

d. Guides service delivery.

e. Is communicated in an understandable manner to stakeholders:

(1) Either prior to or at the time of entry to the program.

(2) On an ongoing basis.

f. Is reflected on an ongoing basis in the engagement of stakeholders.

Intent Statements

A PCLTCC has a written statement expressing its dedication to the person-centered philosophy. Leadership establishes a climate where personnel and persons served are free to engage in practices supported by person-centered philosophy. Persons served experience quality of life with an emphasis on meaningful engagement. This philosophy is emphasized at all levels of the program.

Examples

1.a. The dedication to person-centered philosophy can be expressed in the program's written mission, vision, or values statement. The written statement could also be in a variety of other materials, such as a prospective participant information brochure or packet, admissions packet, contract, admissions agreement, residence and care agreement, life lease, or participant agreement.

1.b.(1) Autonomy in decision making may include deciding to participate in a wellness program, choosing clothing for the day, or determining who comprises the family and support system.

1.b.(5) Holistic service delivery involves maintaining the highest quality of life for persons served, including their physical, emotional, social, spiritual, and mental health. This can be achieved through a comprehensive program of services.

1.c. Leadership may model the person-centered philosophy by encouraging relationships between persons served and personnel. Personnel partner with persons served to make decisions on service delivery. Persons served feel comfortable taking requests to personnel and feel confident that their requests will be honored.

3.C. **2. Appropriate placement of each person served is addressed through:**

a. The entry criteria.

b. The transition criteria.

c. The exit criteria.

d. The resources available.

e. Any resources previously used.

f. Initial and ongoing screenings/assessments.

g. The person's potential to benefit.

h. The person's personal preferences.

Intent Statements

This standard focuses on how information about the long-term care program is used to help ensure that the persons served are in the right setting to address their needs. The organization should be able to discuss how information regarding when it is appropriate for a person served to move into a long-term care setting, when it may be necessary for that individual to transition to a higher level of care within the organization or outside of the organization, and under what circumstances it would be necessary for a person served to leave the long-term care organization is used to make such decisions. Even though referral sources and funders may be involved in placement of persons served, organizations should demonstrate their role in this process because they are ultimately accountable for providing appropriate care.

Examples

2.e. Previously used resources might include whether the person served received physical therapy and would continue to need this service when in long-term care.

3.C. **3. The program shares written information about its specific arrangements for the following services:**

- **a. Behavioral health.**
- **b. Diagnostic.**
- **c. Laboratory.**
- **d. Medical.**
- **e. Pharmacy.**
- **f. Recreation and leisure.**
- **g. Rehabilitation.**
- **h. Social.**
- **i. Spiritual.**
- **j. Including for each:**
  - **(1) Availability on site.**
  - **(2) Capacity.**
  - **(3) Timeliness of response to orders.**
  - **(4) Timeliness of results to the clinician who is making a decision based on those results.**

Intent Statements

In making decisions about where and how to seek services, persons served should be aware of how various services may be accessed. Referral sources can also benefit from clarity so that they are able to ensure appropriate placement for persons served. Services may be provided directly by the program, arrangements may be made to obtain the services from a contracted agency, or a referral to another provider might be made.

Examples

Information about services may be included in a handbook, on a website, in fact sheets, or in other materials. Information may be shared with referral sources and persons served via meetings, tours, phone calls, or one-on-one discussions.

3.g. Rehabilitation could specify physical, occupational, speech-language, or other types.

3.h. Social might include social work or social services.

3.j. For each type of service listed, the program indicates whether the person served may obtain services at the long-term care program or have to be transported to another location to receive the service. Capacity may refer to the space, equipment, or personnel who provide the service. Timeliness of response to orders and timeliness of results to the clinician might give information about how long the steps take to activate the service once it is ordered, prescribed, or determined necessary.

3.C. **4. The initial and ongoing screening/assessment process for the persons served includes:**

- **a. Gathering information on the persons served, including their:**
  - **(1) Important memories and favorite stories.**
  - **(2) Life routines.**
  - **(3) Life roles.**
  - **(4) Family/support system.**
  - **(5) History.**
- **b. Sharing information gained with team members.**

Examples

For persons served who are not able to communicate this information, members of their families/support systems might be involved in this process.

3.C. **5. There is identification and celebration of life-cycle events that are important and meaningful to:**

a. Persons served.

b. Families/support systems.

c. Personnel.

Intent Statements

The PCLTCC takes opportunities to celebrate together events that have meaning in the lives of the persons served and their families/support systems.

Examples

As part of the information shared when a person moves in, persons served are asked about important events throughout the year that they typically celebrate.

Families are encouraged to inform personnel about upcoming events that are special to the person served.

Families and friends are invited and participate in birthdays/anniversaries for each person served.

Milestone events in the lives of persons served are planned for and celebrated with personnel and the persons served.

Families are encouraged to celebrate family events in the community with their loved ones and friends.

3.C. **6. On an ongoing basis, the program:**

a. Assesses the capacity of persons served to make decisions.

b. Educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.

c. Facilitates discussion for decision making.

d. Minimizes barriers to decision making by the persons served.

e. Documents discussions and decisions made by the persons served in their records.

Examples

6.a. Assessment of decision-making capacity may be done in consultation with the family/support system and/or in consultation with or by the physician to ensure that the assessment is done correctly.

3.C. **7. The long-term care program addresses risk reduction for each person served through:**

a. Written assessment of potential risks in the following areas:

(1) Behavior.

(2) Cognition.

(3) Communication.

(4) Dental.

(5) Function.

(6) Health.

(7) Physical.

(8) Medication.

(9) Nutrition.

(10) Pain management.

(11) Psychosocial.

(12) Recreation and leisure.

b. Actions to mitigate identified risks.

Examples

7.a.(6) Assessing risk of urinary tract infection can reduce any potential impacts on overall health including cognition and subsequent safety awareness.

3.C. **8. The program demonstrates an ongoing process to:**

a. Educate the persons served that they have choice.

b. Document the preferences of the persons served.

c. Communicate with all relevant stakeholders the preferences of the persons served.

d. Implement person-centered plans in accordance with the preferences of the persons served.

Intent Statements

To achieve a person-centered culture, leadership and personnel are able to show how, on an ongoing basis through various approaches, the possibility of making choices and communicating preferences is firmly embedded in how services are provided.

3.C. **9. The program fosters a relationship-centered culture in which the persons served and all personnel are empowered to make decisions in partnership based on the preferences, strengths, and needs of the person served.**

Intent Statements

A relationship-centered culture is inherent to person-centered care. It is focused on establishing positive, meaningful interactions between persons served and personnel to enhance quality of life and quality of care. Persons served are empowered, in accordance with their skills and abilities, to make decisions. Relationships help to ensure that individuals have a better understanding of one another.

3.C. **10. Based on the individual needs of the persons served, the long-term care program provides or arranges for:**

a. Health promotion.

b. Services that prevent illness.

c. Health screenings.

d. Disease management.

Examples

10.a. Health promotion is the process of helping people to take control of their lives so that they can choose options that are health giving rather than those that are health risky, such as reducing sugar intake, exercising, drinking plenty of water, washing hands regularly, or other behaviors.

10.b. Services might include annual shots to prevent flu and/or pneumonia.

10.c. Health screenings could be events or activities set up to support health promotion. They could include mammography screenings, dental screenings, blood pressure testing or other types of screenings.

10.d. Disease management could refer to a system of coordinated interventions where self-care efforts are significant in managing chronic conditions. Examples of disease management include an individual with diabetes receiving regular blood sugar monitoring or an individual with asthma receiving regular breathing treatments to avoid acute asthma episodes.

3.C. **11. In accordance with the preferences and choices of the persons served and their families/support systems, the program provides opportunities that encourage:**

a. Social contacts:

(1) Within the program.

(2) External to the program.

b. Relationships:

(1) Within the program.

(2) External to the program.

Intent Statements

The program supports persons served in developing, maintaining, and/or increasing their social contacts and relationships with family members, friends, and significant others both within and external to the organization.

Boundaries are established as appropriate for personal relationships between persons served and between persons served and personnel.

Examples

Families are invited to share meals with persons served.

Persons served are encourage to invite friends to visit and share a meal.

As desired, persons served exchange emails and/or use technology to visit at a distance.

3.C. **12. The program demonstrates the ability to incorporate sensory stimulation into the person-centered plan for those with dementia.**

Intent Statements

Sensory stimulation for persons served with dementia has been shown to decrease agitation and restlessness as well as improve sleep. These

symptoms are very common in most forms of dementia, and certainly in people with Alzheimer's, so sensory stimulation results in improved quality of life for the persons served as well as for caregivers. The program should be prepared to describe examples of purposeful use of sensory stimulation for individuals to the surveyors.

Examples

Sensory stimulation can be anything that stimulates one of the five senses. Music, visual arts, movies, a joke or story, an interesting tactile object, or a pleasant smell may provide appropriate sensory stimulation.

3.C. **13. In response to the preferences of the person served, the program:**

- **a. Assesses the person's use of complementary health approaches.**
- **b. Educates the person served on the efficacy and safety of interventions.**
- **c. Provides information and resources on integrative health, as requested.**

Examples

According to the National Institutes of Health National Center for Complementary and Integrative Health (**www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name**), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

3.C. **14. The rhythm of daily life is directed by each person served, as demonstrated by:**

- **a. Freedom to make choices regarding the cycle of each day, including:**
  - **(1) Bathing.**
  - **(2) Dressing.**
  - **(3) Eating.**
  - **(4) Hygiene.**
  - **(5) Oral care.**
  - **(6) Sleeping.**
  - **(7) Waking.**
- **b. Choice of clothing.**
- **c. Choice of grooming style.**
- **d. Each person's choice to participate in personally meaningful customary routines, including, but not limited to:**
  - **(1) Cleaning.**
  - **(2) Community activities.**
  - **(3) Contact with pets.**
  - **(4) Cooking.**
  - **(5) Exercise/mobility activities.**
  - **(6) Gardening.**
  - **(7) Hobbies.**
  - **(8) Intimacy.**
  - **(9) Recreation.**
  - **(10) Social interaction.**
  - **(11) Spiritual/religious activities.**

Intent Statements

Individuals in a PCLTCC direct the rhythm of their daily life. From rising in the morning to retiring in the evening, the choice of the daily routine is determined by the person served. It is not dictated by the convenience of the personnel or by a schedule designed to create efficiency. Being able to accommodate the person's rhythm of daily living is a hallmark of person-centered long-term care. Persons served should not have to give up everything they are accustomed to when entering long-term care. Participating in the life of the community while maintaining their daily routine is crucial for their quality of life. Living in a community always includes the freedom to exercise individual rights and respect for the rights of others.

Examples

Persons served can be afforded opportunities to continue activities they enjoyed prior to moving into the PCLTCC as well as to pursue activities that will support their growth and development. Some examples of these include:

- Choosing when to wake up, nap, and retire.
- Choosing the schedule for completing their ADLs.
- Participating in meal preparation.
- Creating a garden of flowers or vegetables for use in the community.
- Caring for or simply enjoying the companionship of pets.
- Continuing to participate in activities such as the Rotary, League of Women Voters, or church groups.
- Tutoring students in English as a second language.
- Assisting personnel with tax preparation.
- Engaging in intimacy with a spouse or significant other.
- Enjoying familiar recreational activities.
- Learning a new hobby or skill.
- Opportunities to engage in meaningful work, if desired.
- Engaging in meaningful interactions with other residents, personnel, and members of the local community.

Persons served who wish to do so can be encouraged to participate in the daily routine of their community by continuing to do the things they did at home (e.g., setting the table, dusting, doing laundry, gardening, woodworking.)

3.C. **15. Policies and written procedures address nursing services, including assessment, implementation, and planning, as well as critical decision making regarding:**

a. Education related to identified needs of persons served.

b. Post medical/surgical care.

c. Medications.

d. Pain.

e. Rehabilitation issues.

f. Skin integrity.

g. Need for specialty consultation.

Examples

15.b. Services could include incision care, Foley catheter care, deep vein thrombosis prevention, and respiratory care.

3.C. **16. Policies and written procedures address:**

a. Who provides medical management for the persons served.

b. Who provides rehabilitation management for the persons served, if applicable.

c. When these are not the same physician, mechanisms for coordination, communication, and collaboration.

d. Primary responsibility for medical management, including:

(1) Description of the role and responsibilities of the attending physician.

(2) Description of the roles and responsibilities of other physicians who provide concurrent medical services.

(3) Physician availability.

(4) Appropriate medical decision making.

e. Availability of the physician or physician designee 24 hours a day, 7 days a week.

f. Access to consulting physicians to treat continuing, unstable, or complex medical conditions.

g. Prevention, including:

(1) Prevention of further disability.

(2) Medical complications.

(3) Adverse events.

Intent Statements

16.a. Medical management is provided by a physician whose training and background correspond to both the characteristics of the persons served and the scope of the program. This could be geriatrics, rehabilitation, or other relevant specialties.

16.b. The rehabilitation physician is a physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, etc.) who is qualified by virtue of specialized training and experience in rehabilitation to provide rehabilitation management for the persons served. The rehabilitation physician clearly identifies medical necessity as well as continuing rehabilitation stay.

16.e. The designee is a qualified medical professional who is identified, in accordance with regulatory/licensing requirements, to assist with providing coverage to meet the needs of the persons served.

Examples

16.d.(3) The program addresses physician availability in the event the physician is ill, on vacation, called to jury duty, or attending CME.

3.C. **17. The program communicates in a timely manner with the physician(s) of each person served at the time of:**

- **a. Entry.**
- **b. Significant changes in the status of the person served.**
- **c. Exit/transition.**

3.C. **18. When crisis management is necessary to manage behaviors of the persons served, personnel demonstrate appropriate use of emergency crisis procedures.**

Intent Statements

An unstable or dangerous situation affecting an individual, a group, or the organization can prompt implementation of procedures that are appropriate to the situation and in line with the person-centered plan for the person served.

3.C. **19. The long-term care organization's privileging process defines:**

- **a. Which professionals require privileges to provide services in the long-term care program.**
- **b. Qualifications required to provide professional services in the long-term care program.**
- **c. Experience and training required to provide professional services in the long-term care program.**
- **d. Specific privileges granted.**
- **e. Specific responsibilities in accordance with the privileges granted.**
- **f. A system to monitor performance in executing the privileges granted.**
- **g. A system to address modification or withdrawal of privileges.**
- **h. A mechanism to demonstrate current competency relative to the privileges granted.**
- **i. A system to ensure that practice is consistent with the privileges granted.**

Intent Statements

The organization determines which professionals are subject to the privileging process in order to provide services to persons served in the long-term care program. The privileging process may be implemented and monitored through the organization's credentialing system and medical or professional staff oversight. Credentialing and privileging process will clearly identify who the qualified physicians are and their role in pre-admission, admission, continued stay, and exit/transition activities. This process should also assist with the identification of the roles of physician extenders, consulting physicians, residents/fellows and students.

3.C. **20. The medical director for the program:**

- **a. Is licensed by a professional governing body.**
- **b. Demonstrates appropriate experience and training to provide physician services through a minimum of two years' experience as a collaborative team member providing physician services in a long-term care program.**
- **c. Maintains:**
  - **(1) Licensure.**
  - **(2) Certification.**
  - **(3) Privileges in the organization.**

d. Participates in active clinical practice that relates to the population served.

e. Demonstrates currency in medical practice concerning the persons served, including dementia management.

f. Demonstrates active learning and involvement in the professional community.

Intent Statements

The physician who provides direction to the program has and continues to demonstrate experience, training, and ongoing engagement in long-term care or another relevant field. It is expected that the physician is board certified in a specialty area.

Examples

The medical director of the long-term care program is board certified in geriatric medicine and is a certified medical director. The medical director regularly makes presentations at meetings and writes for journals on issues related to long-term care.

A medical director is board certified in internal medicine and has worked with residents with dementia for the past ten years. This individual is active in and volunteers with the local Alzheimer's Association. Annually, the physician attends medical education programs that present information on current dementia care issues.

3.C. **21. The medical director for the program:**

a. Has a contract with the organization that outlines the medical director's responsibilities.

b. Actively participates in:

(1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.

(2) The development of ongoing relationships with the medical community.

(3) Educational activities with the program personnel.

(4) The establishment of policies and written procedures that identify the functions and responsibilities of the physician.

(5) Performance improvement activities.

(6) Advocacy activities.

(7) Program development and modification.

(8) Establishing the program's policies and procedures.

(9) Resource utilization management.

(10) Stakeholder relationship management.

(11) Marketing and promoting the program.

(12) Strategic planning.

(13) Financial planning and decision making.

(14) Ethical decision making.

Examples

21.a. If the organization does not contract directly with the medical director, other documentation of the expected participation of the medical director with the program such as a scope of services or outline of responsibilities could be shared.

21.b.(4) The policies for physicians clearly address their role and responsibilities in processes from preadmission through admission, continuing stay determination, and discharge.

21.b.(10) Stakeholder relationship management includes the development of and participation with stakeholders of the program, such as the medical directors of insurance companies the program works with and other physicians who refer to the long-term care program or would benefit from education about the program.

3.C. **22. The program fosters teamwork among personnel that addresses:**

a. Individual strengths.

b. Mentoring.

c. Opportunities for performance improvement.

d. Education and skills development regarding team dynamics.

3.C. **23. As appropriate to their roles, the organization provides documented competency-based training for personnel:**

a. At:

(1) Orientation.

(2) Regular intervals.

b. That includes information on:

(1) Aging process.

(2) Assisting persons served with activities of daily living.

(3) Behavior management.

(4) Dementia.

(5) Disease management.

(6) Efficient utilization of healthcare resources.

(7) Fall prevention.

(8) Pain management.

(9) Performance measurement and management.

(10) Prevention related to:

(a) Recurrence of the illness, injury, impairment, or disability.

(b) Potential risks and complications due to the illness, injury, impairment, or disability.

(11) Psychosocial issues.

(12) Safeguarding health records.

(13) Topics identified by persons served.

(14) Topics identified by personnel.

(15) Well-being.

(16) Working with external entities.

Examples

23.b. Examples of the content that may be covered includes:

- Normal versus abnormal aging and palliative approaches to aging that attend to the whole person served including physical, mental, emotional, social, and spiritual needs.
- Explanation of dementia and related disorders, progression, stages, and individual variability.
- Communication techniques.
- Behavior symptoms and how to approach persons served when they display responsive behaviors.
- The role of personality and environmental factors in behavioral symptoms.
- Principles of ethical decision making.
- The interdisciplinary approach to care.
- Working with families/support systems.
- Resources for persons served and their families/support systems.
- Stress reduction techniques for direct care personnel.

3.C. **24. Leadership fosters a continuous learning environment for personnel that:**

a. Identifies and develops emerging leaders.

b. Measures the satisfaction of personnel with the learning opportunities.

c. Addresses performance improvement of the learning environment as needed.

Intent Statements

Education of personnel who care for the persons served is a key component of quality. Leadership ensures that the program has processes in place for initial and ongoing education designed to meet the needs of personnel.

The program identifies the best way for each of its personnel to learn. For some it is in a classroom; for others it is a hands-on approach with a return demonstration; for others it is self-directed, online education; and for others, it is a group discussion. Leadership ensures that personnel

receive the education they need in the style best suited to their needs.

Examples

There may be opportunities for personnel to evaluate the program's teaching mechanisms, how they have been coached, and the feedback they have received from their supervisors. Leadership models the desired behaviors for personnel.

Direct care personnel might need to make on-the-spot decisions that have traditionally been first cleared with their supervisor. Supervisors might need ongoing coaching to help them empower and support the direct care personnel to be decision makers.

Persons served, families/support systems, and personnel may be involved in the creation of a curriculum as well as in the initial and ongoing educational initiatives. Direct care personnel might have a more in-depth curriculum than other personnel who work in the program.

Potential measures of the effectiveness of learning techniques may include:

- Assessment of learning styles, needs, and strengths.
- Success of coaching.
- Appropriateness of level of supervision.
- Feedback regarding quality, quantity, or access to learning techniques.

3.C. **25. The program includes in its data collection system at least one indicator to measure the satisfaction of personnel.**

3.C. **26. Leadership seeks input from persons served regarding personnel performance.**

Examples

The organization asks families and/or resident council members for input regarding personnel.

An organization has a caregiver award, with nominations and selection done by the residents.

Persons served and family members are encouraged to provide feedback regarding personnel at care plan meetings.

3.C. **27. To advance the field of long-term care, leadership supports the program's participation in research opportunities.**

Intent Statements

It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

3.C. **28. The program provides or arranges for family/support system education on how to access resources on behalf of the person served.**

Examples

Resources could include nutritional information, websites that offer information on ordering adaptive equipment, catalogs with activity items that interest the persons served, guidance on how to order certain publications, or other resources to enhance their quality of life or quality of care.

3.C. **29. In accordance with the choice of the person served, the program provides or arranges for education on financial assistance and planning for persons served and families/support systems that addresses:**

a. Benefits.
b. Sustainability of services.
c. Contingency planning.
d. 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

Long-term services and supports might have multiple payer sources and therefore various forms, systems, offices, and criteria that persons

served and their families/support systems must navigate. This standard is not prompting organizations to serve as financial planners; instead, it recognizes that long-term care providers are often aware of ways that persons served can get information from the local community or other resources regarding various funding for services and plan for what may or may not be covered.

Examples

A speaker from a government agency comes to do a presentation for personnel and persons served regarding benefits for certain services.

Brochures regarding prescription drug benefits for moderate income persons describes where to call for more information regarding accessing benefits.

A social worker is available to provide persons served with information regarding limitations in government payment of rehabilitative services and how to appeal coverage decisions.

3.C. **30. The long-term care program:**

- **a. Gathers information on a representative sample of the persons served, including information on:**
  - **(1) Behavior.**
  - **(2) Function.**
  - **(3) Health.**
  - **(4) Infection control.**
  - **(5) Medication.**
  - **(6) Nutrition.**
  - **(7) Pain management.**
  - **(8) Psychosocial.**
  - **(9) Recreation and leisure.**
- **b. At least annually addresses:**
  - **(1) Performance in relationship to established targets in the following areas:**
    - **(a) Behavior.**
    - **(b) Function.**
    - **(c) Health.**
    - **(d) Infection control.**
    - **(e) Medication.**
    - **(f) Nutrition.**
    - **(g) Pain management.**
    - **(h) Psychosocial.**
    - **(i) Recreation and leisure.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Healthcare providers.**

Intent Statements

The information gathered is at the level of the program (a representative sample of persons served within the long-term care program). Targets are established for the long-term care program based on analysis of the representative sample of persons served.

This standard relates to the standards in Section 1.L. Performance Measurement and Management and 1.M. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 30.b.(1)(a)–(i).

Examples

30.a.(1) Behavior could include verbalizations; pacing; lack of recognition of place or person; repetition or words, phrases, or questions; suspicion of others; wandering; and changes in sleep.

30.a.(2) Function could be related to activities of daily living such as eating, bathing, dressing, toileting, transferring (walking), and continence.

30.a.(3) Health could include unplanned medical visits due to illness, medication side effects, and falls.

30.a.(4) Infection control might address vaccination rates for influenza or pneumonia, outbreak management, and appropriate hand hygiene or use of personal protective equipment and supplies by persons served.

30.a.(5) Medication could include reduction in use of anti-psychotics, reducing number of medications taken by individuals, or adverse side effects from medications.

30.a.(6) Nutrition could include vitamin levels, weight maintenance, and adherence to special diets.

30.a.(7) Pain management could include pain assessment, effectiveness of pain medicine, and use of other pain treatments.

30.a.(8) Psychosocial might include effectiveness of psychosocial interventions for behavioral health conditions or completion of a psychosocial assessment in a specified period of time.

30.a.(9) Recreation and leisure might include participation in group activities.

3.C. **31. The program demonstrates the ability to incorporate into the person-centered plan:**

a. A palliative approach to care.

b. End-of-life care.

Examples

Individuals with severe and irreversible conditions might no longer be able to eat at the end of life and might need only comfort care. For example, they may have their mouths moistened and be given oral care.

When persons served are near the end of life, artificial nutrition and hydration might be withheld in accordance with their wishes or advance directives.

Persons served and their families/support systems may receive information about palliative care options, including hospice, when residents appear to have entered the final stages of life. Such signs could include the person's inability to walk without assistance, inability to sit up without support, inability to smile, unrecognizable speech, and swallowing problems.

The program should demonstrate an understanding of personal choice and implement programs to support these choices at the end of life. Programs should support the choices of persons served and should also encourage them to make these known to personnel.

3.C. **32. Current emergency information is readily available in writing for each person served that includes, as applicable:**

a. Advance directives or end-of-life issues.

b. Allergies and sensitivities.

c. Behavioral symptoms.

d. Cognitive status.

e. Communication status.

f. Current diagnoses/conditions and history.

g. Emergency contact information.

h. Equipment and devices.

i. Functional status.

j. Healthcare providers involved in care, including contact information.

k. Hospital preference.

l. Immunization status.

m. Insurance information.

n. Legally appointed decision maker(s), including contact information.

o. Medications.

p. Mental and behavioral healthcare providers involved in care, including contact information.

q. Mental health status.

r. Photograph (for identification of the person served).

s. Prosthetics and orthotics information.

t. Risk factors.

u. Spiritual preferences.

v. Vision.

Intent Statements

Information that is portable is important in emergency situations. An individual's information may be available in paper or electronic format. The program should have a process to ensure that emergency information is updated as needed to remain current.

Examples

32.c. Behavioral symptoms may include a person with diabetes who demonstrates a more aggressive manner when blood sugar is low or a person

who paces when frustrated with an activity. This information is helpful to personnel so that they may respond appropriately to emergencies.

D. Home and Community Services

Description

Home and Community Services 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 desired outcomes 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 personnel, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus on the expectations and outcomes identified by the person served, members of the family/support system, and the service providers. The service providers are knowledgeable of care options and linkages to assist the persons served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the persons 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

All organizations seeking accreditation for Home and Community Services must meet:

- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- All standards in Section 2.A.
- Standards in Section 2.C., as applicable.
- All Standards in Section 2.D., if Standards 3.D.15.–17. in this section are applicable to the program.
- All standards in Section 2.F. if the program delivers services using information and communication technologies
- Standards 1.–14. in this Section 3.D. Standards 3.D.15.–17. also apply if specialized services and assistance due to illness, injury, impairment, disability, or specific age or developmental needs are provided. Standard 3.D.18. also applies if specialized respite services are provided.

Applicable Standards

All organizations seeking accreditation for Home and Community Services must meet Standards 1.–14.

3.D. **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

Whether the home and community services provide a full array of services or only one type of service (as addressed in standards on scope and program description), they demonstrate an awareness and use of community resources to support or enhance individualized services for the person served.

3.D. **2. The home and community services identify and address gaps in service delivery.**

Intent Statements

The home and community services 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 therapist working with a person served observes that the person is no longer able to do household chores because of pain and lack of mobility and as a result, there are now concerns about the safety and cleanliness of the home. The therapist refers the person back to the primary care physician for medical evaluation and a potential referral for homemaker services.

At the level of the program, the home and community services 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.D. **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

By its nature, home and community services may involve providers working independently with persons served in their homes or in the community, without the on-site support of supervisors or colleagues typically available in a facility-based program. This standard relates to Standard 1.I.5. However, to reduce risk and ensure the safety of the persons served, it requires the organization to have procedures for verification of the backgrounds of *all* home and community services personnel, including what background checks are required of various positions and what actions will be taken based on the results or in the event that backgrounds cannot be verified.

Continued employment might also be contingent upon positive verification for some positions; the organization determines when this is the case.

Examples

The nursing assistant or home health aide may attend orientation but not provide direct services to the persons served until background verification is complete.

An annual check of driver's license status may be required for personnel who provide transportation to persons served to demonstrate no infractions have occurred.

3.D. **4. Documented, competency-based training for personnel that addresses the delivery of home and community services:**

a. Is provided:

(1) At orientation.

(2) On an ongoing basis.

b. Includes, but is not limited to:

(1) The unique needs of persons served.

(2) Communication with persons served and their families/support systems.

(3) Communication with other providers serving the persons served

(4) Facilitating active involvement of the persons served and families/support systems in the service delivery process.

(5) Facilitating behavioral supports.

(6) Facilitating cognitive interventions.

(7) Handling developmental/life transitions.

(8) Knowledge of community resources.

(9) Recognition and reporting of suspected abuse and neglect.

(10) Setting and maintaining professional boundaries.

(11) Identifying environmental risks.

Intent Statements

In Section 1.I. Workforce Development and Management standards, organizations identify skill sets that support the achievement of outcomes for the persons served as well as organizational mission and goals. This standard identifies areas that would be included in orientation and ongoing training as appropriate to the delivery of home and community services.

See the Glossary for a definition of *competency-based training*.

It is not expected that all topics be addressed every year but rather that the content and focus of personnel training may vary over time to

reflect new developments and priorities in the field and on the part of the organization.

Examples

These competencies can be obtained through formal education or continuing education; on-the-job training; mentorship by experienced personnel; and ongoing access to materials for independent learning.

4.b.(6) A person served may need to establish techniques to assist with memory of daily tasks that should be completed for health or safety purposes. These aids may be written, electronic, phone calls, etc. Personnel are able to appropriately use or encourage the person served to use the pertinent memory aid.

4.b.(7) Transitions could be from home to job, job to retirement, job to volunteering, or independent living to assisted living.

4.b.(10) The therapeutic relationship requires the establishment of rapport as well as appropriate limits on behaviors. Education might include topics such as refraining from establishing a friendship or relationship outside of the delivery of services and the appropriate balance of emotional engagement and distance so that providers are invested in the persons served but their roles as professionals are not compromised.

4.b.(11) Personnel are trained to observe and assess risks in the environment of the persons served, which vary depending on the type of persons served and settings where services are delivered. For example, a provider may observe:

- Someone in the home of the person served who speaks or otherwise behaves in a way that seems threatening to the person served; nonverbal communication on the part of the person served signaling a threat; new bruising, cuts, or other signs of injury; etc.
- Trip hazards such as rugs, electrical cords, spills, or clutter for someone with balance, sensory, or ambulation concerns or who uses equipment such as a cane, walker, or wheelchair.
- Unsecured guns, knives, or other items that could cause harm to the person served.
- Medications that are not properly stored/secured.
- An exterior door in a home that is blocked with clutter or an exit door in a public setting such as a library or community center that is blocked with equipment, carts, or racks that potentially hinder or obstruct exit in case of emergency.
- Lack of supervision for someone with cognitive impairment who is unsafe to be home alone.

3.D. **5. The program implements policies and written procedures that address the delivery of home and community services, including, at a minimum:**

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. Within the scope of services, the capacity 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 written procedures address the uniqueness of the settings and types of situations personnel 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, e.g., the person refused service, the care worker could not complete the assignment, there was a scheduling error, needed equipment was not available, or there was a weather emergency.

5.g. The scope of services may be focused only on therapeutic interventions and not include social reintegration activities even though the family/support system requests them on behalf of the person served.

The home and community services may provide the persons served with information on expected timeframes for response to questions submitted via electronic platforms (e.g., portals or apps) or outside of business hours.

The home and community services has a rotating system of personnel on call nights and weekends to respond to urgent needs on the part of persons served and caregivers.

The scope of services may include the availability of respite services for family/support systems; if not, the program has information on respite services available in the community.

3.D. **6. Initial and ongoing risk assessments of each person served:**

a. Document, based on identified needs, risks in the following areas:.

(1) Behavioral.

(2) Cognitive.

(3) Communication.

(4) Developmental.

(5) Emotional.

(6) Environmental.

(7) Physical.

(8) Capability of the family/support system.

(9) Other, as appropriate.

b. Are incorporated into the:

(1) Assessment process.

(2) Person-centered planning.

(3) Discharge/transition planning.

Intent Statements

To decrease the potential of harm to the person served, initial and ongoing risk assessments allow the home and community services to address the changing needs of the person served throughout the program and in planning for exit/discharge or transition to another level of care.

Examples

6.a.(3) 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 person served and personnel.

6.a.(5) A person served may exhibit signs of severe depression or express the potential for self-harm, warranting suicide prevention approaches.

6.a.(7) Physical risks may include the potential for falls or impulsivity on the part of the person served when moving around at home or inadequate physical activity, poor nutrition, and eating habits.

6.a.(8) Risk assessment related to the capability of 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.

6.a.(9) Assessing risk of urinary tract infection can reduce any potential impacts on overall health including cognition and subsequent safety awareness.

3.D. **7. Service delivery is scheduled at an agreed-upon time that supports the person-centered plan.**

Intent Statements

There is a process 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.

Examples

Consideration is given to the person served who wakes late morning or prefers a late in the afternoon appointment to allow family members who work to be present.

3.D. **8. 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 home and community services may be at risk in emergent situations because of a variety of factors including age and developmental, cognitive, and physical levels of functioning. To address these risks, the program works with the persons served and, in accordance with the choice of the person served, their families/support systems to provide relevant information and develop plans for how to respond to emergency situations.

8.d.(1)(c) and **8.d.(2)(c)** Recovery after a disaster means the return of the person served to the home or community setting.

Examples

8.c. If there is a history of flooding on the lower level of a building, modifications on a higher level could include changes in room configuration to allow for full time living on the higher level until flooding resolves.

8.d.(1)(c) and **8.d.(2)(c)** Recovery might include physical home repairs (e.g., from water damage), utility recovery, or public health assessment for safe/healthy living conditions.

8.e. Basic needs may include food, water, utilities, medications, etc. Utility needs might include back-up power for a person who uses a power wheelchair or ventilator, phone service to be able to call 911 or reach family members who are away from home, and Wi-Fi to access online emergency information and notification systems.

3.D. **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 at 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 is having some mechanical difficulty with it, it would be the driver's responsibility to notify the appropriate person who could assist the person served.

"Smart homes" utilize information and communication technologies 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 information 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 the electronic keypad to unlock the entry door is not working. The aide notifies the appropriate personnel in the home and community services, who then follow up with the appropriate family member or vendor.

3.D. **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 impacts the opportunity for the person to remain in the 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, have a strained relationship with the person served, etc.

10.a.(3) Interpersonal dynamics refers to the interactions between the person served and spouse/significant other, friends, peers, coworkers, employer, and community.

10.a.(4) This may include the ability of the family/support system to participate in training sessions, learn new skills, communicate 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.D. **11. Policies and written procedures facilitate collaboration with the person served and family/support system in decision making through the following:**

a. Accessible information.

b. Timelines 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

Hearing, accents, and other language issues may pose barriers to communication. The use of a communication board or device or the use of a translator may be necessary.

11.c. The level of understanding of information may be determined though the assessment process, 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.D. **12. The home and community services provide education:**

a. To:

(1) Persons served.

(2) Families/support systems.

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 involved with the person served.

(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 and communicate personal health information helps the persons served and their families/support systems ensure that they receive ongoing quality healthcare.

Such information empowers the persons served to be responsible for an important step in their care, lessens the fragmentation of care among healthcare settings, and helps reduce the risk of medical errors.

Examples

12.b.(2) Examples of other providers with whom the persons served and/or the families/support systems may have to communicate might include the person's primary care physician, pharmacist, or other providers in the community, such as a transportation provider.

12.b.(3) The system or tool used provides a record of relevant personal health information and is portable for persons served so that they have the appropriate information at each health encounter and in case of emergency. Offering the person served a choice of formats—electronic and hard copy—may improve the actual use of the system or tool.

12.b.(8) Safety issues may relate to the disaster preparedness and emergency plan, risk assessments of the persons served, a provider's observations of the home environment, technology that is not working as intended, etc.

3.D. **13. 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, develop 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, the persons served may lack knowledge of options in their area. There may be a need for the home and community services to assist the persons served to become aware of options and resources they will need to develop a plan for housing, transportation and/or technology that would allow them to remain in the home and/or community, to get to and from work, and/or to participate in social activities.

Examples

13.a.(1) Housing options may include supported housing, public housing, older adult communities, or general community housing that is accessible for persons who use a wheelchair.

13.a.(2) Public transportation options may address transportation that is convenient for a person served who has limited endurance, mobility, or cognition; para-transit systems for persons served who use assistive mobility equipment, and the use of rideshare apps.

13.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.D. **14. In accordance with the choice of the person served, the home and community services provide or arrange for financial education, assistance, and/or planning that addresses:**

- **a. Benefits planning.**
- **b. Sustainability of services.**
- **c. Contingency planning.**
- **d. 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

In assisting an individual to live independently in the community, it is important to evaluate present and future costs associated with the living situation. 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.

It is important that the persons served consider being responsible for their own finances if appropriate.

Examples

Factors to be considered include how benefits of the person served might be impacted and the potential changes in funding for services.

Education, assistance, and planning may be provided directly by the home and community services or by referral 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 15.–17.

3.D. **15. 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/cause and anticipated course of the illness, injury, impairment, disability, or 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. Signs and symptoms of emergent medical or psychological conditions.**
- **k. 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 support personnel, the impact of these areas on the service delivery for each person served is observed, considered, reported as applicable or required, and, as needed, addressed in the person-centered plan, including the involvement of additional team members as necessary.

15.b. The home and community services are aware of the effects of medications currently taken by the person served on the person's ability to participate in the services and tolerate therapeutic activity.

3.D. **16. Depending on individual needs, the home and community services provide or arrange ongoing education and training:**

- **a. For:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **b. That address:**
  - **(1) Disease management.**
  - **(2) Health advocacy, including prompt communication about health issues.**
  - **(3) Prevention related to:**
    - **(a) Recurrence of the illness, injury, impairment, disability, or specific age or development need.**
    - **(b) Potential risks and complications due to the illness, injury, impairment, disability, or specific age or developmental need.**
  - **(4) Primary healthcare.**
  - **(5) Utilization of healthcare resources.**
  - **(6) Wellness.**

Intent Statements

The ability for individuals to become engaged with wellness and management of their health conditions is key to their ability to remain in home and community settings. Appropriate

education and training are provided to persons served and their families/support systems based on their needs.

Examples

Persons served may benefit from education on how to advocate for their needs, how to prepare for physician appointments, health screenings and their importance, how to self-manage health conditions, and appropriate use of emergency/urgent care, nurse's lines, telehealth, etc.

Education and training could also focus on the impact of exercise on disease management, such as how exercise impacts blood glucose levels and using a continuous glucose monitor for real-time tracking of blood glucose levels.

Some organizations may have personnel who provide services to persons served but are not equipped to provide education or certain services to persons served and families/support systems because it is beyond the scope of their education and role. In this case, the home and community services demonstrate how they refer or link persons served and families/support systems to other providers or resources that can address the identified needs.

16.b.(1) Persons served may wish to engage with alternative and complementary medicine approaches. The home and community services provide education and resources on the safety and efficacy of such interventions.

Complementary health approaches may include:

- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Use of natural products, such as dietary supplements.
- Homeopathy, naturopathy, and traditional healers such as Elders or Knowledge Keepers.

16.b.(2) It is important for persons served and family members or caregivers to be able to identify signs and symptoms and when it would be appropriate to contact their physician, home and community services provider, EMTs, etc. Signs and symptoms might include frequent falls, loss of consciousness, shortness of breath with chest pains, wounds, or increased inflammation of joints with inability to perform daily tasks. The sudden onset, abruptness, or increased intensity or frequency of these symptoms signal the person served to advocate for care, medications, additional services, etc.

16.b.(5) Education on utilization of healthcare resources might include decision making related to which healthcare provider is the most appropriate to seek advice for specific health concerns or how to use insurance funding most effectively to meet individual needs.

3.D. **17. The home and community services provide or arrange for 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 where medications are controlled by pharmacists, nurses, and physicians. The understanding and competency of a person served and family/support system to manage medications are critical to the person's safety, health, and well-being.

Examples

Education is provided as appropriate to the needs of the persons served and families/support systems, the scope of the home and community services, and in accordance with any relevant practice acts or standards of practice.

17.b.(3) A person has difficulty opening medication bottles so the home and community services provide education about requesting blister packs or easy-to-open bottles. The person served has vision limitations so the home and community services educate the person to request labels with large print.

17.b.(7) When dispensing medications, the nurse identifies each medication to the person served and the reason it is prescribed.

17.b.(8) The home and community services identify that the person served is taking several medications that are prescribed by multiple physicians and educates the person regarding the importance of notifying each prescribing physician about all of the medications currently being taken, not just those related to the condition being managed by each physician.

Applicable Standards

Home and Community Services that provide specialized respite services must also meet Standard 18.

3.D. **18. When respite services are provided somewhere other than the person's own home, the person served brings the following to the respite provider, 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 a healthy, safe, and comfortable environment that will meet the needs of the person while in that setting is critical.

18.d. In order to maintain a person-centered approach, respite services are knowledgeable about the normal routine of the person served.

Examples

18.a.–b. Depending upon the types of persons served, respite providers may need to be able to use a variety of adaptive equipment and assistive technology and may need additional training to develop those competencies. Training might be provided by the family, vendors, or other resources.

18.c.–h. A personal health information tool may be used to provide the information listed.

18.e. Special needs may include nutritional/dietary needs.

E. Case Management

Description

Case Management proactively coordinates, facilitates, and advocates for seamless service delivery for persons with impairments, activity limitations, and participation restrictions based on the following:

- Initial and ongoing assessments.
- Knowledge and awareness of care options and linkages.
- Effective and efficient use of resources.
- Individualized plans based on the needs of the persons served.
- Predicted outcomes.
- Regulatory, legislative, and financial implications.

The delivery of case management may occur in a variety of settings that include, but are not limited to, a healthcare environment, a private practice, in the workplace or in the payer community.

Applicable Standards

An organization seeking accreditation for Case Management must meet:

- Sections 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- Standards 1.–9. in Section 2.A.
- Section 2.F. if the program delivers services using information and communication technologies
- All standards in this Section 3.E.

NOTE: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.E. **1. To meet the needs of the person served, case management:**

a. Identifies:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

b. Coordinates:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

c. Defines its relationships with:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

d. Establishes key communication contacts with:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

3.E. **2. Case management coordinates with:**

a. The persons served.

b. Providers of services to the persons served.

c. Payers.

d. Legal entities, as applicable.

3.E. **3. Case management accesses and utilizes information about:**

a. Regulations.

b. Legislation.

c. Financial issues.

d. Service availability.

e. The healthcare delivery system.

3.E. **4. Case management advocates for:**

- **a. Ethical treatment.**
- **b. Quality-focused, appropriate care.**
- **c. Access to appropriate services.**
- **d. Delivery of care.**
- **e. Efficient use of available resources.**
- **f. Performance measurement and management.**
- **g. Development of resources in the community.**
- **h. Services that:**
  - **(1) Are available.**
  - **(2) Are utilized.**
  - **(3) Minimize and/or prevent impairment.**
  - **(4) Reduce activity limitations.**
  - **(5) Lessen participation restrictions.**
  - **(6) Identify environmental barriers.**
- **i. The safety of the persons served.**

3.E. **5. Case management participates in decisions about, but not limited to:**

- **a. Appropriate use of a full continuum of care.**
- **b. Services.**
- **c. Equipment.**
- **d. Supplies.**
- **e. Community resources.**

Examples

Case management decisions may include identifying and implementing services to help maintain skin integrity for an individual at high risk for wounds due to limited mobility, diabetes, or other conditions.

3.E. **6. Case management facilitates:**

- **a. Communication that:**
  - **(1) Avoids duplication of information.**
  - **(2) Efficiently facilitates necessary services for the persons served.**
- **b. Promotion of health/well-being.**
- **c. Identification of issues concerning benefits.**
- **d. Value-based care.**
- **e. The provision of services to:**
  - **(1) Minimize and/or prevent impairment.**
  - **(2) Reduce activity limitations.**
  - **(3) Lessen participation restrictions.**
  - **(4) Identify environmental barriers.**
- **f. The safety of the persons served.**
- **g. Independent review, as appropriate.**

Intent Statements

6.g. Independent review refers to review by an independent, impartial reviewer of the services provided to the person served.

Examples

6.g. An independent review could take the form of an independent medical examination or a file review by an individual not directly involved in the case.

3.E. **7. The responsibilities of case management include:**

- **a. Reviewing relevant reports to facilitate assessment.**
- **b. Identifying resources.**
- **c. Integrating information on resources into:**
  - **(1) Case management planning.**
  - **(2) Case management implementation.**
- **d. Conducting assessments.**
- **e. Predicting outcomes.**
- **f. Establishing case management plans.**
- **g. Participating in the establishment of discharge/transition plans.**
- **h. Providing case management services.**
- **i. Modifying case management plans.**
- **j. Recommending or ensuring that the individuals on the team change based on the needs of the person served.**
- **k. Achieving the predicted outcomes.**

l. **Recommending or ensuring that the persons served are transferred to the most appropriate level of care, based on need.**
m. **Providing education and training.**
n. **Referring the persons served to other services/programs as needed.**
o. **Communicating with relevant stakeholders.**
p. **Participating in performance improvement activities.**

3.E. **8. In order to inform the persons served about case management either prior to or at the time of initiating services, case management provides information from the performance measurement and management system to the persons served that addresses, at a minimum:**

a. **The characteristics of the persons served.**
b. **The number of persons served per category of individuals who share similar characteristics within a stated period of time.**
c. **Experience of services received and other feedback from the persons served.**

Examples

There are a variety of ways that the information may be shared and which of these ways are used will depend upon the individual needs of the persons served. Some information may be written in different languages, at different reading levels, in larger print size, etc. Some information may be shared orally or through a video presentation.

8.a.–b. The characteristics of the person served may include diagnosis, impairment, activity limitations, level of participation, life role, residential information, age, or gender. Performance information may be categorized along one or a combination of these parameters.

3.E. **9. Initial and ongoing assessments completed by case management:**

a. **Are relevant to the needs of the persons served.**
b. **Predict outcomes that include:**
   (1) **Functional status at discharge/transition.**
   (2) **Disposition at discharge/transition.**
   (3) **Duration of services.**
c. **Consider health status.**
d. **Address resource needs and utilization.**
e. **Address discharge/transition planning.**
f. **Address the integration of available resources.**
g. **Identify:**
   (1) **Factors facilitating the achievement of predicted outcomes.**
   (2) **Barriers to the achievement of predicted outcomes.**
h. **Address funding sources.**
i. **Identify expectations of the:**
   (1) **Funding source.**
   (2) **Employer, if appropriate.**

3.E. **10. Whenever possible, case management encourages the persons to be served and/or their family/support system to visit the programs to which they are referred prior to entry to familiarize them with the:**

a. **Programs.**
b. **Personnel.**

3.E. **11. Case management:**

- **a. Communicates the behavioral and cognitive needs of the persons served to the programs/services with which they interact.**
- **b. Verifies that the programs/services being offered can meet the behavioral and cognitive needs of the persons served.**

3.E. **12. An individual plan based on the needs of each person served addresses the following:**

- **a. Minimizing/preventing impairment.**
- **b. Reducing activity limitations.**
- **c. Lessening participation restrictions.**
- **d. Environmental modifications.**
- **e. Predicted outcomes of case management.**
- **f. Estimated timeframe for case management services.**
- **g. Involvement of the persons served in planning.**
- **h. Communication with appropriate parties.**
- **i. Modification based on the resources of case management.**
- **j. A plan for discharge/transition from case management, including mechanisms for interagency coordination.**

3.E. **13. Case management provides each person served with an individualized written disclosure statement that includes sufficient information to address:**

- **a. The scope of case management services that will be provided.**
- **b. The intensity of case management services that will be provided.**
- **c. Insurance coverage and/or payment structure.**
- **d. Alternative resources to address additional identified needs.**

Intent Statements

The standard requires that each person be provided with individualized information that is specific to the person's situation. This information does not all have to be in one document. The information should be presented in such a way that the person served clearly understands what will be provided and for how long, what will not be provided, and what, if anything, the services will cost.

Examples

13.c. Examples of information shared regarding insurance coverage may be that the payer will fund only four weeks of case management and then will reassess, a co-pay is required, there is a maximum dollar amount available for case management, etc.

13.d. Examples of alternative resources may be referral to another provider of case management, referral to different funding sources, etc.

3.E. **14. The persons served have the benefit of a consistently assigned case manager.**

Intent Statements

The consistency of staffing provides for continuity of services and prevents confusion of the persons served regarding the identity of their case managers. The concept of consistently assigned personnel does not exclude a system of rotation of assignments. If such a system is used, the persons served are notified before a rotation ends and are introduced to their new case manager.

3.E. **15. To ensure the achievement of predicted outcomes, the case manager for each person served:**

- **a. Demonstrates appropriate competencies as defined by the program.**
- **b. Is identified to:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **c. Has the authority to coordinate the provision of care.**
- **d. Is knowledgeable about the program and services being provided to the person served.**

e. Is available to interact with:
- **(1) The person served.**
- **(2) The team of the person served.**
- **(3) The family/support system.**
- **(4) Other stakeholders.**

f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.

g. Is responsible for ensuring communication with:
- **(1) External sources.**
- **(2) Internal sources.**

h. Brings forward to the team the available financial information to facilitate decision making about the following processes:
- **(1) Intake.**
- **(2) Assessment.**
- **(3) Service planning.**
- **(4) Service provision.**
- **(5) Discharge/transition planning.**
- **(6) Long-term follow-up.**

i. Facilitates the involvement of the person served throughout the service process.

j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.

k. Ensures that discharge/transition arrangements are completed.

l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders.

m. Facilitates the implementation of discharge/transition recommendations.

Intent Statements

The surveyors should be able to ask the persons served and their families/support systems about these individuals and get responses that indicate that they know who is coordinating the provision of care for the person served.

Examples

15.h.(1) Financial information that might affect placement decisions for the person served during the intake process is shared with the admitting physician and any team members involved in making recommendations for placement of the person served into the program or referral to a different level of the continuum of services.

3.E. **16. Case management interacts with, facilitates, and communicates with the team providing services which:**

a. Is determined by:
- **(1) The assessment.**
- **(2) The individual planning process.**
- **(3) The predicted outcomes of the person served.**
- **(4) The strategies utilized to achieve the outcomes predicted.**

b. Includes:
- **(1) The person served.**
- **(2) Members of the family/support system, as appropriate.**
- **(3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas:**
  - **(a) Behavior.**
  - **(b) Cognition.**
  - **(c) Communication.**
  - **(d) Functional.**
  - **(e) Medical.**
  - **(f) Pain management.**
  - **(g) Physical.**
  - **(h) Psychological.**
  - **(i) Recreation and leisure.**
  - **(j) Social.**
  - **(k) Spiritual.**
  - **(l) Vocational.**

c. Provides services that address:
- **(1) Impairments.**
- **(2) Activity limitations.**
- **(3) Participation restrictions.**
- **(4) Environmental needs.**

(5) The personal preferences of the person served.

(6) Identifying the characteristics of the intended discharge/ transition environment.

(7) Achievement of predicted outcomes.

Intent Statements

The team composition is determined for each person served through the assessment and individual planning processes. The team is a dynamic group of individuals that may change as the person served progresses through the program. Some professionals may be active team members for the entire length of a person's involvement in the program, while other professionals may become active members of the team as the need for their services is identified.

16.c. CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). In ICF, the term *functioning* refers to all body functions, activities, and participation, while *disability* is similarly an umbrella term for impairments, activity limitations, and participation restrictions. Environmental factors, which may be facilitators or barriers, interact with all of these components. ICF offers the following definitions:

- *Body functions* are physiological functions of body systems (including psychological functions).
- *Body structures* are anatomical parts of the body such as organs, limbs, and their components.
- *Impairments* are problems in body function or structure such as a significant deviation or loss (e.g., the loss of a limb, loss of vision).
- *Activity* is the execution of a task or action by an individual.
- *Activity limitations* are difficulties an individual may have in executing activities. Activities may be limited in nature, duration, and quality (e.g., taking care of oneself or performing the activities of a job).
- *Participation* is involvement in a life situation.
- *Participation restrictions* are problems an individual may experience in involvement in life situations. Participation may be restricted in nature, duration, and quality (e.g., being employed, participating in community activities, or obtaining a driver's license).
- *Environmental factors* make up the physical, social, and attitudinal environments in which people live and conduct their lives (e.g., stairs, terrain, and climate; availability of adaptive equipment and transportation; willingness of an employer to have an injured worker return to work).

Examples

16.b.(3)(e) Medical needs might include nursing, pharmacy, or nutrition needs in addition to needs that would be addressed by a physician.

16.c. An example of how these concepts interrelate might be a personal chef who sustains a cervical spinal cord injury in a motorcycle accident. The impairment is paralysis of all four extremities. During rehabilitation the person served articulates a desire to continue operating the personal chef business. Once home, the person chooses recipes; instructs personal assistants who perform the manual activities related to preparing, cooking, and delivering the food; and tastes the foods as they are being prepared. Installation of mirrors in the kitchen allows viewing of all food preparation. Despite a number of activity limitations related to fulfilling the role of a personal chef, the person has a high level of participation in communicating with customers, food preparation, and running the business. The home environment provides sufficient space for assistants to work with the person in all aspects of the business and maintain the excellent reputation and continued success of the business.

16.c.(5) Although the occupational therapist has identified dressing skills as an area to be addressed in the individual plan, the person served indicates that there is always a family member home in the mornings to assist with dressing, so working on other areas is a higher priority.

The speech-language pathologist is working with the person served on a dysphagia management program and the person's preference is to eat in a private room rather than eating meals in the common dining area.

3.E. **17. Case management facilitates the team's:**

a. Ongoing communication regarding the progress of the person served toward predicted outcomes.

b. Collaboration to achieve predicted outcomes.

3.E. **18. In conjunction with providers of services, case management demonstrates that the persons served make measurable progress toward accomplishment of their predicted outcomes in accordance with predicted timeframes.**

Intent Statements

Predicted outcomes are actively pursued and measured on a regular basis to determine their achievement in the anticipated timeframes and/or the need for modification. If progress toward predicted outcomes is not demonstrated in the anticipated timeframes, the program identifies issues or barriers to outcomes achievement and makes appropriate modifications.

Examples

Conformance may be demonstrated through documentation in the records of the persons served as well as discussion and interviews with personnel, referral sources, payers, and the persons served.

3.E. **19. Information is made available by case management:**

a. Regarding local or regional resources for:

(1) Support.

(2) Advocacy.

(3) Civil rights.

b. To:

(1) The persons served.

(2) Their families/support systems.

Examples

Case management provides information to the persons served regarding voting rights and accessibility. This includes resources to obtain and receive assistance in completing voter registration applications, and who to contact with questions about accessibility to cast a ballot.

Case management provides resources to assist the person served and spouse with information about retirement and disability supports and what their rights are concerning benefits.

3.E. **20. As appropriate, case management has information available regarding local options for:**

a. Lodging.

b. Transportation.

3.E. **21. Discharge/transition planning is done in collaboration with:**

a. The persons served.

b. Families/support systems.

c. Providers in the continuum of services.

d. Other relevant stakeholders.

3.E. **22. When there is a change in the discharge/transition plan there is a mechanism for case management to provide as much notice as possible to:**

a. The persons served.

b. Their families/support systems.

c. Other relevant stakeholders.

Examples

22.a.–b. The discharge plan for the person served has been to go home with family. However, during the training process it becomes evident that the family is not prepared to meet the needs of the person at the time of discharge. The team revises its recommendation to discharge the person to a residential program for a period of time. This change, including the rationale, is clearly communicated and explained to the person served and the family.

22.c. Relevant stakeholders could include appropriate personnel, referral sources, payers, etc.

Case management notifies the vendor who is supplying a walker for the person served that discharge has been delayed 24 hours until the person's blood pressure is stable.

3.E. **23. The discharge/transition process includes recommendations for services needed to maintain or improve the outcomes achieved.**

3.E. **24. There is a written discharge/transition summary for each person served that is relevant to the services that have been provided by case management.**

3.E. **25. When crisis management is necessary to handle behaviors, case management demonstrates appropriate use of emergency crisis procedures.**

Intent Statements

In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would respond to behaviors of the persons served.

Examples

Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression, or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

3.E. **26. When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that address:**

- **a. Education through modeling of socially and culturally acceptable behaviors for:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
  - **(3) Members of the community with whom the persons served regularly interact.**
- **b. Environmental factors to enhance the socially and culturally acceptable behaviors of the persons served.**
- **c. Environmental modifications.**
- **d. Medication management.**
- **e. Training in the implementation of behavior management programs for:**
  - **(1) Personnel.**
  - **(2) Families/support systems.**

Examples

26.a.(3) Members of the community with whom the person served regularly interacts might include a taxi or transportation driver who regularly drives the persons served to their vocational services location; a hair stylist or barber who regularly provides services to the persons served, or wait staff at the local coffee shop frequented by persons served.

26.c. Environmental modifications might include the use of noise-reducing materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and door bells, limiting or controlling where and when people may visit persons served, reducing stimuli such as bright sunlight or odors, and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

3.E. **27. For services/programs used by case management, it verifies that when there is a need to manage behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of the family/support system.**
  - **(3) From the perspective of personnel.**
  - **(4) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the approach, treatment, and/or supports necessary.**
- **f. Address the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
  - **(5) Other persons involved with the person served.**
- **g. Implement the appropriate actions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other personnel.**
  - **(3) The family/support system, as appropriate.**

3.E. **28. Case management:**

- **a. Gathers information on each person served, including information on:**
  - **(1) Changes in:**
    - **(a) Severity of the conditions.**
    - **(b) Comorbidity.**
  - **(2) Mortality.**
  - **(3) Nonmedical interruptions in the delivery of services.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Changes in:**
      - **(i) Severity of the conditions.**
      - **(ii) Comorbidity.**
    - **(b) Mortality.**
    - **(c) Nonmedical interruptions in the delivery of services.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**
    - **(d) Others.**

Intent Statements

This standard relates to the standards in Sections 1.L. Performance Measurement and Management and 1.M. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 28.b.(1)(a)–(c).

28.a.(1)(a) Changes in the severity of the conditions refers to the conditions that necessitate services and case management. The information gathered would cover both changes from entry to discharge and from discharge to follow-up.

Examples

28.b.(5)(d) May include payers and/or other service providers.

3.E. **29. The records of the persons served include:**

- **a. Identification data.**
- **b. Assessment information, including information on health status or a health history.**
- **c. The individual plan, with goals stated.**
- **d. Progress/reassessment documentation.**
- **e. Documentation of critical incidents.**
- **f. Discharge/transition summaries.**
- **g. If appropriate, referral information and medical records, including release forms.**

Examples

29.b. In addition to the information generated through the assessment process, the health status/health history information may include information obtained from current and previous service providers and referral sources, along with information gathered from the persons served by self-report.

3.E. **30. A written analysis of a representative sample of records of the persons served is conducted:**

- **a. At least annually.**
- **b. To include:**
  - **(1) Documentation completed in accordance with the organization's policies.**
  - **(2) Regulatory requirements, if applicable.**
  - **(3) CARF documentation requirements.**
- **c. That includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Documentation completed in accordance with the organization's policies.**
    - **(b) Regulatory requirements, if applicable.**
    - **(c) CARF documentation requirements.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of personnel.**

Intent Statements

This standard relates to the standards in Sections 1.L. Performance Measurement and Management and 1.M. Performance Improvement. In order to analyze performance it is expected that the program identifies objectives, performance indicators, and performance targets for 30.c.(1)(a)–(c).

Please refer to the Glossary for a definition of *representative sample*.

Examples

30.b.(1) Program personnel review and analyze a representative sample of records to determine consistent completion of record content areas, record entries in accordance with established timeframes, and review of discharge recommendations with the persons served and other stakeholders as appropriate.

30.b.(2) The organization identifies its key regulatory agencies and reviews and analyzes a representative sample of records of the persons served to determine if documentation meets identified requirements. Results of the analysis are used in education and training activities to facilitate compliance with regulatory obligations.

F. Independent Senior Living

Description

Independent senior living communities are community housing settings that may be stand-alone or part of continuums of services. Persons served may reside in apartments, cottages, or other settings in the independent senior living environment.

Independent senior living offers a culture of customer service and hospitality as well as an environment of safety and security for persons served. A philosophy of independence, engagement, and well-being guides the communications between personnel and persons served in independent senior living.

As part of the residency and service agreement, various hospitality services may be accessed by persons served, including, but not limited to, transportation, dining, housekeeping, laundry, and social and recreational activities. Dependent on the information in the written agreement between the person served and the program, persons served may pay additional fees for various services. Information on resources in the local community may also be offered to persons served. Persons served manage or make their own arrangements for management of personal care, medications, healthcare, and activities of daily living.

Applicable Standards

An organization seeking accreditation for an Independent Senior Living program must meet:

- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- All standards in Section 2.F. if the program delivers services using information and communication technologies.
- All standards in this Section 3.F.

3.F. **1. Independent senior living:**

- **a. Documents the following parameters regarding its scope:**
  - **(1) Resident population.**
  - **(2) Age range of persons served.**
  - **(3) Housing options.**
  - **(4) Services available, including, but not limited to:**
    - **(a) Activities.**
    - **(b) Dining.**
    - **(c) Housekeeping.**
    - **(d) Laundry.**
    - **(e) Maintenance.**
    - **(f) Transportation.**
  - **(5) For each service available, identifies:**
    - **(a) Settings.**
    - **(b) Hours of services.**
    - **(c) Days of services.**
    - **(d) Frequency of services.**
    - **(e) Fees.**
- **b. Shares information about the scope of services with:**
  - **(1) Persons served.**
  - **(2) Families/support systems, in accordance with the choices of the persons served.**
  - **(3) Other relevant stakeholders.**
  - **(4) The general public.**
- **c. Reviews the scope of services at least annually.**
- **d. Updates the scope as necessary.**

Intent Statements

The scope is defined at the level of the program. It is not expected that the program share all information listed in element 1.a. with every stakeholder but that it provides the persons served, families/support systems, referral sources, payers, and other relevant stakeholders with information that helps them understand what the program 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

The scope of services may be included in an information packet, on the program's website, in a handbook, or in other documentation. The scope of services provides everyone involved with the program information regarding who is served by the program, where individuals live, how the services are provided, and information related to paying fees for services.

If the independent senior living program serves only retirees or is open to all ages, such information may be included in the scope of services. Other information regarding the resident population, such as if the program is most suited to residents who are very active or those who need some help with activities of daily living, may also be included.

Housing options may refer to floor plans such as one- and two-bedroom residences or whether cottages, town homes, or apartments are offered. Information regarding kitchens, parking, and other housing-related details may also be included.

3.F. **2. Based on the scope of the program, the program:**

- **a. Documents its:**
  - **(1) Entry criteria.**
  - **(2) Exit criteria.**
- **b. Shares this information with:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
  - **(3) Other relevant stakeholders.**

Intent Statements

The organization determines which persons are able to reside in the living environment and identifies conditions/time/events for exit.

When establishing the criteria for entry and exit, the capability of the program to provide the setting needed by persons served is considered.

3.F. **3. There is a written agreement between the independent senior living program and the person served:**

- **a. That is presented in an understandable format.**
- **b. Of which a copy is provided to the person served:**
  - **(1) For review prior to entry to the program.**
  - **(2) After it is signed by all appropriate parties.**
- **c. That is available for review by the person served.**
- **d. That is signed by:**
  - **(1) The person served.**
  - **(2) The program's representative.**
- **e. That contains information regarding:**
  - **(1) Entry:**
    - **(a) Criteria.**
    - **(b) Procedures.**
  - **(2) Exit:**
    - **(a) Criteria.**
    - **(b) Procedures.**
  - **(3) Scope of services that will be provided.**
  - **(4) Fee schedule.**
  - **(5) Responsibility for payment of fees.**
  - **(6) Refund policies.**

Intent Statements

Information exchange promotes an understanding between the program and persons served regarding critical components of how service delivery is conducted. Information is shared at appropriate times to support transparency and knowledgeable decision-making.

Examples

Written agreements may be referred to as admission agreements, contracts, residence and care agreements, life leases, or participant agreements.

3.b. Written agreements may be shared a variety of ways at different points in time:

- In an admissions packet
- During a transition planning or move-out discussion with the person served
- At any time if a person served requests to review it

3.e.(2) Transitions may be voluntary or involuntary and may be between levels of care such as independent living and assisted living. Under certain circumstances, transitions may also include movement between one apartment or cottage to another or one room to another.

3.F. **4. The program provides opportunities to orient persons served and their families/support systems to:**

- **a. Familiarize them with the:**
  - **(1) Mission of the program.**
  - **(2) Personnel.**
- **b. Determine their expectations.**
- **c. Respond to questions regarding the living environment.**

Intent Statements

In many cases, initial interactions may be a deciding factor in whether individuals move to a residential setting. Processes are helpful in ensuring that there is consistency in how interactions with those who may seek residence in the program occur.

Examples

Opportunities to learn about the program could include visiting the program, a video tour, providing printed materials via mail or in person, reviewing information available on the organization's website, having telephone calls between program personnel and the person served, and supplying audio recordings about the program.

A couple stops by the program for information late in the afternoon. The receptionist, a new volunteer, refers to a handbook that includes a one-page guide on how to greet visitors, areas of the program to highlight, materials to provide to individuals making inquiries, and follow-up steps.

The marketing or admissions staff of a program provides a "Welcome Visitor" workshop as part of new hire orientation and annually for all personnel who may be involved in visits of potential persons served.

3.F. **5. A culture of customer service that guides responsiveness to persons served is demonstrated by:**

a. Leadership.

b. Personnel throughout the program.

Examples

This type of culture may be demonstrated by how an organization responds to questions or concerns from persons served and how personnel are accessible to problem-solve with persons served in a proactive manner. A customer service policy and related education may also address practices that emphasize responsiveness.

3.F. **6. Activities are available to persons served that:**

a. Meet their interests.

b. Align with their capabilities.

c. Reflect their choices.

d. Promote their personal growth.

e. Enhance their self-image.

f. Improve or maintain their independence whenever possible.

g. Allow for group interaction.

h. Allow for autonomy.

i. Include opportunities in the local community.

Examples

Activities can include those that are offered by the program and those that are organized and implemented by committees of persons served if the program does not have activities included in its scope of services. It may be useful for an organization to identify the types of programs available and any details regarding participation. Activities may reflect interests of the entire population of persons served, rather than a single individual, to determine what is relevant for most individuals. Activities might include painting, photography programs, fashion events, expert speakers on wellness topics, a celebration of Centenarian's Day or other observed days, computer classes, or musical performances.

3.F. **7. The program makes available:**

a. Formal and informal educational opportunities.

b. Access to:

(1) Information of interest.

(2) Health and wellness information.

(3) Other media.

Examples

The program supports group learning activities such as current events discussion and might invite local experts or persons served to provide lectures on art, history, music, political science, or other topics of interest to persons served.

The program might schedule outings or notify persons served of events at the local community college including movies, art, music, and education.

Information on health and wellness topics of interest might be made available online or through books, pamphlets, presentations, a health fair hosted by the program, or attending a community health fair.

3.F. **8. Independent senior living implements communication mechanisms that address:**

a. The needs of:

(1) The persons served.

(2) The program.

(3) Other stakeholders.

b. Emergent issues.

c. Contingency planning.

d. Decisions made by the person served.

Intent Statements

A variety of ways to foster communication between the program, persons served, and others is important to ensuring that expectations are being met and that there is clarity about important policies, strategic issues, or other information impacting individuals. Mechanisms for the exchange of information may include both verbal and written methods.

Examples

Communication mechanisms may include resident associations, personnel such as service coordinators, volunteers, or others who serve as liaisons with individuals. Regular information sessions or meetings may be held to provide updates and opportunities for questions to be addressed. Annual reports, memos, newsletters, and other documents may also serve as an aspect of the overall communication approach.

3.F. **9. There are regular meetings between personnel and the persons served to discuss issues concerning the living environment.**

Intent Statements

See the Glossary for the definition of *regular*.

Examples

Meetings may be held monthly, quarterly, or annually and may include town-hall meetings with persons served to provide an overview of scheduled repairs or renovations, updated safety procedures, new laundry equipment and how it works, information about using updated thermostats in apartments, parking lot changes, or other topics regarding the living environment. Communications might also be meetings with individual persons served or with groups of persons served such as individuals living on a certain floor of a building or neighborhood of a campus.

3.F. **10. Independent senior living educates the persons served about safety and security measures, including, but not limited to:**

- **a. Staffing.**
- **b. Surveillance systems that are used.**
- **c. Entry to and exit from the property.**
- **d. Entry to and exit from individual residences.**
- **e. What to do in case of an emergency.**
- **f. Personal security options.**

Examples

Education about safety and security measures may be conducted through meetings with individuals, safety fairs, or other events to make persons served aware of related features within the organization.

10.a. Staffing could highlight the security team, their roles, their shifts, and the number of security personnel on duty at various times.

10.b. Surveillance systems could include security personnel walking through the building or patrolling the grounds as well as door sensors to prevent inappropriate entry into the organization. Education for persons served could include information about safety cameras throughout the building and who monitors them.

10.c.–d. Specific measures may be related to driving onto the campus for a gated community, announcing guests at the front desk of a building, sign-in logs, and buzzers at individual living cottages, apartments, or units.

10.e. Depending on the policies of the organization, education may address whether persons served should contact program personnel or emergency responders from the local community in the event of a medical emergency. It may also address emergent situations such as what to do in the event of a theft or break-in or how to respond to and report an undesired or unknown visitor.

10.f. Personal security options could include whether an individual may have alarms on the cottage or apartment, if there are emergency response devices such as pull cords in individual units, or other available options for personal security.

3.F. **11. The program provides sufficient information for the persons served to understand their rights with respect to the organization's policy regarding emergency procedures.**

3.F. **12. The program offers information to the persons served about:**

- **a. Advance directives.**
- **b. Resuscitation, including:**
  - **(1) Provision of information for making a decision.**
  - **(2) The right to refuse resuscitation.**

c. Any legal requirements related to:
(1) Advance directives.
(2) Resuscitation.
d. Resources available to document their decisions.

3.F. **13. The program makes current information available:**
a. To the persons served.
b. To families/support systems.
c. Regarding:
(1) Adult protective services.
(2) Care management services.
(3) Community service organizations.
(4) Crisis intervention programs.
(5) In-home services, including:
(a) Home healthcare services.
(b) Homemaker services.
(6) Meal delivery services.
(7) Specialized services unique to the population served.
(8) Transportation options.
(9) Well-being and health promotion.
(10) Other services, as requested.

Intent Statements

The program is aware of resources available in the community that may assist persons served and their families/support systems.

Examples

Programs may maintain a resource library, offer participant/family education, host family council meetings, conduct town hall meetings, post information on bulletin boards or in newsletters, and/or make referrals to local agencies.

13.c.(5)(a) Home healthcare could include in-home services by healthcare professionals such as nurses or therapists.

13.c.(5)(b) Homemaker services could include light housekeeping, meal preparation, shopping or companion services.

13.c.(7) This may include mental health services, Alzheimer's Association, home safety evaluations, pharmacy delivery, and home modification companies.

13.c.(10) This may include services such as hospice, durable medical equipment, and hearing aids.

3.F. **14. In accordance with the choice of the person served, independent senior living implements a mechanism to make available current written emergency information for each person served that:**
a. Is stored in a consistent location in individual residences.
b. Includes, as appropriate to each person served:
(1) Advance directives.
(2) Allergies.
(3) Current diagnoses/conditions and history.
(4) Emergency contact information.
(5) Equipment and devices.
(6) Hospital preference.
(7) Healthcare providers, including contact information.
(8) Immunization status.
(9) Insurance information.
(10) Medications.
(11) Other relevant information.

Examples

Current emergency information that is maintained by persons served on their own, stored in a central location in their living unit, and portable is important in emergency situations. If the organization does not maintain this information on behalf of residents, it could suggest a system or structure to persons served so that this information can be organized and available, although not all residents may choose to implement the mechanism. Ways to trigger review of and updates to the emergency information could also be part of the mechanism.

The program should be prepared to discuss the mechanism it uses to make this information available. Surveyors will not need to review the private information maintained by persons served but may ask them about the mechanism.

3.F. **15. The program provides information on persons served contracting for outside services, including:**

- **a. Exploring services.**
- **b. Hiring services.**
- **c. Managing services.**
- **d. Information exchange with program personnel.**
- **e. Terminating services.**

Intent Statements

If persons served contract for outside services such as personal care attendants, companions, private duty care, cleaning assistance, or other services, the program provides information to persons served to minimize potential risks associated with unknown individuals providing services to persons served.

Examples

Information offered by the program may be in the form of a newsletter, fact sheet, town hall meeting, resident council presentation, or other venue. The information could address topics such as background checks, orientation of contracted individuals to the program on issues such as emergency response and visitation policies, information exchange that should occur with program personnel should an issue or question arise, and education for the persons served regarding responsibilities related to engaging outside services.

3.F. **16. The program demonstrates efforts to maintain or improve the physical environment, including:**

- **a. Preventive maintenance.**
- **b. Cleanliness.**
- **c. Plans for capital improvements of property.**

Examples

16.c. Changes in weather patterns may indicate a future need for air conditioning or supplemental cooling.

3.F. **17. 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 the program.**
- **b. At stated intervals throughout employment.**
- **c. In response to the information received.**

Intent Statements

This standard relates to Standard 1.I.5. 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 cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

Examples

A housekeeper, dining server, or driver may attend orientation but may not provide direct service to the persons served until background verification is complete.

3.F. **18. The program provides training for all personnel:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes information on:**
  - **(1) Aging issues.**
  - **(2) Communication of unusual occurrences regarding persons served.**
  - **(3) Documentation and record keeping requirements of the program, as appropriate to the job.**
  - **(4) Legal requirements affecting the program or the personnel.**

(5) Psychological issues of the persons served.

(6) Social/cultural issues of the persons served.

(7) Specific training directly related to the program.

(8) Well-being.

Examples

18.b.(2) Unusual occurrences could include difficulty walking, repeating the same questions frequently, or calling the front desk for assistance much more frequently than usual.

18.b.(3) This might include the front desk maintaining a sign-in sheet of all parties entering the properties. Maintenance might keep records of repair requests for individual residences. Transportation personnel might record drop-off and pick-up details of persons served at the local shopping mall.

18.b.(4) Legal requirements might address whether to enter an unoccupied residence, privacy requirements, or emergency response procedures when an individual is in distress.

18.b.(5) Psychological issues might include signs of depression or loneliness and understanding the grieving process when an individual dies.

18.b.(6) Social/cultural issues could include appropriate attire at meal times or addressing persons served and personnel by their full name rather than by a first name as a sign of respect.

18.b.(7) Specific training related to the program might include information related to the role of the residents' council or various clubs that exist in the organization. It could include a history of the program and key milestone events that are important to be aware of.

18.b.(8) Training might focus on the various domains of well-being including physical or emotional health, lifestyle behaviors, or social connectedness. It may address how activities and interactions can impact well-being for both persons served and personnel.

3.F. **19. The program makes available:**

a. Access to:

(1) Wi-Fi.

(2) Technology that:

(a) Promotes engagement in meaningful activity.

(b) Enhances quality of life.

b. Resources for the use of technology.

Intent Statements

19.a.(1) Across aging services providers, Wi-Fi access is becoming a vital component of service delivery, enhancing social connection and engagement for persons served and enabling communication between programs, persons served, families/support systems, and other stakeholders.

It is not required that Wi-Fi access be provided throughout an entire building or campus but that the program identify where service is available and may be used by persons served and others.

19.a.(2) It is the choice of the person served to use technology and in what way.

Examples

19.a.(1) Wired Internet, cellular network hotspots, and satellite Internet could be used to provide Wi-Fi internet access. If there are barriers to providing Wi-Fi internet access an organization may include this in its technology and accessibility planning.

19.a.(2) The variety of technology, devices, and applications used by older adults is continuously growing and varies from simple to sophisticated. Some may be owned by persons served and some by the program. Examples range from smart-home technology to robotic pets and meal delivery to iPads, smartphones, and virtual assistants that support older adults in engaging in meaningful activity.

19.b. The resources offered to support the use of technology might be individualized or offered to a group, accessed via community programs at a library or senior center, or provided via online tutorials or printed materials.

Examples could include a speaker to talk about internet security, e.g., how to connect one's personal technology (phone, laptop, iPad) to the

internet and how to select and safeguard passwords; local high school volunteers that partner with persons served to learn about smart phone technologies and apps; and providing information on courses offered at a nearby library on how to avoid online fraud and scams targeting older adults.

3.F. **20. The program works with local community resources on emergency preparedness concerning the unique needs of persons served to address:**

- **a. Emergency preparedness.**
- **b. Power restoration.**
- **c. Evacuation.**
- **d. Transportation.**
- **e. Shelter.**
- **f. Recovery.**
- **g. Public health concerns.**

Intent Statements

The program works with community resources (e.g., first responders, civil defense, homeland security, Red Cross) to educate them about the unique needs of persons served, including persons with dementia if applicable to the program, and how to ensure that those needs can be met in the event of an emergency.

20.f. Recovery after a disaster means the return of the person served to the home or community setting.

Examples

Programs could communicate about the unique needs of the population served with local community leaders who work in fire departments, hospitals, pharmacies, first responder organizations, public health organizations, or other community organizations. "Work with" could be that aging services providers are involved in local meetings, serve on a local committee, share information via email with a local agency or organization to strategize regarding emergency preparedness topics and the unique mobility, cognitive or other issues that might be useful for community leaders to be aware of regarding the population served by the aging services provider.

20.f. Recovery might include transportation from the recovery center; home repairs needed due to damage from fire, water, or wind; utility recovery; or public health assessment for safe/healthy living conditions.

20.g. Public health concerns might include infections such as influenza, COVID-19, and monkey pox; air quality and weather-related conditions; fraud and scams that target older adults; gun violence; and rising rates of suicide.

3.F. **21. To enhance recruitment and retention of personnel, the program:**

- **a. Demonstrates outreach to expand its future workforce.**
- **b. Provides opportunities for career development.**
- **c. Provides mechanisms for personnel to:**
  - **(1) Recognize successes.**
  - **(2) Acknowledge challenges.**
  - **(3) Solve problems.**
  - **(4) Participate in the service delivery planning process.**
  - **(5) Participate in program development.**

Intent Statements

The field of aging services continues to face significant workforce challenges. This standard addresses how programs can proactively focus on finding talent within current personnel and also strategically thinking about nontraditional candidates. This standard relates to 1.I.6. that includes addressing the well-being of the workforce as it is increasingly becoming a factor in recruiting and retaining personnel.

Examples

To tap into potential sources for employees or volunteers, programs may have leaders attend functions, and the organization may advertise job opportunities to retired teachers, department of aging programs for retired workers, high school student exchange programs, and international cultural exchange programs.

To attract workers the program may offer internship and apprenticeship opportunities.

It may modernize recruitment processes by using social media to advertise positions and technology to expedite its response to inquiries and applications.

3.F. **22. The program demonstrates planning for sustained emergency conditions that includes:**

- **a. Contingency planning for workforce shortages.**
- **b. Expedited onboarding of personnel.**
- **c. Establishing priorities for service delivery.**
- **d. A policy that specifies whether the program allows essential caregivers during sustained emergency conditions.**
- **e. If the program allows essential caregivers:**
  - **(1) Identification of who may fulfill the role of an essential caregiver.**
  - **(2) Written procedures regarding the scope of their involvement with the persons served.**
- **f. Procurement of supplies.**
- **g. Communication that:**
  - **(1) Is timely.**
  - **(2) Is transparent.**
  - **(3) Includes:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) The workforce.**
    - **(d) Other stakeholders.**
- **h. Collaboration with community resources.**
- **i. A process for ethical decision-making.**

Intent Statements

An emergency situation that poses risk to health, property, and/or life requires immediate action to be taken. While many emergencies are resolved in a discrete timeframe, there are a growing number of situations (such as a pandemic or ongoing environmental concerns) that last for an extended period of time. Such circumstances may necessitate a change in priorities and routine practices. The purpose of this standard is to proactively consider what actions are needed to maintain service delivery during sustained emergency conditions.

22.a.–c. During periods of sustained emergency conditions significant workforce-related challenges may occur or intensify. Contingency planning for workforce shortages is intended to help programs prioritize needs, safeguard the health and safety of persons served, and continue to deliver essential services. In alignment with identified priorities, the program may implement an expedited onboarding process in which mission-critical topics are addressed and remaining subject areas are deferred to a later date.

22.d.–e. The concept of an essential caregiver emerged during the COVID-19 pandemic. Essential caregivers are not general visitors, nor are they considered members of the workforce; rather they are individuals designated by the person served who assist in meeting the person's needs with the goal of supporting and enhancing person-centered care. They may also be referred to as essential visitors, essential care partners, or other similar terms.

Residential programs are expected to indicate in policy whether they allow essential caregivers during periods of sustained emergency conditions, and, if they do, parameters for who may fulfill the role and what they may and may not do. Many states/provinces and other jurisdictions have enacted essential caregiver requirements. When that is the case, an organization is expected to comply with any applicable licensing, regulatory, or insurance-related requirements.

22.g. During a sustained emergency situation, it is important that information be communicated in a transparent, accurate, and timely manner to all relevant stakeholders. Information is shared in a manner and format that is easily understood and reflective of the diversity of communication needs.

22.i. Within the context of residential programs, sustained emergency situations pose a number of unique ethical challenges. As part of an organization's ethical codes of conduct (related to Standard 1.A.6.), established ethical principles can be used as a guide for addressing complex dilemmas including those related to infection control and prevention.

Examples

22.a.–c. Contingency planning may include temporary use of administrative or corporate personnel in alternate service delivery roles, establishing relationships with local academic institutions to engage students/trainees, and use of staffing agencies.

22.e. If essential caregivers are allowed, procedures may cover topics such as visitation parameters, vaccine and screening requirements, the process and expectations for communication, training requirements, and the integration of essential caregivers into the person-centered plan.

22.f. The organization reviews its existing supply chain for essential goods and materials. Systems are in place that document existing and necessary stockpiles and processes outlined in order to ensure the ongoing adequacy of resources. Examples could include vertical collaboration, which would foster enhanced relationships between suppliers and customers, or horizontal collaboration, which would result in cooperation between similar providers to enhance supply chain access.

22.g. Using an online platform, the leadership team gathers daily to record brief updates that are then widely disseminated. Phone calls or one-on-one contacts are made to those who are unable to access the recordings. Once a week, interactive sessions are held offering all in attendance the opportunity to ask questions.

The organization's website serves as a valuable communication portal for internal and external stakeholders as well as the general public.

Automated calling or texting systems are deployed to ensure uniform and timely messaging. Individuals for whom translation or other individualized responses would be needed are proactively identified and their unique needs addressed.

To prevent duplication and possible miscommunication, individual leadership team members are assigned to serve as designated liaisons for key stakeholder groups, e.g., professional associations, local public health authorities, resident and family councils, and others.

22.i. Examples of ethical concerns could relate to supporting persons with memory loss during quarantine requirements, establishing care priorities during periods of workforce shortages, resident relocation and isolation, and implementation of requirements that vary across an organization's levels of care (e.g., independent living, assisted living, and person-centered long-term care community).

Learning circles are held to openly discuss and address vaccine hesitancy concerns amongst personnel in a confidential and supportive manner.

Ethics committees with diverse membership, including persons served, may be used to work through dilemmas in a constructive fashion.

G. Personal Supports Services

Description

Personal supports services are designed to provide instrumental assistance to persons and/or families served. They may also support or facilitate the provision of services or the participation of the persons served in other services/programs, such as employment or community integration services. Services and supports, which are primarily delivered in the home or community, are not provided by skilled healthcare providers (please see the Glossary for a definition of *skilled healthcare provider*), and typically do not require individualized or in-depth service planning.

Services can include direct personal care supports such as personal care attendants and housekeeping and meal preparation services. Services can also include transporting persons served, information and referral services, translation services, senior centers, programs offering advocacy and assistance by professional volunteers (such as legal or financial services), training or educational activities (such as English language services); music therapy; recreation therapy; mobile meal services; or other support services, such as supervising visitation between family members and aides to family members.

A variety of persons may provide these services/supports other than a program's staff, such as volunteers and subcontractors.

Applicable Standards

An organization seeking accreditation in personal supports services must meet the standards in this section and the standards in the following sections:

- All standards in Section 1.
- All standards in Section 1.A. and 1.C.–1.M.; 1.B. Governance is optional unless the organization is also seeking accreditation for a Continuing Care Retirement Community.
- 2.A. Standards 1.–9.
- 2.E. Standards 1.–17.
- All standards in this Section 3.G.

3.G. **1. The program clearly identifies the supports and services provided.**

3.G. **2. Personnel receive training that includes:**

a. Promoting supports that are directed by the person served.

b. Advocating for the needs of persons served.

c. Guidelines for participating in the service planning for persons served, when applicable.

d. Where appropriate, supportive therapeutic techniques.

e. As appropriate to the service provided, safety training that includes:

(1) First aid/CPR.

(2) Biohazards.

(3) Physical hazards.

(4) Body mechanics.

f. If transportation is provided:

(1) Proper seat restraints, including, when children are served, car seat installation.

(2) Wheelchair tie-downs, when applicable.

(3) Safe driving techniques.

Examples

2.a. Older adults and people with disabilities may need help with their daily tasks of life. Consumer-directed models of care afford persons served the opportunity to place their preferences and needs at the center of the services and supports provided.

3.G. **3. When direct personal care supports are provided, the program implements a plan and written procedures for:**

a. The supervision of personnel, including provision of timely feedback to enhance skills.

b. Addressing unplanned absences to ensure continuity of supports.

Intent Statements

The intent of this standard is to ensure that all personnel who provide personal care supports receive appropriate supervision or direction. See the Glossary for the definition of *personnel*.

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.

3.a. This may include information on best practices or identify areas for improvement.

3.G. **4. When applicable, training in the use of adaptive devices and equipment is provided to:**

a. Personnel.
b. The person served.
c. The family.
d. Caregivers.

Examples

Adaptive devices and equipment use would be dependent on the type of service supports provided and the population served. Some examples are wheelchairs, lifts, breathing devices, and feeding devices.

3.G. **5. When needed, assistive technology is used and reasonable accommodations are made in:**

a. The development of services and supports.
b. The ongoing provision of services.

Examples

The organization considers reasonable accommodations and uses assistive technology to convey information about services when needed. Accommodations and technology may entail the use of communication devices, video and audio recordings, pictures, and materials in each person's and/or family's primary language. Many modifications are simple and inexpensive. When necessary, the program also provides education on technology applications. Refer to the glossary for definitions of *assistive technology* and *reasonable accommodations*.

3.G. **6. If the personal supports service provides training or an educational activity for the persons served, the program includes a written description for each offering that includes:**

a. Focus on the needs of the trainees.
b. Requirements for participation, if any.
c. Objectives for the activity.
d. Instructional methods and materials.
e. The sequence and hours of instruction.
f. Regular review and revision/updates as needed.

Examples

Activities might include offerings such as English language services; fitness classes; craft classes; computer classes; classes on retirement and pension planning; information/education regarding caregiver resources in the community; health-specific topics such as diabetes, heart health, and osteoporosis; healthy nutrition; stress management; elder fraud and abuse issues; or falls prevention.

3.G. **7. If information and referral services are provided, the program demonstrates:**

a. Knowledge of available services/resources.
b. Knowledge of support systems that are relevant to the persons served.
c. Facilitation of access to available services/resources.
d. Availability at times and locations convenient to the persons served.

H. Continuing Care Retirement Community

Description

Continuing Care Retirement Communities (CCRCs) foster a culture of independence, safety, and community. These types of communities might also be known as Life Plan Communities. They include a tiered approach to services that are offered in multiple levels of care including independent living and assisted living and/or skilled nursing care. Persons served reside in residential living settings that may include single-family homes, cottages, apartments, and/or condominiums, usually on one campus.

Entry to the CCRC and the provision of services and amenities are addressed in accordance with a written agreement between the CCRC and the person served. In addition to housing, communal services may include dining, transportation, wellness activities, health services, and a range of other supportive services. The CCRC strives for seamless transitions between levels of care, balancing the preferences with the needs of the persons served. A spirit of community with a focus on overall well-being combine to enhance the quality of life for the persons served.

NOTE: *An organization seeking accreditation for a CCRC will use the* Continuing Care Retirement Community Standards Manual.

Applicable Standards

An organization seeking accreditation for a Continuing Care Retirement Community must meet:

- All standards in Section 1.
- All standards in Section 2.A.
- All standards in Section 2.B.
- Standards in Section 2.C., as applicable.
- All standards in Section 2.D.
- All standards in Section 2.F. if the program delivers services using information and communication technologies.
- All standards in this Section 3.H.

3.H. **1. The CCRC:**

a. Identifies the structure of its continuum, including:

(1) What is offered on campus.

(2) What is offered external to the main campus.

(3) What level(s) of care is owned by the CCRC.

(4) What level(s) of care is contracted by the CCRC.

b. Discloses this information to prospective persons served and their families/support systems.

Intent Statements

As CCRC models continue to evolve their continuum structure, it is important to have information available regarding where and how services are provided.

3.H. **2. Marketing efforts accurately reflect the:**

a. Structure of the CCRC.

b. Ownership/management of the CCRC.

c. Levels of care available.

Examples

2.a. Structure might include what levels of service are offered by the CCRC, locations of the CCRC, and whether the CCRC is part of a multi-site organization or a health system.

3.H. **3. The CCRC:**

- **a. Defines its relationships with the components of the continuum.**
- **b. Defines responsibilities of the components of the continuum.**
- **c. Identifies key communication contacts within the components of the continuum.**
- **d. Demonstrates:**
  - **(1) Coordination of services to meet individual needs.**
  - **(2) Integration of services provided through interaction and feedback:**
    - **(a) Within its own continuum.**
    - **(b) With other service providers/ systems.**

Examples

3.a. CCRCs might identify whether parts of the continuum are owned and if there are contracts or collaborations in place for various components of the continuum.

3.b. Responsibilities might identify whether residents have preferred access to components of the continuum or whether a preferred access arrangement does not exist.

3.c. There might be administrators or other personnel who are the key contacts for persons served and personnel at each component of the continuum.

3.d. Managing care and transitions might include ways that services can be provided to individuals within the CCRC continuum and with other service providers that have relationships with the CCRC.

3.H. **4. In accordance with the terms of their written agreements, the persons served have preferred access to levels of care.**

Intent Statements

If preferred access to levels of care, such as, but not limited to, assisted living or nursing care are part of the written agreement between the person served and the organization, the methods for this access should be clear.

3.H. **5. To promote seamless service delivery for the persons served:**

- **a. The CCRC proactively communicates, coordinates, facilitates, and advocates for appropriate transitions.**
- **b. Exit/transition planning addresses:**
  - **(1) Preferences of the person served.**
  - **(2) Rhythm of daily life.**
  - **(3) The understanding of the family/ support system regarding the current status of the person served.**
  - **(4) Expectations of the:**
    - **(a) Person served.**
    - **(b) Family/support system.**
  - **(5) Spouse and/or others living with the person served.**
  - **(6) Contingency plans.**
  - **(7) The environment of the next component of the continuum of care.**
  - **(8) Capability of the family/support system.**
  - **(9) Financial resources.**
  - **(10) Access to health services.**
  - **(11) Transportation.**
  - **(12) Identification of resources that are or will be involved with the person served.**
  - **(13) Mechanisms for coordination with other resources.**
  - **(14) Person-centered plan for each person served.**
  - **(15) Designation of the individual(s) who will be responsible for coordination of the person-centered plan of the person served.**

Intent Statements

For organizations to offer access to supportive living as the needs of persons served change over time, team communication, coordination, and facilitation of appropriate service delivery become increasingly important. Many aspects of service delivery planning have to come together. Providers should be prepared to discuss their various approaches to service delivery.

Examples

5.a. Transitions could be within the CCRC or to other service providers depending on the written agreement between the organization and person served.

5.b. Individuals may transition to higher levels of service or they may leave the CCRC, depending on the written agreement.

5.b.(1) Preferences might include the type of unit the person has in assisted living, or it might be a preference for a specific personal care attendant.

5.b.(2) The person served may sleep late or may be an early riser or might prefer to have a late lunch each day.

5.b.(3) The family might benefit from information regarding the progression of dementia and the necessary supportive services for the person served in the memory support program.

5.b.(4) Expectations might be regarding the ability of the person served to continue driving, maintaining an apartment, or paying bills without assistance.

5.b.(5) A couple who reside together might have one individual who needs to transition to the nursing center while the other continues to live in the independent living apartment. Planning considers how these individuals will continue to maintain their relationship, as they have never lived apart.

5.b.(6) A contingency plan might be needed if no nursing beds are available for a current resident. Will the person receive home care until a spot becomes available?

5.b.(7) If a person served who enjoys gardening moves from a cottage to assisted living, a plan might be developed for access to a communal garden because the new environment does not offer a personal outdoor space.

5.b.(8) As the person served moves to a higher level of service, the capability of the family/support system to make decisions on behalf of the person may need to be addressed. If the capability to make decisions does not exist, another plan may need to be developed.

5.b.(9) Financial resources might include how to access a benevolent fund or whether government payer sources cover needed services.

5.b.(10) When transitioning to a higher level of service or to another organization, individuals may not be able to continue using their same healthcare providers, or they may not be able to visit the same on-site clinic or pharmacy.

5.b.(11) When a person served transitions from independent living to assisted living and gives up driving, the person may need to use the weekly shuttle service offered by the organization or hire a personal transportation provider.

5.b.(12) Resources could include adaptive equipment or therapy animals to help individuals maintain independence or communicate.

5.b.(13) If resources include adaptive equipment, transition planning might include how to coordinate with a vendor regarding appropriate use and maintenance of the equipment.

5.b.(14) Information from the person-centered plan may be shared, with appropriate consent, to facilitate a smooth transition. A planning meeting with personnel and family might be conducted.

5.b.(15) An individual might be identified to the person served and other members of the team to coordinate and facilitate the transition.

3.H. 6. The records of the persons served follow them throughout the continuum of care.

Examples

Records to foster continuity of care through transition might follow the persons served. Such records could include medications, advance directives, emergency contacts, and allergies. Relevant records might be provided to support the continuity of care at transition between levels of care, but the entire record might not follow the persons served throughout their time in the community due to confidentiality or terms of their written agreements with the CCRC; for example, clinical counseling notes might be confidential, but the counselor might provide relevant history to the social worker in the health center as the person served transitions. Records of persons served might be available for reference as needed, and they might be tracked electronically or in hard copy depending on the processes in place at the CCRC.

SECTION 4

Specialty Program Designation Standards

A. Dementia Care Specialty Programs

Description

A Dementia Care Specialty Program delivers services that focus on the unique and changing physical, cognitive, communication, emotional, psychosocial, behavioral, occupational, medical, palliative, educational, environmental, and leisure/recreational needs of persons with dementia. Leadership fosters a relationship-centered culture in which persons served, families/support systems, and all personnel are empowered to make decisions in partnership based on the preferences, strengths, and needs of the person served.

The program integrates services to support persons served with dementia to live their best life, including:

- Preserving dignity and personhood.
- Minimizing the impact of impairments and secondary complications.
- Maximizing participation, including well-being, quality of life, and inclusion in the community.
- Decreasing environmental barriers.
- Promoting personal safety and security.

A Dementia Care Specialty Program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. It provides access to information, services, and resources to enhance the lives of the persons served and their families/support systems, facilitate engagement in meaningful activity, promote personal health and well-being, and preserve quality of life.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons with dementia.

Current research and evidence inform the implementation of service delivery models and strategies.

A Dementia Care Specialty Program engages and partners with stakeholders to increase access to services by advocating for persons with dementia to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large.

A person-centered philosophy is embraced and modeled by all personnel. Caring and respectful relationships make persons served, personnel, and other stakeholders feel valued.

Applicable Standards

Programs seeking accreditation as a Dementia Care Specialty Program must meet the program description and all standards in this section in addition to the related program-specific standards in Section 3 and all applicable standards in Sections 1 and 2. This specialty program accreditation may be sought in conjunction with the following programs:

- Adult Day Services
- Assisted Living
- Person-Centered Long-Term Care Community
- Home and Community Services
- Case Management
- Independent Senior Living
- Personal Supports Services
- Continuing Care Retirement Community

4.A. **1. To empower the persons served with dementia to make decisions each day that are consistent with their abilities, the program, on an ongoing basis:**

- **a. Assesses the ability of the persons served with dementia to make decisions.**
- **b. Minimizes barriers to decision making by the persons served with dementia.**
- **c. Communicates with the persons served with dementia regarding the immediate consequences associated with choices and behaviors that pose a potential risk to their health or safety.**
- **d. Facilitates appropriate support for decision making by the persons served with dementia.**
- **e. Documents significant discussions and decisions made by the persons served with dementia in their records.**

Intent Statements

While complex decisions may not always be feasible, there are more simple decisions that a person served with dementia may be able to continue to make in order to maintain quality of life. The program personnel demonstrate approaches to communicating with the person served in a manner that clarifies the person's decision-making capacity because it can fluctuate over time, including at different times of the day.

Examples

1.a. Assessing the ability of the persons served to make decisions at different points in the day when they may be better able to interact with care providers may occur through careful observation, communication, and documentation to determine what cognitive patterns may be occurring.

1.c. Different activities pose different levels of risk. Programs can continue to offer increased autonomy in lower risk activities with minimal consequences (choice of clothing style) while communicating the increased possibility of negative consequences of high risk activities (walking in an unfamiliar or unsupervised environment outdoors).

1.e. This could include decisions that impact the person-centered plan of care, decisions that come up repeatedly, and high-level decisions. Significant discussions and decisions could also be related to nutrition, social interactions, or communications with family members. It may be important to document that discussions occurred with the person served and the nature of the discussion in order to be clear among caregivers why a specific decision was made.

4.A. **2. The environment addresses the unique needs of persons with dementia, including:**

- **a. Promoting the dignity and self-worth of the persons served.**
- **b. Maintaining the safety of the persons served.**
- **c. Maximizing the functioning of persons served in the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Mobility.**
  - **(4) Occupational.**
  - **(5) Physical.**
  - **(6) Sensory.**
  - **(7) Social.**
- **d. Optimizing their independence.**

Intent Statements

2.c.(6) Providing appropriate sensory stimulation for persons with Alzheimer's disease and other forms of dementia has been shown to decrease agitation and restlessness as well as improve sleep. Sensory stimulation translates to improved quality of life for both the person served and the caregivers. Sensory stimulation uses everyday objects to arouse one or more of the five senses (sight, smell, hearing, taste, and touch), with the goal of evoking positive feelings.

Examples

2.c.(6) Sensory stimulation activities might include:

- Talking and reading aloud to the person served.
- Giving a hand massage.
- Providing a change of scenery by taking the person outdoors or going for a short walk.
- Bringing in objects the person does not normally have around, such as sand, seashells, or other items.

Depending on how the person served reacts, the person providing services might alter the activity or switch to a different sense to find stimuli that inspire a response.

4.A. **3. The ongoing screening/assessment process includes information about the person's:**

a. Life history.
b. Important memories.
c. Favorite stories.
d. Daily routines.
e. Comfort/reminiscence objects.
f. People of importance.

Intent Statements

This standard supplements Standard 2.A.14. on initial and ongoing written screenings/assessments of the persons served. By using a person-centered approach to screening/assessment the program gains an understanding of the person living with dementia, including the person's values, beliefs, interests, abilities, likes and dislikes, etc., and uses this information to inform the person-centered plan addressed in Standard 2.A.15. As a person's dementia progresses, an ongoing process for screening/assessment provides information on changing needs and preferences.

Examples

3.a. Life history may be gathered over time through a variety of techniques, including guided questions during a one-on-one conversation; observation; and information taken from group activities using photographs, music, food, or other items that might spark conversation. Information gathered might include accomplishments, losses, significant experiences, hopes, dreams, preferences, important roles, and ways of dealing with previous challenges or stressful situations. Understanding the whole person in this way provides greater understanding and appreciation of the person served and the person's experiences and promotes dignity and respect.

3.f. People of importance may include extended family such as nieces, nephews, grandchildren, and others such as friends, neighbors, and individuals from the person's spiritual community. People of importance may also include significant others/life partners as individuals may or may not wish to publicly identify as a member of the LGBTQ community.

4.A. **4. The program provides or arranges for education:**

a. To the persons served.
b. To families/support systems.
c. In accordance with identified needs that addresses, but is not limited to:
(1) Dementia, including:
(a) Signs and symptoms.
(b) Progression.
(c) Types of dementia.
(d) Coexisting conditions.
(e) Lived experience of dementia.
(2) Maintaining relationships.
(3) Skills training, including:
(a) Activities.
(b) Therapeutic approach to behavior.
(c) Communication skills, including communication with:
(i) Persons served.
(ii) Service providers.
(d) Caregiver self-care.
(4) Coping with changes.
(5) Driving.
(6) Falls.
(7) Incontinence.

(8) Loss and grief.
(9) Legal issues.
(10) Mobility.
(11) Palliative care.
(12) Planning for the future.
(13) Risk of elopement.
(14) Sexuality.
(15) Skin integrity.
(16) Community resources.
(17) Payer sources.

Examples

4.b. Education is important to assist the family/support system in its understanding of the evolving needs of a person with dementia and to address concerns related to the role of being a caregiver.

4.c.(1)(e) "Lived" experience may refer to gaining a better understanding of how an individual with dementia might be perceiving the surroundings and interactions with others as dementia progresses.

4.c.(3)(d) Examples of caregiver self-care may include counseling for caregiver stress reduction, online support groups to share experiences and gain insights, techniques for caregiver well-being and nutrition, respite care options, and other resources that may assist the caregiver to manage physical and mental fatigue as well as grief.

4.c.(5) Education related to driving may include identifying whether a person served is able to drive safely and awareness of how to access local resources for individuals who no longer drive, including volunteer driver programs and various forms of public transportation such as paratransit and other services.

4.c.(9) Legal issues may include education and information for persons served and their families/support systems for drafting and maintaining advance directives, do not resuscitate (DNR) orders, and powers of attorney so that the representative of the person served may facilitate service delivery in a way that reflects the wishes of the person served.

4.c.(16) Community resources might include respite care, volunteer drivers, friendly visitor programs, and pet therapy programs.

4.c.(17) Persons served and their families/support systems may not have knowledge of funding sources for various services, so the program might link individuals with local, state/provincial, or national information resources to help navigate the various funding sources for services, equipment, and specific types of care.

4.A. **5. Personnel implement a positive, therapeutic approach to behavior.**

Intent Statements

Responsive behaviors is a term that is used to describe the behaviors of people with dementia, such as agitation, wandering, or depression. The term shows how the actions, words, and gestures of people with dementia are a response to their current environment. When trying to understand the behaviors of a person served, it is important to employ a positive, therapeutic approach to respond to words, gestures, and actions that the person makes to communicate meanings, needs, and concerns. Positive therapeutic approaches are typically multidisciplinary and consider the following:

- What external factors may be influencing the behavior?
- Is the behavior a problem for the person served or for me?
- Will the "solution" cause more anxiety than the problem?

Ultimately, because persons with dementia cannot be expected to change, the idea is to accept individuals as they are in this moment.

4.A. **6. As appropriate, the program incorporates into the person-centered plan:**
a. A palliative approach to care.
b. End-of-life care.

Intent Statements

Persons served, families/support systems, and personnel have opportunities to discuss end-of-life issues and participate in planning remembrance or memorial activities and creating end-of-life protocols.

Examples

Families/support systems are 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 person served so that the person does not die alone.

The person served and family/support system are interviewed about preferences for the dying process (e.g., five wishes, music, individuals present, preparation and notification, comfort items, and spiritual needs); care planning includes these preferences.

Memorial gardens may be developed outside on organization property in remembrance of those lost.

Memorials that reflect the person may be evident throughout the organization.

Do not resuscitate (DNR) orders are known and strictly adhered to. Efforts are made to clarify issues related to a person's end-of-life wishes to avoid any misunderstanding on the part of personnel and/or the family/support system.

Programs may provide opportunities for personnel to express their grief by supporting them so they may attend the funeral of a person served.

4.A. **7. If the program utilizes volunteers, it provides documented, competency-based training to volunteers that addresses:**

a. Communication.

b. Dementia.

c. Post-incident debriefing opportunities.

d. Therapeutic approach to behavior.

Intent Statements

Volunteers can be valuable to a program, and it is important to have those individuals who interact with persons served and who impact service delivery receive competency-based training. This standard would not include a volunteer who assists with projects such as letter-stuffing for a one-time fundraising event.

Examples

Volunteers who assist with outings might receive training on emergency procedures, communication approaches, and how to maintain safety of individuals.

7.c. When incidents involving a person served occur during the volunteer engagement, the organization may find it helpful to debrief with the volunteer following an incident such as a person served beginning to cry during an art activity and/or yelling for help. Debriefs might be in a quiet location, shortly after the incident, and may provide an opportunity to explain potential causes, strategies that worked and did not work, and how to manage the stress or other emotions that may have resulted from the incident.

7.d. Volunteers might receive competency-based training regarding sexuality topics that are important to understand and respond to therapeutically if behaviors are exhibited by persons served.

4.A. **8. The program manager for the dementia care specialty program:**

a. Is qualified by virtue of training and experience in dementia care.

b. Has responsibility and authority to direct:

(1) Resource utilization.

(2) Performance improvement activities.

(3) Program development and modification.

(4) Educational activities for program personnel.

(5) Stakeholder relationship management.

(6) Advocacy activities.

(7) The development of ongoing relationships with the community.

(8) Promotion of the program.

Intent Statements

The organization determines who is the manager for the dementia care program. The manager may be an administrator, a director, or another position and may have responsibility for multiple

programs including the dementia program. The manager should have training and experience specific to dementia care and should demonstrate responsibility to direct the key functional areas identified in the standard. It is also important that the manager's style aligns with the program's mission. To manage relationships and conduct advocacy, communication approaches such as empathy, collaborative problem solving, and effective listening should be demonstrated by the manager.

4.A. **9. Ongoing input to the dementia care specialty program:**

- **a. Is provided by a physician who:**
  - **(1) Serves the program as at least one of the following:**
    - **(a) Medical director.**
    - **(b) Chair or member of a professional advisory committee.**
    - **(c) A consultant with a formal arrangement.**
    - **(d) Medical liaison.**
  - **(2) Is licensed by a professional governing body.**
  - **(3) Maintains:**
    - **(a) Licensure.**
    - **(b) Certification.**
    - **(c) Privileges in the organization, as applicable.**
  - **(4) Is qualified by virtue of training and experience in dementia.**
  - **(5) Participates in active clinical practice that relates to the population served.**
  - **(6) Demonstrates currency in medical practice concerning the persons served.**
  - **(7) Demonstrates active learning and involvement in the professional community.**
- **b. Addresses, but is not limited to:**
  - **(1) Development of ongoing relationships with the medical community.**
  - **(2) Establishment of policies and written procedures that address health issues, including monitoring.**
  - **(3) Performance improvement activities.**

Intent Statements

Because persons with dementia have complex needs, it is important to have access to physician expertise at various points during service delivery. While some organizations may have a paid medical director position, this standard does not require an organization to have such a position. The physician input may be obtained by contracting or consulting with a physician for various services.

Examples

The physician providing input may be a geriatrician, neurologist, etc. who is qualified by virtue of specialized training and experience in dementia and provides input for the persons served in the dementia care specialty program.

4.A. **10. The program facilitates collaboration in decision making through:**

- **a. Opportunities for the sharing of information through:**
  - **(1) Communications that are scheduled at the convenience of the family/support system.**
  - **(2) Information exchanges.**
- **b. Accessible information.**
- **c. Timelines for the exchange of information.**
- **d. Determining whether the information is understood by:**
  - **(1) The person served.**
  - **(2) The family/support system.**
  - **(3) Personnel.**
- **e. Documenting significant discussions and decisions made by the persons served in their records.**

Intent Statements

Collaboration, understanding, and effective decision making that reflects the knowledge and perspectives of families/support systems,

persons served, and personnel can happen only if there is a well-organized system of communication. The program should identify how the various communication systems are maintained and then referenced when decisions are made on behalf of the person served.

Examples

10.a. The program may utilize various types of information and communication technologies (e.g., email, text, phone, Zoom, FaceTime) to interact with members of the family/support system who live at a distance or who may be unavailable due to work demands, family obligations, or their own health limitations.

10.d. Information might be first shared verbally in simple, brief statements and then also provided as a written summary. To determine if someone understood the information, the communicator might review it at a later time to determine if major points were understood and if questions are outstanding. If a situation lends itself to asking for a brief explanation back in the listener's own words, that may also be a useful strategy.

4.A. **11. As needed for families/support systems, the program provides, arranges, or assists with arrangements for services, including:**

- **a. Advocacy education.**
- **b. Assistive technology.**
- **c. Community resources.**
- **d. Counseling.**
- **e. Emotional support.**
- **f. Reasonable accommodations.**
- **g. Respite.**
- **h. Support, including, but not limited to:**
  - **(1) Family/support system-to-family/support system.**
  - **(2) Peer-to-peer.**

Intent Statements

11.b. and **11.f.** Refer to the Glossary for definitions of *assistive technology* and *reasonable accommodations*.

Examples

11.c. Community resources may include transportation to and from appointments; caregivers to accompany the person served to appointments; and services not provided by the program, which might include vision services, dental care, audiology, and nonmedical services such as shopping and personal grooming services.

4.A. **12. Within the scope of the program, the rhythm of daily life is directed by each person served, as demonstrated by:**

- **a. Accommodating the choices of the person served regarding the cycle of each day, including:**
  - **(1) Bathing.**
  - **(2) Dressing.**
  - **(3) Eating.**
  - **(4) Hygiene.**
  - **(5) Oral care.**
  - **(6) Sleeping.**
  - **(7) Waking.**
  - **(8) Resting.**
- **b. Choice of clothing.**
- **c. Choice of grooming style.**
- **d. Each person's choice to participate in personally meaningful customary routines, including, but not limited to:**
  - **(1) Cleaning.**
  - **(2) Community activities.**
  - **(3) Contact with pets.**
  - **(4) Cooking.**
  - **(5) Exercise/mobility activities.**
  - **(6) Gardening.**
  - **(7) Hobbies.**
  - **(8) Intimacy.**
  - **(9) Recreation.**
  - **(10) Relaxation.**
  - **(11) Social interaction.**
  - **(12) Spiritual/religious activities.**

Intent Statements

The extent to which each area is considered may vary for each person served. The care team, in collaboration with the person served, strives to support the person served at the highest level of choice, well-being, and independence possible.

Examples

12.d. Personally meaningful customary routines might include:

- Reading and discussing news articles.
- Birthday and holiday recognitions.
- Trivia and word games.
- Stretching, range-of-motion, and light resistance exercises.
- Dancing.
- Reminiscing.
- Sing-alongs.

4.A. **13. When the program provides food services, it fosters independence through implementation of procedures:**

a. To manage social dynamics.

b. That allow persons served to select:

(1) What they want to eat.

(2) When they want to eat.

(3) Where they want to eat.

c. To address necessary adaptations.

d. That balance the choices of the persons served and their health and nutrition needs.

Intent Statements

Observation of the behaviors of the persons served and their dining experience is critical, especially if they are not able to articulate what, when, where, or with whom they want to eat.

Examples

Procedures reflect the population served in areas such as food presentation, adaptations, provision of finger foods, helping persons identify what they want to eat, and allowing persons to set the pace of eating.

13.a. To manage social dynamics, persons served might have choice regarding where in the dining space they sit in order to have a positive experience, or with whom they might dine. If some persons served cannot sit for periods of time to dine while others sit for an extended period of time, these differences might be considered in identifying where individuals dine in order to have a positive social experience.

13.b. The persons served may leave food uneaten, which may indicate that it was not what they ordered, they did not like the taste, it was the wrong consistency, they were not hungry, they were not seated where or with whom they wanted, there is something bothersome about the environment such as temperature or noise, they are waiting for others, or they are missing equipment such as special utensils.

13.d. Balancing independence and nutrition of persons served is important for quality of life. Individuals with dementia may experience loss of hunger, difficulty in recognizing food, and difficulty chewing or swallowing. They may also exhibit behaviors that impact dining experiences. Procedures can help to support managing all of these issues in a way that also offers choice.

4.A. **14. The organization provides documented competency-based training for personnel, as appropriate to their roles:**

a. At:

(1) Orientation.

(2) Regular intervals.

b. That includes:

(1) Dementia, including:

(a) Signs and symptoms.

(b) Progression.

(c) Types of dementia.

(d) Coexisting conditions.

(e) Lived experience of dementia.

(2) Delirium.

(3) Depression.

(4) Suicide risk assessment and prevention strategies.

(5) Identifying the personal preferences of the persons served.

(6) Loss and grief.

(7) Communication.

(8) Therapeutic approach to behavior.

(9) Observation skills.

(10) Sexuality.

(11) Skin integrity.

(12) Meaningful engagement of persons served on an ongoing basis.

(13) Therapeutic approach to activity development and implementation.

(14) Gathering information about the person served in the following areas:

(a) Life history.

(b) Important memories.

(c) Favorite stories.

(d) Daily routines.

(e) Comfort/reminiscence objects.

(f) People of importance.

(15) Advocacy.

(16) Teamwork.

(17) Pain.

(18) Palliative approach to care.

(19) End-of-life care.

(20) Hospice.

Intent Statements

14.b.(12) Almost every interaction in daily routines offers opportunities for meaningful engagement and activity-based care. Personnel are trained to actively seek opportunities, both planned and spontaneous, to engage in meaningful and purposeful interactions with the persons served.

Examples

14.b.(4) Identifying persons served in distress or exhibiting self-injurious behavior is part of ensuring that individuals receive the care and support needed to prevent suicide. Approaches might include teaching personnel about warning signs, screening protocols, and care approaches including assessing the environment to reduce access to means like balconies or windows.

14.b.(13) Therapeutic service delivery approaches might integrate favorite music, favorite foods, and other types of sensory engagement.

14.b.(14) Gathering information about the person served as part of the screening/assessment process may be enhanced by other conversation and observation approaches that may also be necessary to gather and maintain current information in light of frequent changes with the person served. It may be useful to have competency-based training focus on behavior versus asking questions about each area. Gathering information using various approaches may be useful to understand the current reality of the person served along with the person's communication level.

Practices might include observing and interpreting the meaning of behaviors and key words, phrases, or sounds used by the person served and what they indicate about the person. Strategies for understanding and responding to the information shared by the person served may include validation, mirroring, distraction, redirection, and cueing.

14.b.(17) Assessment of pain in individuals with dementia may require observations of behavior consistent with the presence of pain, as well as the use of tools such as the Pain Assessment in Advanced Dementia Scale (PAINAD) or the Discomfort Scale for Dementia of the Alzheimer's Type (DS-DAT).

4.A. **15. The tools used to measure experience with services received and other feedback are appropriate to elicit input from persons with dementia.**

Intent Statements

Persons served with dementia comprise the largest and most vulnerable group of persons served among elders. Their inclusion strengthens the reliability of data gathered and provides a more realistic view of individuals' experience with service delivery.

Numerous research groups have worked to develop reliable and valid tools to capture perceptions of individuals with dementia. When choosing a tool to gather data from persons served about their experience with service

delivery and other feedback, programs should be aware of how the tool was designed and field-tested for use with a dementia population.

Tools for this population are often administered through an interview. If this method is used, the program ensures that interviewers are trained to effectively interview persons with dementia, including strategies for handling challenging situations and when to discontinue an interview.

4.A. **16. Within its scope of practice and expertise, the dementia care specialty program acts as a resource to the community.**

Examples

The dementia care specialty program can offer valuable expertise to individuals in the local community to increase awareness of dementia topics. Serving as a resource might include having information on a website, speaking at local events, communicating with the fire department about persons who have dementia and how this impacts emergency response, developing free flyers for the public, conducting family workshops on signs of dementia and available resources, educating the public on early detection of dementia using biomarkers, and presenting information at local healthcare training programs about signs of dementia and what they mean.

4.A. **17. To advance the field of dementia care, leadership supports:**

- **a. The program's participation in research opportunities.**
- **b. The provision of information about available clinical trials and other research opportunities to:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
  - **(3) Personnel.**

Intent Statements

It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

17.a. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the dementia care specialty program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to dementia care on its research agenda.

4.A. **18. Leadership demonstrates a partnership approach to person-centered dementia care through the exchange of resources and education with:**

- **a. Persons served.**
- **b. Personnel.**
- **c. Families/support systems.**
- **d. Governing board, when applicable.**
- **e. Other stakeholders as appropriate.**

Intent Statements

18.d. Please refer to the Glossary for a definition of *governing board*.

4.A. **19. The program maintains knowledge of and coordination with local, regional, provincial, national, or international resources to facilitate:**

- **a. Specialized dementia services.**
- **b. Use of appropriate subspecialties.**
- **c. Advocacy.**

Examples

19.c. Advocacy might include being involved with a professional advocacy association, inviting regulators to a program to see how services are provided, or meeting with legislators regarding important policies impacting people with dementia and their families.

B. Palliative and End-of-Life Care Specialty Program

Description

The Palliative and End-of-Life Care Specialty Program demonstrates a person- and family-centered approach to providing holistic support to individuals who are experiencing life-limiting conditions. Early integration of palliative care allows the program to address the cultural, physical, emotional, psychosocial, religious, and spiritual needs and preferences of the persons served. The program seeks to understand the values, beliefs, wishes, and end-of-life choices of the persons served through advance care planning and implementation of individualized, interdisciplinary care plans.

The palliative care specialty program provides or arranges for grief and bereavement supports/resources and end-of-life care. The program educates providers across the continuum of care about palliative and end-of-life care and advocates for underserved populations. It utilizes current research and evidence-based practices to provide effective care and support to persons served and their families/support systems. The program demonstrates the commitment, capabilities, and resources to comprehensively address the complex needs of persons with life-limiting conditions across a variety of settings.

Applicable Standards

Programs seeking accreditation as a Palliative and End-of-Life Care Specialty Program must meet the program description and all standards in this section in addition to the related program-specific standards in Section 3 and all applicable standards in Sections 1 and 2. This specialty program accreditation may be sought in conjunction with the following programs:

- Adult Day Services
- Assisted Living
- Person-Centered Long-Term Care Community
- Home and Community Services
- Case Management
- Independent Senior Living
- Personal Supports Services
- Continuing Care Retirement Community

4.B. **1. A philosophy of palliative care:**
- **a. Is documented.**
- **b. Is modeled by:**
  - **(1) Leadership.**
  - **(2) Personnel.**
- **c. Guides service delivery.**
- **d. Is communicated in an understandable manner to:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
  - **(3) Other stakeholders.**

Examples

The written philosophy statement might address commitment to:

- Focusing on relationships with the persons served.
- Respect for the values, wishes, and end-of-life choices of the persons served.
- Quality of life through the end-of-life.
- Upholding the cultural, religious, and spiritual beliefs and practices of the persons served.
- Autonomy in decision-making about medical treatment and comfort care.
- Holistic support for persons served and families/support systems including their cultural, physical, emotional, psychosocial, religious, and spiritual needs and preferences.
- Empowering persons served to be their own decision makers.
- Early integration of palliative care.

The program's philosophy of palliative care could be embedded in mission, vision, values, or other written statements of the organization or program in which palliative care is delivered. It may be shared on a website; in a variety of materials, such as a prospective participant brochure or packet, orientation packet, contract,

admissions agreement, residence and care agreement, life lease, or participant agreement; or during discussions/meetings with persons served and their families/support systems.

4.B. **2. The palliative care program implements a strategy for early integration that includes:**

a. Engagement of persons served with palliative care once a life-limiting condition is diagnosed.

b. Education of relevant stakeholders about early integration.

Examples

2.b. Relevant stakeholders might include community agencies, referral sources, home and community services, volunteers, administrative staff, primary care physicians (to help identify early palliative care referrals), and educational institutions (e.g., nursing programs, personal support worker programs).

Education might include workshops, lunch and learn sessions, developing resource material and making it publicly available on websites, targeted training for referral agencies, presentations at educational conferences, social media communication, and testimonials and stories from persons served and families on experiences related to early integration.

Topics might include understanding palliative care, grief and bereavement support, volunteer roles in palliative care, and when to refer individuals to palliative care.

4.B. **3. Advance care planning for each person served includes:**

a. The ongoing gathering and documentation of information including, but not limited to, the person's:

(1) Hopes.

(2) Values.

(3) Wishes.

(4) Fears.

(5) End-of-life choices.

(6) Understanding of their illness.

(7) Cultural beliefs and practices.

(8) Religious and spiritual beliefs and practices.

(9) Life history.

(10) Important memories.

(11) Meaningful stories.

(12) Daily routines.

(13) Comfort/reminiscence objects.

(14) People of importance.

b. Integration of the information gathered into the person-centered plan.

c. Implementation of:

(1) End-of-life choices.

(2) Other actions in accordance with legal/regulatory requirements at the end of life.

Intent Statements

The program integrates services to support persons served with life-limiting conditions to live their best life while also planning for their decline through:

- Honoring and respecting where persons served currently are in understanding of their illness and their life's journey.
- Providing understandable information, education, and support with regard to medical information, advance care planning, and other discussions about end of life.
- Demonstrating awareness that facing or discussing mortality can profoundly impact the symptoms, emotions, behavior, and decision-making of the persons served and may present in unexpected ways.
- Providing a safe space for the sharing of fears, hopes, and unmet needs.
- Witnessing, validating, and valuing the life stories, strengths, and challenges of each person served.

This standard complements Standard 2.A.14. on initial and ongoing written screenings/assessments of the persons served. By using a person-centered approach to gathering information, the program gains an understanding of the person living with a life-limiting condition, including the person's values, beliefs, interests, abilities, likes and dislikes, etc., and uses this information to inform the person-centered plan.

3.a. Gathering information from the persons served is a fluid process that allows for changes and fluctuations over time and for barriers related to choices of the person served to be identified and addressed.

Examples

3.a.(4) ears could include becoming a burden, leaving families and loved ones and concern for their well-being after death, pain and suffering, loss of control and independence, changes in appearance, isolation, the unknown, or judgment from others regarding how one has lived their life or final wishes.

3.a.(7)–(8) As illness progresses, the persons served may need assistance finding alternate ways to participate in cultural, religious or spiritual events or activities, such as attending an event virtually or having members of that community visit the persons served to participate at their location.

In many cultures, healthcare extends beyond mainstream medicine to include approaches such as herbal remedies, traditional Chinese medicine, acupuncture, smudging, spiritual rituals, and sacred objects. See Standard 6 on complementary and alternative health approaches.

3.a.(9) Life history may be gathered through a variety of techniques, including guided questions during a one-on-one conversation; observation; and information taken from activities using photographs, music, food, or other items that might spark conversation. Information gathered might include accomplishments, losses, significant experiences, hopes, dreams, preferences, important roles, and ways of dealing with previous challenges or stressful situations. Understanding the whole person in this way provides greater understanding and appreciation of the person served and their experiences and promotes dignity and respect.

3.a.(12) Knowing the physical capabilities and physical comfort of the persons served allows for changes in some aspects of daily routines. Daily routines could include sleep/rest patterns, personal care, meal times, physical activity, medication regimes, hobbies, and socializing with family and friends.

3.a.(14) People of importance may include spouses/significant others/life partners, siblings, nieces, nephews, grandchildren, and others such as friends, neighbors, and individuals from the person's spiritual community. Persons served may experience fatigue or lack of desire to engage with people of importance. These may fluctuate and therefore necessitate opportunities.

3.c.(1) End-of-life choices might include returning to one's home, entering hospice care, funeral and memorial planning, organ and tissue donation, comfort care, reconciliation and closure, legacy work, bucket lists, bequests and donations.

4.B. **4. The program supports collaborative decision making through:**

- **a. The exchange of information at the convenience of:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **b. Accessible information.**
- **c. Timely exchange of information.**
- **d. Determining whether the information is understood by:**
  - **(1) The person served.**
  - **(2) The family/support system.**
  - **(3) Personnel.**
- **e. Documenting significant discussions and decisions made by the persons served in their records.**

Intent Statements

Well-organized and timely communication is essential to collaboration, understanding, and effective decision making that reflects the knowledge and perspectives of persons served, families/support systems, and personnel. Collaborative decision making engages the person served and the family/support system and is facilitated through acknowledgment and validation of their preferences, needs, desires, and capacity for decision making.

Examples

4.a. The program may utilize various types of information and communication technologies (e.g., email, text, phone, Zoom, FaceTime) to interact with members of the family/support

system who live at a distance or who may be unavailable due to work demands, family obligations, or their own health limitations.

4.b. Accessible information may include access to a translator, information expressed in plain language, large print, braille, assistive technologies, videos, and visual aids.

4.d. Information might be first shared verbally in simple, brief statements using plain language and then also provided as a written summary. To determine if someone understood the information, the communicator may ask for the information to be explained back in the person's own words or might review it at a later time to determine if major points were understood or questions are outstanding.

4.B. **5. The program:**

- **a. Meets the educational needs of:**
  - **(1) Persons served.**
  - **(2) Families/support system.**
- **b. Considers the readiness of the person served and the family/support system to receive the information.**
- **c. Provides education that includes, but is not limited to:**
  - **(1) Anticipated changes in health based on prognosis.**
  - **(2) Anticipated changes in the delivery of care.**
  - **(3) What to expect at the end of life.**
  - **(4) Medical orders.**
  - **(5) Advance directives.**
  - **(6) Legal decision-making authority.**
  - **(7) Symptom management.**
  - **(8) Grief.**
  - **(9) System navigation.**

Examples

5.c.(1) Anticipated changes in health based on prognosis might include changes in food consumption, fluid intake, sleep patterns, breathing patterns, and pain tolerance; decrease in social interactions; and general restlessness.

5.c.(4) Medical orders might include do-not-resuscitate orders, orders for transfer to other levels of care such as an emergency room or hospice, and orders for nutrition and hydration.

5.c.(9) System navigation might address financial resources and compassionate care benefits the family can access and what steps need to be taken following the death of the persons served including reporting and forms to complete.

Persons served may be disenrolled or discharged from palliative and end-of-life care programs when health status improves, and this can result in changes in funding or benefits.

4.B. **6. In response to the preferences of the person served, the program:**

- **a. Assesses the person's use of complementary health approaches.**
- **b. Educates the person served on the efficacy and safety of interventions.**
- **c. Provides information and resources on integrative health, as requested.**

Examples

According to the National Institutes of Health National Center for Complementary and Integrative Health (**www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name**), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

4.B. **7. The program:**

a. Educates persons served regarding:

(1) Dignity of risk.

(2) The potential outcomes associated with choices and behaviors that pose a risk to their well-being or safety.

b. Documents significant discussions and decisions made by the persons served in their records.

Intent Statements

Dignity of risk refers to the right to make one's own decisions even if those decisions involve some risk. While the health and safety of persons served is paramount, the preferences and choices of the person served may take precedence over the advice of family members, providers, or others. Under these circumstances, the program educates the persons served about the potential outcomes associated with choices and behaviors that pose potential risks to their well-being or safety, providing the opportunity for the persons served to make an informed decision to engage or not engage in the behavior.

Examples

The program educates the person served about the risks of choosing to:

- Continue smoking cigarettes, drinking alcohol, or using other drugs following diagnosis with a life-limiting condition.
- Consume foods that are counter to nutritional guidance for a medical condition such as congestive heart failure.
- Live alone despite identified safety concerns in the home and the need for support with daily activities.
- Decline treatment that could prolong life.

4.B. **8. For continuity of care, when there is a discharge/transition in care of the person served, the program:**

a. Communicates timely with the:

(1) Person served.

(2) Family/support system.

b. Provides a warm hand-off to the next provider.

c. Conveys key information about the person served to the next environment of care.

Intent Statements

Communicating essential information is important to continuity of care when a person served transitions to another level or environment of care within the same organization, to another organization, or home. Particularly at the end of life, timeliness is of the essence.

This standard relates to Standards 2.A.22.and 23. on transition/exit from the program.

The concept of a warm handoff involves direct interaction between providers, often in the presence of the person served and members of the family/support system. Such communication supports the person served being an active member of the team, even if the individual is not able to actively acknowledge understanding of the information exchanged, and allows for transparency, questions, and clarification or confirmation of the information conveyed.

4.B. **9. In accordance with their choices, the program provides or arranges for grief and bereavement supports and resources for families/support systems.**

Intent Statements

Each person's experience of grief is unique. Supports and resources are available to families/support systems throughout their journey, from the early stages of grieving through the loss of their loved ones and afterward.

Examples

Supports could include referrals to internal and external services such as spiritual and religious support, support groups, traditional healers, pastoral/chaplain care, and counseling. Resources could include pamphlets, websites, books, and workshops.

Grief and bereavement support may include follow-up services for the family/support system, death anniversary support, and letters of remembrance.

4.B. **10. At the end of life, the program provides or arranges for holistic support 24 hours a day/7 days a week of persons served and their families/support systems.**

Intent Statements

Regardless of advance care planning and preparation, persons served and their families/support systems may require a higher level of support as end of life approaches. The program provides and/or arranges for holistic support that eases the distress of persons served and their loved ones during this phase of life. Twenty four hours a day, seven days a week, support is accessible and timely.

Examples

Holistic support may include answering questions about changes in the status of the person served; what to expect as death approaches; symptom management; providing support for emotional, social, religious, spiritual, or existential needs; identifying resources to help with personal care, meals, medication pick-up, or transportation; and notifications/actions that need to occur once the person dies.

Supports may be provided in person or via phone, text, Zoom, or other use of technology.

4.B. **11. Ongoing medical input to the palliative care specialty program is provided by a physician or advance practice provider who:**

- **a. Serves the program as at least one of the following:**
  - **(1) Medical director.**
  - **(2) Chair or member of a professional advisory committee.**
  - **(3) A consultant with a formal arrangement.**
  - **(4) Medical liaison.**
- **b. Is licensed by a professional governing body.**
- **c. Maintains:**
  - **(1) Licensure.**
  - **(2) Certification, as applicable.**
  - **(3) Privileges in the organization, as applicable.**
- **d. Is qualified by virtue of training and experience in palliative and end-of-life care.**
- **e. Participates in active clinical practice that relates to the population served.**
- **f. Demonstrates active learning and involvement in the professional community.**

Intent Statements

The program complies with relevant legal, regulatory, and payer requirements in determining what type of provider can fulfill this role.

The physician or advanced practice provider who provides medical input to the program demonstrates experience, training, and ongoing engagement in palliative care. If a physician fulfills this role, it is expected that the physician is board certified in a specialty area.

4.B. **12. As appropriate to their roles, the program provides documented competency-based training for personnel, including volunteers:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes, but is not limited to:**
  - **(1) Anticipatory grief.**
  - **(2) Caregiver support.**
  - **(3) Common end-of-life trajectories.**
  - **(4) Conversations regarding end-of-life.**
  - **(5) Cultural considerations related to death and dying.**
  - **(6) Cultural humility.**
  - **(7) Grief and bereavement.**
  - **(8) Legal decision-making authority.**
  - **(9) Professional boundaries.**
  - **(10) Signs of imminent death.**
  - **(11) Symptom management.**
  - **(12) Trauma-informed care.**

Intent Statements

12.b.(6) The way in which cultural, spiritual, and religious beliefs and practices influence a person's response to life-limiting illness will be unique for

each person served. Cultural humility allows personnel to engage with the intention of learning from the persons served; honoring their beliefs, customs, and values; acknowledging differences; and accepting all individuals for who they are.

Examples

12.b.(1) Education could include a definition of anticipatory grief, how to recognize and acknowledge it, and how to validate and support the person served and family members when anticipatory grief presents.

12.b.(2) Education on supporting caregivers could include strategies to ease emotional burden, the importance of and how to access respite care, and referrals to members of the interdisciplinary team with expertise in counseling.

12.b.(9) Training topics could include navigating compassion fatigue, work-life balance, the use of personal disclosures/stories, empathy and professionalism, managing personal attachment, understanding roles and responsibilities including limitations, respecting the choices and decisions of persons served, and conflicts of interest.

12.b.(11) Symptom management may include non-pharmacological and pharmacological methods. Education for personnel might include identification of common symptoms experienced by the persons served and how the program can address those symptoms given the expertise on the interdisciplinary team and other services that could be arranged for persons served outside of the program.

4.B. **13. On an ongoing basis, the program supports the well-being of personnel experiencing grief through:**

a. Timely debriefings.

b. Opportunities to express grief and remembrance.

c. Access to resources that support personnel well-being.

Intent Statements

There is recognition of the stress, grief, and loss experienced working in palliative care. Depending on the size and scope of the program, various opportunities are available to support well-being and minimize or counteract the compassion fatigue of personnel.

Examples

13.b. Personnel may help plan or attend memorial or other remembrance services and activities.

13.c. Resources might include supervisory and peer support groups or individual sessions to address challenges, share wisdom, and celebrate 'small victories,' relaxation/quiet spaces, employee assistance programs, training on coping strategies and how to manage personal grief, open-door and flexible workplace policies, and on-site wellness activities.

4.B. **14. The program implements a process to address ethical concerns related to palliative and end-of-life care situations.**

Intent Statements

As part of an organization's ethical codes of conduct (related to Standard 1.A.6.), established ethical principles can be used as a guide for addressing complex dilemmas. Addressing concerns in a confidential and supportive manner is key as a decision or resolution of a problem is not always the desired or expected outcome of the process.

Examples

Learning circles, ethics committees, and consultations with an ethicist may be used to address ethical concerns.

Examples of ethical concerns in palliative and end-of-life care include:

- A person served refusing life-sustaining treatment while family members want continued treatment to prolong life.
- Withholding or withdrawing life-sustaining treatment.
- A person served in the terminal phase of illness who did not identify a health care proxy and has no living will with advance directives and family members disagree on the use of life-sustaining measures.
- Pain management administration and the potential for hastening death.

- Changes in consent and capacity.
- Medical interventions that are non-beneficial or futile.

4.B. **15. Within its scope of practice and expertise, the program demonstrates efforts to educate providers across the continuum of care regarding:**

a. Palliative care.

b. End-of-life care.

c. Advocacy for underserved populations.

Examples

The program acts as a resource to other providers across the continuum of care who may encounter or provide services to persons experiencing life-limiting conditions. It may provide educational sessions or materials, consultation, or training to providers on topics such as development of service models and programs for persons served; advocacy activities; appropriate service referrals; recognition of factors facilitating and barriers to achievement of optimal outcomes; and collaboration with providers on the timing of advance care planning and interventions.

15.c. Underserved populations might include older adults; persons who are incarcerated, uninsured, live in rural areas, in a lower socioeconomic status, experiencing homelessness or at risk of becoming unhoused, or experiencing substance use disorders.

4.B. **16. To advance the field of palliative and end-of-life care, leadership supports:**

a. The program's participation in research opportunities.

b. The provision of information about available clinical studies and other research opportunities to:

(1) Persons served

(2) Families/support systems.

(3) Personnel.

Intent Statements

It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc. Regional, state, and national provider associations often facilitate or share information about research opportunities.

Examples

The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the palliative care specialty program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to palliative care on its research agenda.

The organization participates in associations in which researchers and clinicians interact to influence research in the field, e.g., American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, National Coalition for Hospice and Palliative Care, Pan-Canadian Palliative Care Research Collaborative, Canadian Palliative Care Nursing Association, and Pallium.

4.B. **17. The organization establishes a policy on medical assistance in dying.**

Intent Statements

A policy establishes the organization's position on medical assistance in dying (MAID) so that persons served, families/support systems, personnel, and other relevant stakeholders may understand whether MAID is available, accessible, or addressed by the program, and, if so, in what way. The program complies with all legal and regulatory obligations related to MAID.

Examples

If MAID is legal in the jurisdiction, an organization may still consider it in conflict with religious, ethical, or other principles and prohibit its use or access.

If MAID is not legal in the jurisdiction, the policy indicates whether the program will assist persons served with information and resources on where MAID is available.

APPENDIX A

Required Written Documentation

When used in the CARF standards, the following terms always indicate the need for written evidence to demonstrate conformance: *policy*, *plan*, *documented*, *documentation*, and *written*. The following tables list only those standards that explicitly require some form of written evidence to demonstrate conformance. This appendix is intended to provide a quick reference to such standards and provide a tool that organizations may find helpful in preparing for their surveys.

What is *not* included in this Appendix:

During a site survey, an organization may provide a variety of documents and written materials related to standards that are not listed here, including:

- Documents and written materials that demonstrate conformance to standards that do not explicitly require written evidence; e.g., procedures that do not specify written or education or training that does not specify documented.
- Documents and written materials that support conformance to standards but are not specifically required by the standards; e.g., minutes of meetings or orientation packets for persons served.

NOTE: *This appendix is available in an editable electronic format in the Resources section of Customer Connect (**https://customerconnect.carf.org**).*

Section 1. ASPIRE to Excellence®

Standard(s)	Requirements	Location of Documents
1.A. Leadership		
1.A.5.a.	Policies and written procedures on the use of artificial or augmented intelligence (AI), if applicable	
1.A.6.a. and b.	Written 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 adopted by organization leadership	
1.A.7.b.	For U.S. organizations receiving federal funds, written procedures that address exclusion of individuals and entities from federally funded healthcare programs	
1.A.7.c.(1)	For U.S. organizations receiving federal funds, documentation of staff member designated to serve as the organization's compliance officer	

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements	Location of Documents
1.A.9.a.	Written procedures related to organizational fund-raising, if applicable	
1.B. Governance		
1.B.1.	Governance policies that facilitate ethical governance, assure stakeholders that governance is active and accountable, and meet legal requirements of governance	
1.B.2.	Governance policies that address board selection, orientation, development, education, leadership, structure, and performance	
1.B.5.	Governance policies that address executive leadership development and evaluation, including a written review of performance and succession plan	
1.B.6.	Governance policies that address executive compensation	
1.C. Strategic Planning		
1.C.2.b. and c.	Strategic plan	
1.E. Legal Requirements		
1.E.2.	Written procedures to guide personnel in responding to subpoenas, search warrants, investigations, and other legal action	
1.E.3.	Policies and written procedures on records	
1.F. Financial Planning and Management		
1.F.2.c.	Budget documents reasonable projections of revenues, expenses, and capital expenditures and approval by the identified authority	
1.F.4.d.	Financial solvency remediation plans, if appropriate	
1.F.5.a.	Fiscal policies and written procedures including internal control practices	
1.F.6.b.	Documented review of representative sample of bills of the persons served, if the organization bills for services provided	

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements	Location of Documents
1.F.8.b.	Documented results of annual financial statement review or audit by an independent, authorized accountant including, if applicable, resulting recommendations and management's response to recommendations	
1.F.9.	Documentation of independent financial audit completed within 120 days of fiscal year end	
1.F.11.a.	Investment policy, if the organization has material investments	
1.F.16.a. and b.	Documented capital needs assessment that addresses existing capital assets and future capital asset needs	
1.F.18.a.	Long-range financial plan	
1.G. Risk Management		
1.G.1.a.	Risk management plan	
1.G.3.	Written procedures regarding communications that address media relations and social media	
1.G.4.	Policies related to the organization's use of technology and data	
1.G.5.	Documented reviews of contract services, if applicable	
1.H. Health and Safety		
1.H.2.	Written procedures to promote the safety of persons served and personnel	
1.H.4.	Documentation of competency-based training on health and safety for personnel at orientation and at least annually	
1.H.5.	Written emergency and evacuation procedures	
1.H.7.	Written evidence of unannounced tests of each emergency procedure, including analyses	
1.H.8.	If services are provided in locations that are not owned/leased or controlled/operated by the organization, written procedures that address safety at the service delivery site for persons served and personnel	
1.H.10.	Written procedures regarding critical incidents	
1.H.11.	Written analysis of critical incidents	

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements	Location of Documents
1.H.12.	Written procedures regarding infections and communicable diseases	
1.H.13.h.	Written emergency procedures related to transportation services	
1.H.13.l.	Documented reviews of contracts for transportation services, if applicable	
1.H.14.b.	Health and safety self-inspection reports	
1.H.15.b.	External health and safety inspection reports	
1.H.16.	Written procedures for safe handling, storage, and disposal of hazardous materials	
1.I. Workforce Development and Management		
1.I.1.	Documentation of the composition of the organization's workforce	
1.I.4.b.	Written job descriptions	
1.I.5.	Written procedures related to verification of backgrounds, credentials, and fitness for duty, if required, of the workforce	
1.I.7.d.(1)	Policies and written procedures related to workforce engagement	
1.I.8.a.–c.	Documentation of competencies, assessments of competencies, and timeframes/frequencies related to the competency assessment process	
1.I.9.	Written procedures for performance appraisals	
1.I.13.	Documentation of initial and ongoing personnel training on cybersecurity and the technology used in performance of job duties	
1.J. Rights of Persons Served		
1.J.1.	Policies on the rights of persons served	
1.J.3.a.	Policy and written procedure by which persons served may make a formal complaint	
1.J.3.b.	Complaint forms, if applicable	
1.J.3.c.	Documentation of formal complaints received	
1.J.4.	Documented analysis of all formal complaints	

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements	Location of Documents
1.K. Accessibility		
1.K.2.b.	Accessibility plan	
1.K.3.d.	Documentation of requests for reasonable accommodations	
1.L. Performance Measurement and Management		
1.L.3.a.	Performance measurement and management plan that addresses all elements listed in the standard	
1.L.4.	For each program/service seeking accreditation, documented objectives and performance indicators to measure results achieved for the persons served (effectiveness)	
1.L.5.	For each program/service seeking accreditation, documented objectives and performance indicators to measure experience of services received and other feedback from the persons served	
1.L.6.	For each program/service seeking accreditation, documented objectives and performance indicators to measure experience of services and other feedback from other stakeholders	
1.L.7.	For each program/service seeking accreditation, documented objectives and performance indicators to measure the resources used to achieve results for the persons served (efficiency)	
1.L.8.	For each program/service seeking accreditation, documented objectives and performance indicators to measure service access	
1.L.9.	Documented objectives and performance indicators to measure business function in priority areas determined by the organization	
1.L.10.	Documented education and training for personnel in accordance with their roles and responsibilities for performance measurement and management	
1.M. Performance Improvement		
1.M.1.a.–f.	Documented analysis of service delivery performance	
1.M.1.g.(2)	Action plan(s) to address improvements needed	
1.M.2.a.–e.	Documented analysis of business function performance	

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements	Location of Documents
1.M.2.f.(2)	Action plan(s) to address improvements needed	

Section 2. The Care Process for the Persons Served

Standard(s)	Requirements	Location of Documents
2.A. Program/Service Structure		
2.A.1.a.	Documentation of scope of services	
2.A.3.	Documented entry, transition, and exit criteria	
2.A.8.	Written procedures regarding holding of funds of persons served, if applicable	
2.A.9.a.	Documentation regarding related entities, if applicable	
2.A.11.	Written agreements signed by persons served and the program representative that include all items listed in the standard	
2.A.13.	Written screenings/assessments	
2.A.14.	Initial and ongoing written screenings/assessments	
2.A.15.	Person-centered plans for each person served that include all items listed in the standard	
2.A.23.b.	Documentation of discussions with the families/ support systems of persons served	
2.A.27.	Policy on the use of chemical and physical restraints	
2.A.28.	Written procedures regarding the use of chemical or physical restraints	
2.A.29.	Written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances	
2.A.31.	Policies that address advance directives and resuscitation	
2.A.34.	Written philosophy of health and well-being for the persons served	
2.A.35.p.	Documentation of activities promoting well-being for persons served evident in the person-centered plan for each person served	

Section 2. The Care Process for the Persons Served (Continued)

Standard(s)	Requirements	Location of Documents
2.A.40.i.	Emergency plans take into consideration the unique needs of persons served who require respiratory management	
2.A.42.	Records of persons served that include all items listed in the standard	
2.B. Residential Communities		
2.B.2.	Policies regarding how the program provides, arranges, or assists with arrangements for the services listed	
2.B.5.a.(1)	Policies that address medication management/ assistance	
2.B.7.	Policies that address services arranged by the person served, pets, service animals, upkeep and maintenance of individual residences, smoking, and guests	
2.B.9.	Policies and written procedures that allow persons served to receive visitors 24 hours a day if desired	
2.B.16.d.	Policy addressing whether the program allows essential caregivers during sustained emergency conditions	
2.B.16.e.(2)	Written procedures regarding the scope of involvement of essential caregivers with the persons served	
2.C. Care Process for Specific Diagnostic Categories		
2.C.1.e.	Documentation of significant discussions and decisions made by the persons served with dementia in their records	
2.C.6.	Documented competency-based training for volunteers that addresses the topics listed in the standard	
2.C.7.	Documented competency-based training for personnel that addresses the topics listed in the standard	
2.D. Skin Integrity and Wound Care Standards		
2.D.1.	Written procedures addressing skin integrity and wound care that include all areas listed in the standard	
2.D.3.	Initial and ongoing assessments of each person served that document information about skin integrity, as identified in the standard	

Section 2. The Care Process for the Persons Served (Continued)

Standard(s)	Requirements	Location of Documents
2.D.5.a.	Written protocols for wound care needs that are within the scope of the program, including documented initial and ongoing assessments of wounds and a plan for follow-up care	
2.D.5.b.	Written protocols for referrals to or coordination with appropriate specialists for wound care needs that are outside the scope of the program	
2.D.7.	Documentation of competency-based training for personnel who provide services related to skin integrity and wound care, provided at orientation and regular intervals	
2.D.8.a.	Documentation of a service delivery indicator(s) to measure performance related to skin integrity	
2.D.8.c.	Written analysis of information gathered on persons served regarding skin integrity	
2.E. Care Process for Personal Supports Services		
2.E.8.	Policy that identifies the program's role related to medication management	
2.E.9.	Written procedures that address compliance with all applicable laws and regulations pertaining to medications and controlled substances, if applicable	
2.E.12.	Records of persons served that include all items listed in the standard	
2.F. Service Delivery Using Information and Communication Technologies		
2.F.1.	Written procedures related to use of information and communication technologies to deliver services	
2.F.2.	Documentation of competency-based training for personnel as specified in the standard	

Section 3. Program Specific Standards

Standard(s)	Requirements	Location of Documents
3.A. Adult Day Services		
3.A.2.b.	Documentation of the program's role in and use of a continuum of care	
3.A.3.	Calculated unit cost data	

Section 3. Program Specific Standards

Standard(s)	Requirements	Location of Documents
3.A.7.	Current emergency information for each person served that addresses all items in the standard	
3.A.8.	Policies that address services arranged by the person served, pets, service animals, smoking, and guests	
3.B. Assisted Living		
3.B.1.	Documentation of the characteristics of the population the program can serve	
3.B.6.	Policies that address PRN (as needed) medications	
3.B.9.	Written indicators to measure falls and well-being	
3.B.11.	Written procedures that address criminal background checks for personnel	
3.B.13.	Current emergency information for each person served that addresses all items in the standard	
3.C. Person-Centered Long-Term Care Community		
3.C.1.a.–b.	Documented person-centered philosophy that addresses the listed areas	
3.C.3.	Written information about the program's specific arrangements for the listed services	
3.C.6.e.	Documentation of discussions and decisions made by the persons served in their records	
3.C.7.a.	Written risk assessments in the areas listed	
3.C.15.	Policies and written procedures that address nursing services	
3.C.16.	Policies and written procedures that address medical and rehabilitation management	
3.C.21.	Contract with the medical director for the program that outlines his or her responsibilities	
3.C.23.	Documented competency-based training for personnel	
3.C.32.	Current emergency information for each person served that addresses all items in the standard	

Section 3. Program Specific Standards

Standard(s)	Requirements	Location of Documents
3.D. Home and Community Services		
3.D.3.	Written procedures to verify backgrounds of all personnel	
3.D.4.	Documentation of competency-based training for personnel that addresses the delivery of home and community services	
3.D.5.	Policies and written procedures addressing delivery of home and community services	
3.D.6.a.	Initial and ongoing risk assessments of each person served	
3.D.8.	Individual disaster preparedness and emergency plans that address all areas listed in the standard	
3.D.11.	Policies and written procedures to facilitate collaboration with the person served and family/support system in decision making	
Section 3.I. Case Management		
3.E.12.	Individual plans	
3.E.13.	Individualized written disclosure statements	
3.E.24.	Written discharge/transition summaries	
3.E.28.b.	Written analysis of information gathered on persons served	
3.E.29.	Records of the persons served	
3.E.30.	Written analysis of representative sample of records of persons served	
3.F. Independent Senior Living		
3.F.1.a.	Documented parameters regarding scope of services	
3.F.2.a.	Documented entry and exit criteria	
3.F.3.	Written agreements signed by persons served and the program representative that include all items listed in the standard	
3.F.17.	Written procedures for personnel background verification	
3.F.22.d.	Policy addressing whether the program allows essential caregivers during sustained emergency conditions	

Section 3. Program Specific Standards

Standard(s)	Requirements	Location of Documents
3.F.22.e.(2)	Written procedures regarding the scope of involvement of essential caregivers with the persons served	
3.G. Personal Supports Services		
3.G.3.	Plan and written procedures for the supervision of personnel, including provision of timely feedback to enhance skills, and for addressing unplanned absences to ensure continuity of supports	
3.G.6.	If training/education is provided, a written description for each offering that includes all items listed	

Section 4. Specialty Population Designations

Standard(s)	Requirements	Location of Documents
4.A. Dementia Care Specialty Programs		
4.A.1.e.	Documentation of significant discussions and decisions made by the persons served with dementia in their records	
4.A.7.	Documented competency-based training for volunteers that addresses the topics listed in the standard	
4.A.9.b.(2)	Policies and written procedures that address health issues, including monitoring, established with physician input	
4.A.10.e.	Documentation of significant discussions and decisions made by the persons served with dementia in their records	
4.A.14.	Documented competency-based training for personnel that addresses the topics listed in the standard	
4.B. Palliative and End-of-Life Care Specialty Program		
4.B.1.a.	Philosophy of palliative care	
4.B.3.a.	Information gathered for advance care planning that addresses all elements in the standard	
4.B.3.b.	Person-centered plans	
4.B.4.e.	Significant discussions and decisions made by persons served documented in their records	

Section 4. Specialty Population Designations

Standard(s)	Requirements	Location of Documents
4.B.7.b.	Significant discussions and decisions made by persons served documented in their records	
4.B.12.	Competency-based training for personnel on the topics listed in the standard	
4.B.17.	Policy on medical assistance in dying	

APPENDIX B

Operational Timelines

The following tables list standards that require activities be conducted at specific time intervals. The evidence assembled as part of survey preparation should support that these activities occur at the specified intervals.

During an original survey, an organization is expected to demonstrate that the activity has occurred at least once within the specified time period prior to the survey.

The timelines for the standards listed in the last table, Activities to be Conducted at a Frequency Determined by the Organization (e.g., verification of backgrounds, credentials, and fitness for duty of members of the workforce, or data collected about persons served at appropriate intervals during services) may be influenced by various factors such as regulatory requirements or the needs of the organization and the persons served. For these standards, the organization should identify the frequency at which the activities are scheduled to be conducted. The survey team will look for evidence that the organization adheres to the timelines it has identified.

What is *not* included in this Appendix:

- Standards that require an organization's policy or written procedure to include a timeframe, such as timeframes for addressing a formal complaint or entering information into the records of the persons served, are not listed in this appendix.
- Standards that require activities be conducted on an *ongoing* or *as needed* basis are not included in this Appendix.

Please contact your resource specialist with any questions.

NOTE: *This appendix is available in an editable electronic format in the Resources section in Customer Connect (**https://customerconnect.carf.org**).*

Activities to be Conducted at Least Annually

Related Standard	Activity	Date of Last Occurrence	Document Source
Section 1. ASPIRE to Excellence®			
1.A. Leadership			
1.A.5.b.	Policies and written procedures on artificial or augmented intelligence reviewed, if applicable		
1.B. Governance			
1.B.2.g.(3), (5)–(6)	Self-assessment of entire board; written conflict-of-interest and ethical-code-of-conduct declarations signed		
1.B.5.b.(1)	Executive leadership succession plan reviewed for relevance		

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity	Date of Last Occurrence	Document Source
1.B.6.e.(6)	Review of executive compensation records		
1.B.7.	Review of governance policies		
1.C. Strategic Planning			
1.C.2.d.	Strategic plan reviewed for relevance		
1.F. Financial Planning and Management			
1.F.2.a.	Budgets are prepared before the start of the fiscal year		
1.F.8.	Review or audit of the financial statements of the organization by an independent accountant authorized by the appropriate authority		
1.F.9.	Independent financial audit completed within 120 days of the fiscal year end		
1.F.11.b.	Investment policy reviewed for relevance, if applicable		
1.F.12.	Leadership reviews the investment results in accordance with the investment policy		
1.F.13.b.	Cash management strategy reviewed for relevance		
1.F.18.d.	Long-range financial plan reviewed for relevance		
1.G. Risk Management			
1.G.1.b.(1)	Risk management plan reviewed for relevance		
1.G.2.a.	Review of organization's insurance package for adequacy		
1.G.5.d.	Documented reviews of contract services, if applicable		
1.H. Health and Safety			
1.H.4.b.	Personnel receive competency-based training in health and safety topics listed in the standard		
1.H.7.	Unannounced test of each emergency procedure, including as relevant to the procedure, complete actual or simulated physical evacuation		
1.H.11.	Written analysis of all critical incidents provided to or conducted by leadership		
1.H.13.l.	If transportation services are contracted, the contract is reviewed against Standards 1.H.13.a.–k.		

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity	Date of Last Occurrence	Document Source
1.H.15.	Comprehensive health and safety inspection conducted		
1.J. Rights of Persons Served			
1.J.2.a.(3)	The rights of persons served are communicated to persons served in a program longer than one year		
1.J.4.	Documented analysis of all formal complaints		
1.K. Accessibility			
1.K.2.c.	Accessibility plan reviewed for relevance		
1.L. Performance Measurement and Management			
1.L.3.b.	Performance measurement and management plan reviewed for relevance		
1.M. Performance Improvement			
1.M.1.	Documented analysis of service delivery performance		
1.M.2.	Documented analysis of business function performance		
Section 2. Care Process for the Persons Served			
2.A. Program/Service Structure			
2.A.1.c.	Review of scope of services		
2.A.25.d.	Personnel training on safety and security measures		
2.A.30.b.	Competency-based training for personnel responsible for medications		
2.D. Skin Integrity and Wound Care Standards			
2.D.8.c.	Written analysis of information gathered on persons served regarding skin integrity that includes all areas identified in the standard		
2.E. Care Process for Personal Supports Services			
2.E.6.c.	Safety and security measures addressed in personnel training		
2.E.10.b.	Competency-based training on medication for personnel who are responsible for medications		

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity	Date of Last Occurrence	Document Source
Section 3. Program Specific Standards			
3.A. Adult Day Services			
3.A.3.a.	Unit cost data calculated at least annually as part of the budgeting process		
3.C. Person-Centered Long-Term Care Community			
3.C.30.b.	The program annually address performance in relationship to established targets in the areas listed in the standard.		
3.E. Case Management			
3.E.28.b.	Written analysis of information gathered on persons served		
3.E.30.a.	Written analysis of representative sample of records of persons served		
3.F. Independent Senior Living			
3.F.1.c.	Scope of services is reviewed		

Activities to be Conducted at Least Semiannually

Related Standard	Activity	Date of Last Occurrence	Document Source
Section 1. ASPIRE to Excellence®			
1.H. Health and Safety			
1.H.14.	Comprehensive health and safety self-inspections		

Activities to be Conducted at Least Quarterly

Related Standard	Activity	Date of Last Occurrence	Document Source
Section 1. ASPIRE to Excellence®			
1.F. Financial Planning and Management			
1.F.6.	Documented review of a representative sample of bills of the persons served, if applicable		

Activities to be Conducted at Least Monthly

Related Standard	Activity		
Section 1. ASPIRE to Excellence®			
1.F. Financial Planning and Management			
1.F.3.c.	Review of actual financial results		

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity		
Section 1. ASPIRE to Excellence®			
1.B. Governance			
1.B.2.g.(4)	Periodic self-assessment of individual members of the board		
1.B.5.a.	Formal written review of executive leadership performance		
1.F. Financial Planning and Management			
1.F.16.c.	Capital needs assessment is reviewed regularly		
1.H. Health and Safety			
1.H.13.b.	When transportation services are provided to persons served, a regular review of the driving records of all drivers		
1.H.13.k.	Maintenance of vehicles owned or operated by the organization according to the manufacturers' recommendations		
1.I. Workforce Development and Management			
1.I.4.c.	Review and update of written job descriptions		
1.I.5.c.	Verification of backgrounds, credentials, and fitness for duty, if required, of the workforce		
1.I.8.c.	Timeframes/frequencies related to the competency assessment process		
1.I.9.e.	Timeframes/frequencies related to the performance appraisal process		

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity		
Section 2. Care Process for the Persons Served			
2.A. Program/Service Structure			
2.A.8.c.(1)	Provision of information to persons served on the status of their funds		
2.D.7.a.(2)	Training provided at regular intervals to personnel who provide services related to skin integrity and wound management		
2.B. Residential Communities			
2.B.15.	Regular meetings between personnel and the persons served to discuss issues concerning the living environment		
2.C. Care Process for Specific Diagnostic Categories			
2.C.7.a.(2)	Competency-based training for personnel at regular intervals		
2.F. Service Delivery Using Information and Communication Technologies (ICT)			
2.F.6.	Maintenance of equipment in accordance with manufacturers' recommendations		
Section 3. Program Specific Standards			
3.B. Assisted Living			
3.B.10.a.(2)	Personnel training at regular intervals		
3.C. Person-Centered Long-Term Care Community			
3.C.23.a.(2)	Competency-based training for personnel at regular intervals		
3.D. Home and Community Services			
3.D.3.b.	Verification of backgrounds of all personnel at stated intervals		
3.F. Independent Senior Living			
3.F.9.	Regular meetings between personnel and the persons served to discuss issues concerning the living environment		
3.F.18.a.(2)	Personnel training at regular intervals		
3.G. Personal Supports Services			
3.G.6.f.	Regular review of written descriptions for training/educational activities offered		

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity		
Section 4. Specialty Program Designation Standards			
4.A. Dementia Care Specialty Programs			
4.A.14.a.(2)	Personnel training at regular intervals		
4.B. Palliative and End-of-Life Care Specialty Program			
4.B.12.a.(2)	Competency-based training for personnel at regular intervals		

APPENDIX C

Required Training

The following tables list the standards that explicitly require an organization to provide some form of education or training to personnel, persons served, and/or other stakeholders.

Some standards require competency-based training or education. As defined in the Glossary, competency-based training is an approach to education that focuses on the ability to demonstrate adequate skills, knowledge, and capacity to perform a specific set of job functions.

What is *not* included in this Appendix:

- Standards that 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 are not listed in this Appendix.
- Many standards require sharing or exchange of information with persons served, personnel, and/or other stakeholders. Although this may be accomplished through educational efforts, such standards are not listed in this Appendix.

NOTE: *This appendix is available in an editable electronic format in the Resources section in Customer Connect (**https://customerconnect.carf.org**).*

Section 1. ASPIRE to Excellence®

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
1.A. Leadership				
1.A.6.c.	Education on ethical codes of conduct	Personnel and other stakeholders	No	None specified
1.A.7.d.	Training on corporate compliance	Personnel	No	None specified
1.A.8.	Education to stay current in the field	Personnel	No	None specified
1.A.9.b.	Training related to fundraising written procedures, if applicable	Appropriate personnel	No	Initial and ongoing
1.B. Governance				
1.B.2.b., d.	Board member orientation and education	Board members	No	None specified

Section 1. ASPIRE to Excellence®

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
1.F. Financial Planning and Management				
1.F.5.b.	Training related to fiscal policies and written procedures	Appropriate personnel	No	Initial and ongoing
1.H. Health and Safety				
1.H.3.	Education designed to reduce identified physical risks	Persons served	No	None specified
1.H.4.	Health and safety training that addresses all areas listed in the standard	Personnel	Yes	Orientation and at least annually
1.H.11.b.(7)	Education and training based on analysis of critical incidents	Personnel	No	None specified
1.H.12.b.	Training on procedures regarding infections and communicable diseases	Persons served, personnel, and other stakeholders	No	None specified
1.H.13.g.	If the program provides transportation for persons served, training regarding the organization's transportation procedures and unique needs of persons served	Drivers who provide transportation for persons served	No	None specified
1.I. Workforce Development and Management				
1.I.8.f.	Education and training included in workforce development activities	Personnel	No	None specified
1.I.13.a. and b.	Training on cybersecurity and technology used to perform job duties	Personnel	No	Initial and ongoing
1.L. Performance Measurement and Management				
1.L.10.	Education and training in accordance with roles and responsibilities for performance measurement and management	Personnel	No	None specified

Section 2. Care Process for the Persons Served

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.A. Program/Service Structure				
2.A.25.d.	Safety and security measures addressed in personnel training	Personnel	No	At least annually
2.A.30.	Training on medications	Personnel responsible for medications	Yes	Upon hire and at least annually
2.A.37.a.	Formal and informal educational opportunities provided or arranged for persons served	Persons served	No	None specified
2.A.40.h.	Training related to respiratory management (if the program serves any persons who require respiratory management)	Persons served and families/ support systems	No	None specified
2.A.46.	Education on how to recognize and respond to changing needs of the persons served	Personnel and volunteers	No	None specified
2.A.49.a.	Education regarding end-of-life choices, as needed	Persons served	No	None specified
2.B. Residential Communities				
2.B.3.c.(4)	Education on community resources for social services	Persons served	No	None specified
2.C. Care Process for Specific Diagnostic Categories				
2.C.3.	Education that includes all areas listed in the standard, in accordance with identified needs	Persons served and families/ support systems	No	None specified
2.C.6.	Training that addresses all areas listed in the standard, if the program utilizes volunteers	Volunteers	Yes	None specified
2.C.7.	Training for personnel that includes all areas listed in the standard, as appropriate to their roles	Personnel	Yes	Orientation and regular intervals
2.D. Skin Integrity and Wound Care Standards				
2.D.4.a.(6)	Education related to identified skin integrity risks	Persons served, families/support systems, and personnel	No	None specified

Section 2. Care Process for the Persons Served (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
2.D.5.a.(7)	Education related to identified wound care needs	Persons served, families/support systems, and personnel	No	None specified
2.D.7.	Training related to skin integrity and wound management that includes all areas listed in the standard	Personnel who provide services related to skin integrity and wound management	Yes	Orientation and regular intervals
2.D.8.c.(5)	Education and training related to performance analysis of skin integrity indicator(s)	Persons served, families/support systems, personnel, and other stakeholders	No	None specified
2.E. Care Process for Personal Supports Services				
2.E.10.	Training on medication that includes all topics listed in the standard	Personnel who are responsible for medications	Yes	Upon hire and at least annually
2.E.16.	Education on identifying and responding to changing needs of persons served	Personnel and volunteers	No	None specified
2.F. Service Delivery Using Information and Communication Technologies (ICT)				
2.F.2.	Training on how to deliver services effectively via information and communication technologies and the equipment used in service delivery, including hardware and software	Personnel who deliver services via information and communication technologies	Yes	None specified
2.F.3.	Instruction and training on equipment used in service delivery via information and communication technologies and creating an appropriate environment to receive services	Persons served, families/support systems, and others, as appropriate	No	None specified

Section 3. Program Specific Standards

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.A. Adult Day Services				
3.A.4.a. and 3.A.4.d.	Advocacy education and general education, as needed	Families/support systems	No	None specified
3.A.6.	Education regarding medications administered while the person served attends the program	Persons served and families/ support systems	No	None specified
3.B. Assisted Living				
3.B.10.	Training that addresses all areas listed in the standard, as needed and in accordance with job responsibilities	Personnel	No	Orientation and regular intervals
3.C. Person-Centered Long-Term Care Community				
3.C.6.b.	Education regarding consequences associated with choices and behaviors of persons served that pose a potential risk to their health or safety	Persons served	No	Ongoing
3.C.8.a.	Ongoing process to educate persons served that they have choice	Persons served	No	Ongoing
3.C.13.b.	Education on the efficacy and safety of interventions, in response to the preferences of the person served	Persons served	No	None specified
3.C.15.a.	Education related to identified needs of persons served, addressed in policies and written procedures for nursing services	Nursing personnel	No	None specified
3.C.22.d.	Education and skills development regarding team dynamics	Personnel	No	None specified
3.C.23.	Training that addresses all areas listed in the standard, as appropriate to roles	Personnel	Yes	Orientation and regular intervals
3.C.28.	Education on how to access resources on behalf of the person served	Families/support systems	No	None specified
3.C.29.	Education on financial assistance and planning that addresses all areas listed in the standard	Persons served and families/ support systems	No	None specified

Section 3. Program Specific Standards (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.D. Home and Community Services				
3.D.4.	Training that addresses all areas listed in the standard	Personnel	Yes	Orientation and ongoing basis
3.D.12.	Education that includes all areas listed in the standard, in accordance with identified needs	Persons served and families/ support systems	No	None specified
3.D.14.	Education on financial topics listed in the standard, in accordance with the choice of the person served	Persons served	No	None specified
3.D.16.	Education and training to address all areas listed in the standard, in accordance with identified needs	Persons served and families/ support systems	No	None specified
3.D.17.	Education on medication that addresses all areas listed in the standard, as appropriate	Persons served and families/ support systems	No	None specified
3.E. Case Management				
3.E.26.a.	Education through modeling of socially and culturally acceptable behaviors	Persons served, families/support systems, and members of the community with whom the persons served regularly interact	No	None specified
3.E.26.e.	Training in the implementation of behavior management programs	Personnel and families/support systems	No	None specified
3.F. Independent Senior Living				
3.F.7.a.	Formal and informal educational opportunities are available	Persons served	No	None specified
3.F.10.	Education about safety and security measures that includes all areas listed in the standard	Persons served	No	None specified
3.F.18.	Training that includes all areas listed in the standard	Personnel	No	Orientation and regular intervals

Section 3. Program Specific Standards (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
3.G. Personal Supports Services				
3.G.2.	Training that includes all areas listed in the standard	Personnel	No	None specified
3.G.4.a.	Training in the use of adaptive devices and equipment, when applicable	Personnel	No	None specified
3.G.4.b.–d.	Training in the use of adaptive devices and equipment, when applicable	Person served, family, and caregivers	No	None specified

Section 4. Specialty Program Designations

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.A. Dementia Care Specialty Programs				
4.A.4.	Education that includes all areas listed in the standard, in accordance with identified needs	Persons served and families/ support systems	No	None specified
4.A.7.	Training that addresses all areas listed in the standard, if the program utilizes volunteers	Volunteers	Yes	None specified
4.A.11.a.	Advocacy education, as needed	Families/support systems	No	None specified
4.A.14.	Training for personnel that includes all areas listed in the standard, as appropriate to their roles	Personnel	Yes	Orientation and regular intervals
4.B. Palliative and End-of-Life Care Specialty Program				
4.B.2.b.	Education about early integration of palliative care	Relevant stakeholders	No	None specified
4.B.5.	Education on topics listed, as needed	Persons served and families/ support systems	No	None specified
4.B.6.b.	Efficacy and safety of complementary health interventions	Persons served	No	None specified

Section 4. Specialty Program Designations (Continued)

Standard(s)	Training Requirements	Provided To	Competency-Based	Frequency
4.B.7.a.	Dignity of risk and potential outcomes associated with choices and behaviors that pose a risk	Persons served	No	None specified
4.B.12.	Training for personnel on the topics listed	Personnel, including volunteers	Yes	Orientation and at regular intervals
4.B.15.	Education on palliative care, end-of-life care, and advocacy for underserved populations	Providers across the continuum of care	No	None specified

APPENDIX D

Resources

Following are some resources that may be helpful to your organization in implementing or conforming to the CARF standards. Resources may be relevant to multiple standards.

CARF does not endorse or expect the use of any specific products, companies, or resources. Resources listed are not inclusive of all resources available on a topic and are provided as guidance only.

Resources include references to websites, organizations, and publications. When available, links are provided. Some websites contain multiple helpful resources.

If you discover a broken link, or would like to submit a resource you feel may be helpful, please submit your feedback for consideration to **documents@carf.org**.

NOTE: *This appendix is available in an editable electronic format in the Resources section of Customer Connect (**https://customerconnect.carf.org**).*

Section 1. ASPIRE to Excellence®

1.A. Leadership

Resources on person-centered philosophy:

- National Center on Advancing Person-Centered Practices and Systems (NCAPPS) **https://ncapps.acl.gov/**

Resources related to corporate compliance:

- U.S. Department of Health and Human Services Office of Inspector General:
  - **https://oig.hhs.gov**
  - **https://oig.hhs.gov/documents/compliance-guidance/1135/HHS-OIG-GCPG-2023.pdf**
  - **https://oig.hhs.gov/compliance/101/index.asp**
  - **https://exclusions.oig.hhs.gov**
- System for Award Management Exclusions: **https://sam.gov/content/exclusions**
- CMS Compliance Program Policy and Guidance: **https://www.cms.gov/medicare/audits-compliance/part-c-d/compliance-program-policy-and-guidance**
- CMS Provider Compliance: **https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance**
- Federal Register (final rulings for regulations) Modernization of Compliance Program Guidance Documents: **https://www.federalregister.gov/documents/2023/04/25/2023-08326/modernization-of-compliance-program-guidance-documents**

- U.S. Department of Health and Human Services Office for Civil Rights HIPAA Enforcement:
  https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html
- Healthcare Compliance Association:
  https://www.hcca-info.org/
- U.S. Department of Justice Civil Rights Division Americans with Disabilities Act (ADA):
  https://www.ada.gov
- Social Security (Title XIX, grants to states for medical assistance programs):
  https://www.ssa.gov/OP_Home/ssact/title19/1900.htm

Resources related to evidence-based practice and research:

Professional associations are frequently used resources for information on evidence-based practices, clinical practice guidelines, accepted practices in the field, and peer-reviewed publications. Additional resources for information on research and evidence-based practice include:

- National Rehabilitation Information Center:
  https://www.naric.com
- Center on Knowledge Translation for Disability and Rehabilitation Research (KTDRR):
  https://ktdrr.org/resources/index.html
- U.S. Department of Veterans Affairs Office of Research and Development:
  https://www.research.va.gov/services/rrd.cfm
- Center for International Rehabilitation Research Information and Exchange (CIRRIE):
  https://publichealth.buffalo.edu/rehabilitation-science/research-and-facilities/funded-research/center-for-international-rehab-research-info-exchange.html

Resources related to fundraising:

- Charity Watch:
  https://www.charitywatch.org/home
- Charities Review Council:
  https://smartgivers.org/
- Charity Navigator:
  https://www.charitynavigator.org
- Certified Fund Raising Executive (CFRE) International:
  https://www.cfre.org
- Association of Fundraising Professionals:
  https://afpglobal.org/
- IRS Tax Exempt Organization Search:
  https://www.irs.gov/charities-non-profits/tax-exempt-organization-search
- Charities Institute Ireland Guidelines for Charitable Organisations Fundraising from the Public:
  https://www.charitiesinstituteireland.ie/pages/guidelines-for-charitable-organisations

- Government of Canada Fundraising by Registered Charities:
  https://www.canada.ca/en/revenue-agency/services/charities-giving/charities/policies-guidance/fundraising-registered-charities-guidance.html
- Charity Village:
  https://resources.charityvillage.com/free-downloadable-guides/

Resources related to valuing of donations include:

- Goodwill Value:
  https://www.goodwillgreatermc.org/docs/default-source/donations/goodwillgreatermc-doanted_value_guide_202412.pdf?sfvrsn=5a30010f_1
- Salvation Army Donation Value Guide:
  https://satruck.org/Home/DonationValueGuide
- IRS Determining the Value of Donated Property:
  https://www.irs.gov/uac/about-publication-561
- Government of Canada: Determining Fair Market Value of Non-Cash Gifts:
  https://www.canada.ca/en/revenue-agency/services/charities-giving/charities/operating-a-registered-charity/issuing-receipts/ determining-fair-market-value-gifts-kind-non-cash-gifts.html

IRS information on documentation of charitable contributions:

- **https://www.irs.gov/charities-non-profits/contributors/returns-and-reports-required-to-substantiate-charitable-contributions-of-donated-property**
- **https://www.irs.gov/charities-non-profits/contributors/cash-donations**

1.B. Governance

- Boardsource® Empowering Boards. Inspiring Leadership:
  https://www.boardsource.org
- BoardVoice:
  https://boardvoice.ca/resources/governance-resources/

1.C. Strategic Planning

- TechSoup Nonprofit Marketplace:
  https://www.techsoup.org

Resources related to social determinants of health:

- Healthy People 2030:
  https://odphp.health.gov/healthypeople
- Kaiser Family Foundation Beyond Health Care—The Role of Social Determinants in Promoting Health and Health Equity:
  https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
- Government of Canada Social Determinants of Health and Health Inequalities:
  https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Centers for Disease Control and Prevention Social Determinants of Health:

- **https://www.cdc.gov/about/priorities/social-determinants-of-health-at-cdc.html?**
- **https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html?**

1.D. Input from Persons Served and Other Stakeholders

- Health Quality Ontario Engaging with Patients and Caregivers about Quality Improvement—A Guide for Health Care Providers:
  https://www.hqontario.ca/portals/0/documents/qi/qip/patient-engagement-guide-1611-en.pdf

1.E. Legal Requirements

- U.S. Department of Health and Human Services. Exclusions Program Office of Inspector General:
  https://oig.hhs.gov/exclusions/
- U.S. Citizenship and Immigration Services, Employment Eligibility Verification:
  https://www.uscis.gov/i-9

1.G. Risk Management

Resources related to technology and data policies and procedures:

- International Organization for Standardization ISO/IEC 27001 Information Security Management Systems:
  https://www.iso.org/standard/27001
- Healthcare Information and Management Systems Society—Cybersecurity and Privacy:
  https://www.himss.org/resources-cybersecurity-and-privacy
- National Institute of Standards and Technology (NIST) Computer Security Resource Center:
  https://csrc.nist.gov/publications/sp
- SANS Institute:
  - Security Policy Templates:
    https://www.sans.org/security-resources/policies
  - Resources:
    https://www.sans.org/security-resources/?msc=main-nav

1.H. Health and Safety

Resources related to emergency preparedness, planning, and procedures:

Local Red Cross associations, state/provincial or other jurisdictional regulations, regional 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 U.S. FEMA has established an emergency planning guide for business and industry that provides advice for creating and maintaining an overall emergency management plan specific to each organization's corporate culture. Other free emergency procedures that may be incorporated into your plans are also available online. Resources include:

- **https://www.fema.gov/**
- **https://www.ada.gov/emergencyprepguide.htm**

Other websites that offer resources for developing emergency procedures include:

- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers:
  - **https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid**
  - **https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness/emergency-preparedness-rule**
  - **https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-emergency-preparedness**
  - **https://asprtracie.hhs.gov/cmsrule**
  - **https://ltcombudsman.org/uploads/files/issues/cms-ep-rule-resources-at-your-fingertips.pdf**
- U.S. Department of Homeland Security Active Shooter Preparedness:
  https://www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf
- Ready:
  https://www.ready.gov
- National Library of Medicine Emergency Preparedness for Vulnerable Populations:
  https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2646456/
- U.S. Department of Labor Occupational Safety and Health Administration Emergency Preparedness and Response:
  https://www.osha.gov/emergency-preparedness
- Disaster Resources for People with Disabilities and Others:
  https://www.jik.com/disaster.html
- disability911 Disaster Preparedness for People with Disabilities:
  https://www.ilru.org/projects/disability911
- Amputee Coalition resources for emergency preparedness:
  https://www.amputee-coalition.org/resources/when-disaster-strikes
- Tips for Retaining and Caring for Staff after a Disaster:
  https://files.asprtracie.hhs.gov/documents/tips-for-retaining-and-caring-for-staff-after-disaster.pdf

- Public Safety Canada:
  https://www.publicsafety.gc.ca.
- Provincial or territorial emergency measures organizations can also be used as resources.
  - Public Safety Canada Your Emergency Preparedness Guide:
    https://www.getprepared.gc.ca/cnt/rsrcs/pblctns/yprprdnssgd/index-en.aspx
  - Canadian Centre for Occupational Health and Safety Emergency Planning:
    https://ccohs.ca/oshanswers/hsprograms/planning.html
- Capacity-Building Toolkit for Including Aging & Disability Networks in Emergency Planning:
  https://www.naccho.org/uploads/downloadable-resources/Capacity-Building-Toolkit-for-Aging-and-Disability-Networks-2-5-19.pdf

Bedbug management:

- U.S. Environmental Protection Agency:
  https://www.epa.gov/bedbugs
- Centers for Disease Control and Prevention:
  https://www.cdc.gov/bed-bugs/about/index.html?
- Government of Canada:
  https://www.canada.ca/en/health-canada/services/pest-control-tips/bedbugs-how-do-i-get-rid-them.html

Resources related to infection control:

- Centers for Disease Control and Prevention Infection Control:
  https://www.cdc.gov/infection-control/hcp/
- Association for Professionals in Infection Control and Epidemiology:
  https://www.apic.org
- U.S. Department of Labor Occupational Safety and Health Administration Infectious Diseases:
  https://www.osha.gov/healthcare/infectious-diseases
- State/provincial or other jurisdictional departments of health outbreak manuals
  - Public Health Agency of Canada:
    https://www.canada.ca/en/public-health.html
  - Infection Prevention and Control Canada:
    https://www.ipac-canada.org

Resources specific to hand hygiene:

- Infection Prevention and You:
  https://infectionpreventionandyou.org/
- Centers for Disease Control and Prevention Hand Hygiene in Healthcare Settings:
  https://www.cdc.gov/handhygiene/index.html

Resources specific to medication disposal:

- Dispose My Meds:
  https://www.disposemymeds.org
- U.S. Food and Drug Administration:
  https://www.fda.gov/drugs/buying-using-medicine-safely/safe-disposal-medicines

Resources specific to transportation:

- National Aging and Disability Transportation Center:
  https://www.nadtc.org

1.I. Workforce Development and Management

- Internal Revenue Service, Independent Contractor (Self-Employed) or Employee?:
  https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee
- Canada Revenue Agency, Employee or Self-Employed:
  https://www.canada.ca/en/revenue-agency/services/forms-publications/publications/rc4110/employee-self-employed.html
- Society for Human Resource Management:
  https://www.shrm.org
- HR Hero:
  https://blr.com/solutions/hr-solutions/
- Human Resources Professional Association:
  https://www.hrpa.ca/
- Association for Talent Development:
  https://www.td.org
- O*Net Online:
  https://www.onetonline.org
- U.S. Office of Personnel Management:
  https://www.opm.gov
- Government of Canada Job Bank Employer Resources:
  https://www.jobbank.gc.ca/hiring/resources/diversity
- Government of Canada Work in Canada:
  https://www.canada.ca/en/immigration-refugees-citizenship/services/work-canada.html
- Medical license portability, Interstate Medical Licensure Compact:
  https://imlcc.com
- Interstate licensure resources for health care providers, states, and health care organizations:
  https://telehealth.hhs.gov/licensure
- Center for Connected Health Policy Licensure Compacts:
  https://www.cchpca.org/topic/licensure-compacts/
- MindTools SMART Goals:
  https://www.mindtools.com/a4wo118/smart-goals

Resources related to Cybersecurity Training:

- U.S. Department of Health and Human Services CyberSecurity Awareness Training:
  https://www.hhs.gov/about/agencies/asa/ocio/cybersecurity/security-awareness-training/index.html
- KnowBe4 Security Awareness Program:
  https://www.knowbe4.com/

Resources related to Workforce Wellness:

  - National Academy of Medicine National Plan for Health Workforce Well-being:
    https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/
  - Ontario Chamber of Commerce—Mental Wellness in the Workplace, A Playbook for Employers:
    https://occ.ca/wp-content/uploads/Mental-Wellness-in-the-Workplace-Employers.pdf
  - U.S. Department of Health and Human Services Office of the Surgeon General, Workplace Mental Health and Well-Being:
    https://www.hhs.gov/surgeongeneral/priorities/workplace-well-being/index.html
  - Canadian Centre for Occupational Safety:
    https://www.ccohs.ca/workplace-mental-health-toolkit
- The Gerontologist, Volume 61, Issue 4, June 2021 Special Issue: Workforce Issues in Long-Term Care:
  https://academic.oup.com/gerontologist/issue/61/4

1.K. Accessibility

Resources related to accessibility:

- U.S. Department of Justice—Civil Rights Division Americans with Disabilities Act (ADA):
  https://www.ada.gov
- Checklist for Readily Achievable Barrier Removal:
  https://archive.ada.gov/checkweb.htm
- Government of Canada About an Accessible Canada:
  https://www.canada.ca/en/employment-social-development/programs/accessible-canada.html
- World Wide Web Consortium Web Accessibility Initiative:
  https://www.w3.org/WAI
- AudioEye Color Contrast Accessibility Checker Tool:
  https://www.audioeye.com/color-contrast-checker/?wc3
- Center for Hearing Access at The Shedd Institute resources on ADA-compliant listening systems and strategies:
  https://centerforhearingaccess.org/
- Virginia Commonwealth University Rehabilitation Research and Training Center:
  https://vcurrtc.org

Resources related to diversity:

- National Center for Cultural Competence:
  https://nccc.georgetown.edu/
- U.S. Department of Health and Human Services Office of Minority Health Think Cultural Health:
  https://thinkculturalhealth.hhs.gov
- A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities:
  https://www.hptn096.org/wp-content/uploads/2022/10/HO_8_Toolkit_CLAS-for-HCOs.pdf
- Human Rights Campaign Tools for Equality and Inclusion:
  https://www.hrc.org/resources
- National Council of Nonprofits Why Diversity, Equity, and Inclusion Matter for Nonprofits:
  https://www.councilofnonprofits.org/tools-resources/why-diversity-equity-and-inclusion-matter-nonprofits
- Society for Human Resource Management Inclusion and Diversity:
  https://www.shrm.org/topics-tools/topics/inclusion-diversity
- Canadian Centre for Diversity and Inclusion:
  https://ccdi.ca/home
- University of Alberta Indigenous Canada, a free course that explores the histories and contemporary perspectives of Indigenous people living in Canada:
  https://www.ualberta.ca/admissions-programs/online-courses/indigenous-canada/index.html
- Indigenous Cultural Safety Collaborative Learning Series:
  https://www.icscollaborative.com
- Centres for Learning, Research & Innovation in Long-Term Care; Supporting Equity, Diversity, and Inclusion in Long-Term Care:
  https://clri-ltc.ca/diversity

Resources related to health literacy:

- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality Health Literacy:
  https://www.ahrq.gov/health-literacy/index.html
- Center for Plain Language:
  https://centerforplainlanguage.org/
- Government of Canada Resources of the Language Portal of Canada:
  https://www.noslangues-ourlanguages.gc.ca/en/index
- ABC Life Literacy Canada
  : **https://abclifeliteracy.ca/**

Section 2. Process for the Persons Served

A. Program/Service Structure

- Trauma-Informed Care Implementation Resource Center:
  www.traumainformedcare.chcs.org
- Aging With a History of Trauma:
  https://cdn.fedweb.org/fed-42/3828/Aging%2520with%2520Trauma_Full_Report.pdf
- Podcasts:
  - Trauma Informed Care in Residential Long Term Care for Older Adults:
    www.insocialwork.org/episode.asp?ep=263
  - The Impacts of Trauma in Later Life:
    www.insocialwork.org/episode.asp?ep=208
- National Institute on Aging: Sexuality:
  www.nia.nih.gov/health/topics/sexuality
- National Resource Center on LGBTQ+ Aging
  www.lgbtagingcenter.org/
- National Center on Advancing Person-Centered Practices and Systems:
  https://ncapps.acl.gov
- Aging Innovation Resource Library:
  https://aginginnovation.org/tools-resources/
- ADD National Center to Reframe:
  www.reframingaging.org
- Caregiving Resources:
  - The Ontario Caregiver Organization:
    https://ontariocaregiver.ca/
  - Caregiver Action Network:
    www.caregiveraction.org
  - National Alliance for Caregiving:
    www.caregiving.org
  - AARP Family Caregiving:
    www.aarp.org/caregiving
  - Family Caregiver Alliance:
    www.caregiver.org
  - International Alliance of Carer Organizations:
    www.internationalcarers.org
- ACL Elder Justice:
  https://elderjustice.acl.gov
- National Center on Elder Abuse:
  https://ncea.acl.gov
- Healthcare Excellence Canada:
  https://www.healthcareexcellence.ca/en/resources/patient-safety-and-incident-management-toolkit/

- Registered Nurses' Association of Ontario Clinical Best Practice Guidelines, Promoting Safety: Alternative Approaches to the Use of Restraints:
  https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints
- International Council on Active Aging:
  www.icaa.cc
- The Eden Alternative:
  www.edenalt.org
- Mather Institute:
  www.matherinstitute.com/
- Disability Health and Well-being:
  https://www.cdc.gov/disability-and-health/health-well-being/
- National Resource Center for Engaging Older Adults:
  www.engagingolderadults.org
- Government of Canada:
  www.canada.ca/en/public-health/services/health-promotion/aging-seniors.html
- National Academy of Medicine National Plan for Health Workforce Well-being:
  https://nam.edu/initiatives/clinician-resilience-and-well-being/national-plan-for-health-workforce-well-being/
- The Gerontologist, Volume 61, Issue 4, June 2021 Special Issue: Workforce Issues in Long-Term Care:
  https://academic.oup.com/gerontologist/issue/61/4
- Ontario Chamber of Commerce—Mental Wellness in the Workplace: A Playbook for Employers:
  https://occ.ca/wp-content/uploads/Mental-Wellness-in-the-Workplace-Employers.pdf
- National Coalition for Hospice and Palliative Care—Clinical Practice Guidelines for Quality Palliative Care:
  www.nationalcoalitionhpc.org/ncp
- Five Wishes:
  www.fivewishes.org
- Advance Care Planning Canada:
  www.advancecareplanning.ca
- C-TAC (Coalition to Transform Advanced Care):
  www.thectac.org
- Serious Illness Conversation Guide:
  www.ariadnelabs.org/serious-illness-conversation-guide-training
- Canadian Hospice Palliative Care Association:
  www.chpca.ca
- Public Health Palliative Care International:
  https://phpci.org

- Canadian Virtual Hospice—Coming Full Circle: Advance Care Planning created by Indigenous peoples for Indigenous peoples in Canada: **https://livingmyculture.ca/media/3846/cvh-22459-coming-full-circle-fin-eng-fillable-spreads.pdf**
- Center for Plain Language: **https://centerforplainlanguage.org**
- Plain Language Action and Information Network Federal Plain Language: Guidelines: **https://plainlanguage.gov/guidelines/**
- World Health Organization Principle: Understandable: **https://www.who.int/about/communications/understandable/plain-language**
- CARF Suicide Prevention: **https://carf.org/resources/suicide-prevention/**
- CARF-2016 Quality Practice Notice (QPN) on Suicide Prevention: **https://carf.org/wp-content/uploads/2023/09/Quality-Practice-Notice_Suicide-Prevention_Sept-2016.pdf**

B. Residential Communities

- American Art Therapy Association: **www.arttherapy.org**
- American Music Therapy Association: **www.musictherapy.org**
- American Dance Therapy Association: **www.adta.org**
- Canadian Art Therapy Association: **www.canadianarttherapy.org**
- LeadingAge Pandemic Playbook: **https://playbook.leadingage.org/**
- Argentum Essential Caregiver Toolkit: **www.argentum.org/wp-content/uploads/2020/10/Essential_Caregiver_Toolkit_Oct2020_Final.docx**
- Ethical Decision Making in Long Term Care—A Guide, Pioneer Network: **www.pioneernetwork.net/wp-content/uploads/2021/08/Ethical-Decision-Making-in-Long-Term-Care-8-25-21.pdf**
- 10 Ethical Principles in Geriatrics and Long-Term Care: **www.hmpgloballearningnetwork.com/site/altc/content/10-ethical-principles-geriatrics-and-long-term-care-2**

C. Care Process for Specific Diagnostic Categories

- Person-Centered Assessment and Care Planning: **https://academic.oup.com/gerontologist/article/58/suppl_1/S32/4816742**
- The Alzheimer Society of Canada: **www.alzheimer.ca**
- WorkSafe BC: *Dementia: Understanding risks and preventing violence:* **www.worksafebcmedia.com/media/WebBooks/Dementia/#/**
- The Canadian Institute for Health Information: **www.cihi.ca/en/dementia-in-canada**

- The Alzheimer's Disease Education and Referral (ADEAR) Center:
  www.nia.nih.gov/health/about-adear-center
- Safety in Dementia:
  https://safetyindementia.org
- Driver Safety:
  - AAA: Senior Driver Safety & Mobility:
    https://exchange.aaa.com/safety/senior-driver-safety-mobility
  - AARP: Driver Safety:
    www.aarp.org/auto/driver-safety/driving-tips
- Falls and Injury Prevention:
  - National Center for Injury Prevention and Control:
    www.cdc.gov/injury/index.html
  - World Health Organization:
    https://www.who.int/publications/i/item/978924002191-4
  - British Columbia Ministry of Health Planning Prevention of Falls and Injuries Among the Elderly:
    https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/fall-prevention
  - Ontario Osteoporosis Strategy:
    https://osteostrategy.on.ca/ltc-toolbox/
  - Canadian Fall Prevention Education Collaborative:
    http://canadianfallprevention.ca
- Helpguide.org:
  www.helpguide.org/articles/alzheimers-dementia/alzheimers-behavior-management.htm
- Forget Me Not—Palliative Care for People with Dementia:
  www.ncbi.nlm.nih.gov/pmc/articles/PMC2600060
- Pain Assessments in Clients with Dementia:
  https://rehabpub.com/pain-management/chronic/pain-assessment-in-clients-with-dementia/
- Your Conversation Starter Kit for Families and Loved Ones of People with Alzheimer's Disease or Other Forms of Dementia:
  https://theconversationproject.org/wp-content/uploads/2017/02/ConversationProject-StarterKit-Alzheimers-English.pdf
- Alzheimer's Association End-of-Life Planning
  https://www.alz.org/help-support/i-have-alz/plan-for-your-future/end_of_life_planning
- Alzheimer's Association Curriculum Review and essentiALZ certification:
  www.alz.org/professionals/professional-providers/dementia-care-training-certification
- Alzheimer's Association Canada:
  www.alz.org/ca/what-we-do-canada.asp
- Alzheimer Society of Toronto Health Care Professional Education:
  https://alz.to/health-care-professionals/Health Care Professional Education

- PC P.E.A.R.L.S.®: 7 key elements of person-centered care of people with dementia in long-term care homes:
  https://alzheimer.ca/en/help-support/im-healthcare-provider/providing-person-centred-care
- Alzheimer's Society UK:
  www.alzheimers.org.uk/about-dementia/treatments/drugs/drugs-used-relieve-behavioural-and-psychological-symptoms
- Family Caregiver Alliance Caregiver's Guide to Understanding Dementia Behaviors:
  www.caregiver.org/caregivers-guide-understanding-dementia-behaviors

D. Skin Integrity and Wound Care Standards

- American Board of Wound Management:
  www.abwmcertified.org
- Assessment and Management of Pressure Injuries for Interprofessional Teams, Registered Nurses' Association of Ontario:
  http://rnao.ca/bpg/guidelines/pressure-injuries
- Evidence-Based Approach to Advanced Wound Care Products:
  www.ncbi.nlm.nih.gov/pubmed/26429618
- European Pressure Ulcer Advisory Panel:
  www.epuap.org
- National Pressure Injury Advisory Panel:
  https://npiap.com/
- Wound, Ostomy and Continence Nurses Society (WOCN):
  www.wocn.org
- Wounds International:
  www.woundsinternational.com
- Association for the Advancement of Wound Care:
  http://aawconline.org
- Braden Scale for Predicting Pressure Sore Risk:
  www.in.gov/health/files/Braden_Scale.pdf

E. Care Process for Personal Supports Services

- Institute for Safe Medication Practices Canada Medication Reconciliation (MedRec):
  www.ismp-canada.org/medrec/
- University of Southern California Training Resources on Elder Abuse:
  https://trea.usc.edu/
- Administration for Community Living Consumer Choice and Control:
  https://acl.gov/programs/consumer-control

F. Service Delivery Using Information and Communication Technologies

- U.S. Department of Health and Human Services Health Resources and Services: Administration Obtaining Informed Consent:
  https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/obtaining-informed-consent
- Southwest Telehealth Resource Center Telemedicine & Informed Consent: How Informed Are You?
  https://southwesttrc.org/blog/2017/telemedicine-informed-consent-how-informed-are-you
- U.S. Department of Health and Human Services Health Resources and Services Administration Creating an Emergency Plan:
  https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/creating-an-emergency-plan/
- American Telemedicine Association:
  https://www.americantelemed.org
- U.S. Department of Veterans Affairs Telehealth Services:
  https://www.telehealth.va.gov
- International Journal of Telerehabilitation:
  https://telerehab.hpu.edu/index.php/Telerehab
- U.S. Department of Health and Human Services Health Resources and Services Administration Office for the Advancement of Telehealth:
  https://www.hrsa.gov/rural-health/telehealth
- U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services Telehealth and Remote Patient Monitoring:
  https://www.cms.gov/files/document/mln901705-telehealth-services.pdf
- Center for Connected Health Policy National Telehealth Policy Resource Center:
  https://cchpca.org
- Telehealth Resource Centers Telehealth Access Points (TAPs) Best Practices Guide:
  https://telehealthresourcecenter.org/resources/toolkits/telehealth-access-points-taps-best-practices-guide/
- Canadian Medical Protective Association Virtual Care:
  https://www.cmpa-acpm.ca/en/covid19/virtual-care

Section 3. Program Specific Standards

A. Adult Day Services

- National Adult Day Services Association:
  www.nadsa.org

B. Assisted Living

- Center for Excellence in Assisted Living:
  https://theceal.org/

C. Person-Centered Long-Term Care Community

- Using Antibiotics Wisely in Long-Term Care: **https://choosingwiselycanada.org/long-term-care/antibiotics**
- National Center for Complementary and Integrative Health (NCCIH): **www.nccih.nih.gov**
- Office of Cancer Complementary and Alternative Medicine (OCCAM): **https://cam.cancer.gov**
- National Cancer Institute Pain Control: Support for People with Cancer: **www.cancer.gov/publications/patient-education/pain-control**
- National Institutes of Health Office of Dietary Supplements: **https://ods.od.nih.gov**
- MedlinePlus Herbs and Supplements: **https://medlineplus.gov/druginfo/herb_All.html**
- American Cancer Society Complementary and Alternative Medicine: **www.cancer.org/treatment/treatments-and-side-effects/complementary-and-alternative-medicine.html**
- U.S. Food and Drug Administration: Dietary Supplements: **www.fda.gov/food/dietary-supplements**
- Research Institute on Aging's Huddle Up: **https://the-ria.ca/resources/huddle-up**

D. Home and Community Services

- Advancing States: **https://www.advancingstates.org/**
- Office of Disability Employment Policy at the Department of Labor: **www.dol.gov/agencies/odep/program-areas/employment-supports/emergency-preparedness**
- Disaster Resources for People with Disabilities and Emergency Managers: **www.jik.com/disaster.html**
- Amputee Coalition When Disaster Strikes Fact Sheet: **www.amputee-coalition.org/resources/when-disaster-strikes/**
- National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities: **www.diversitypreparedness.org**
- The Disaster Recovery Information Exchange (DRIE): **www.drie.org**
- Disaster Preparedness for People with Disabilities: **www.disability911.com**
- Public Safety and Emergency Preparedness Canada: **https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/mrgnc-prprdnss/mrgnc-mngmnt-trnng-en.aspx**
- National Association of Home Care and Hospice: **https://nahc.org**
- Canadian Home Care Association: **https://cdnhomecare.ca**

E. Case Management

- American Case Management Association:
  https://www.acmaweb.org/
- Case Management Society of America:
  https://cmsa.org/
- National Association of Social Workers:
  https://www.socialworkers.org/

F. Independent Senior Living

- American Seniors Housing Association:
  www.ashaliving.org/

  Please refer to Sections 2.A. Program/Service Structure and 2.B. Residential Communities for additional resources related to Independent Senior Living.

G. Personal Supports Services

Please refer to Section 2.E. Care Process for Personal Supports Services.

H. Continuing Care Retirement Community

- National Continuing Care Residents Association:
  www.naccra.com

Section 4. Specialty Program Designation Standards

A. Dementia Care Specialty Programs

Please refer to Section 2.C. Care Process for Specific Diagnostic Categories for dementia-related resources.

B. Palliative and End-of-Life Care Specialty Programs

- Clinical Practice Guidelines for Quality Palliative Care by the National Coalition for Palliative and Hospice Care:
  https://www.nationalcoalitionhpc.org/clinical-practice-guidelines/
- Dying with Dignity: Resources related to end of life options and decisions:
  https://www.dyingwithdignity.ca/education-and-resources/
- Canadian Virtual Hospice—The Learning Hub for Health Care Providers:
  https://www.virtualhospice.ca/learninghub/
- Pallium Canada:
  https://www.pallium.ca/taking-ownership/
- Canadian Virtual Hospice—My Grief:
  https://www.mygrief.ca
- Canadian Virtual Hospice—Kids Grief:
  https://www.kidsgrief.ca
- CaringInfo, a program of the National Hospice and Palliative Care Organization:
  https://www.caringinfo.org/
- Center to Advance Palliative Care:
  https://www.capc.org/

- Canadian Virtual Hospice—Living my Culture: Resources to honour culture, spirituality and traditions for those living with serious illness, end-of-life and grief support to others. Resources support First Nations, Inuit, Metis, Chinese, Ethiopian, Filipino, Indian, Iranian, Italian, Pakistani, and Somali: **https://livingmyculture.ca/culture/**
- Canadian Partnership Against Cancer: First Nations, Inuit and Metis approaches to palliative and end-of-life care in Canada: **https://www.partnershipagainstcancer.ca/topics/indigenous-palliative-care-approaches/summary/**
- The Conversation Project by the Institute for Healthcare Improvement: **https://theconversationproject.org/**
- Hospice Foundation of America: **https://hospicefoundation.org/**

Glossary

Note: *This glossary has been prepared for use with all CARF standards manuals. Terms have been selected for definition because they are subject to a wide range of interpretation and therefore require clarification of their usage in CARF's standards and materials. The glossary does not define practices or disciplines.*

CARF has not attempted to provide definitions that will be universally applicable. Rather, the intention is to define the meanings of the terms as they are used by CARF.

These definitions apply to all programs and services seeking accreditation. In some instances, glossary terms are used differently in different standards manuals. In such cases, the applicable manual is noted in parentheses after the term heading and before the definition.

Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Acquired brain injury: Acquired brain injury (ABI) is an insult to the brain that affects its structure or function, resulting in impairments of cognition, communication, physical function, or psychosocial behavior. ABI includes both traumatic and nontraumatic brain injury. Traumatic brain injuries may include open head injuries (e.g., gun shot wound, other penetrating injuries) or closed head injuries (e.g., blunt trauma, acceleration/deceleration injury, blast injury). Nontraumatic brain injuries may include those caused by strokes, nontraumatic hemorrhage (e.g., ruptured arterio-venous malformation, aneurysm), tumors, infectious diseases (e.g., encephalitis, meningitis), hypoxic injuries (e.g., asphyxiation, near drowning, anesthetic incidents, hypovolemia), metabolic disorders (e.g., insulin shock, liver or kidney disease), and toxin exposure (e.g., inhalation, ingestion). ABI does not include brain injuries that are congenital, degenerative, or induced by birth trauma.

Acquired impairment: An impairment that has occurred after the completion of the birthing process.

Acquisition: The purchase by one legal entity of some or all of the assets of another legal entity. In an acquisition, the purchasing entity may or may not assume some or all of the liabilities of the selling entity. Generally, the selling entity continues in existence.

Activities of daily living (ADL): The instructional area that addresses the daily tasks required to function 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.

Behavioral change approach: (Employment and Community Services) A behavioral change approach is a method or technique used to promote desirable behaviors and eliminate unwanted behaviors. Behavioral change approaches include planned activities, interventions, and strategies developed and carried out with the purpose of reinforcing desirable behaviors and eliminating unwanted behaviors over a period of time.

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.

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.

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.

Contract: A written agreement between two or more parties that sets forth enforceable obligations between or among the parties.

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).

Co-pharmacy: The use of two or more medications from the same class, e.g., two antidepressant medications or two antipsychotic medications.

Core values: The essential and enduring tenets of an organization. They are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those inside the organization.

Corporate citizenship: An organization's efforts, activities, and interest in integrating, contributing, and supporting the communities where it delivers services to better address the needs of persons served.

Corporate status: The existence of an entity as a corporation under applicable law. Maintenance of corporate status typically requires ongoing compliance with state requirements.

Costs: The expenses incurred to acquire, produce, accomplish, and maintain organizational goals. These include both direct costs, such as those for salaries and benefits, materials, and equipment, and indirect costs, such as those for electricity, water, building maintenance, and depreciation of equipment.

Cultural competency: An organization's ability to recognize, respect, and address the unique and diverse needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, religious, and/or social groups or sexual orientation.

Culturally normative: Providing the persons served with an opportunity to experience patterns and conditions of everyday life that match as closely as possible those patterns and conditions typical of the mainstream experience in the local society and community. This requires the use of service delivery systems and settings that adapt to the changing norms and patterns of communities in which the persons served function so as to incorporate the following features:

- Rhythms of the day, week, and year and life cycles that are "normal" or typical of the community.
- A range of choices, with personal preferences and self-determination receiving full respect and consideration.
- A variety of social interactions and settings, including family, work, and leisure settings and opportunities for personal intimacy.
- Normal economic standards.
- Life in housing typical of the local neighborhoods.

Culture: The integrated pattern of human behavior that includes the thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, social, or other group.

Customers: The persons served, families, communities, funding agencies, employers, etc., who receive or purchase services from the organization.

Data: A set of values of qualitative or quantitative variables, e.g., facts, objective information, or statistics collected, assembled, or compiled for reference, analysis and use in decision-making.

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).

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, 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 video recordings.

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 applicable law 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 city, county, state, federal, tribal, provincial, or similar jurisdiction.

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]*.)

Implement: Consistent actions that demonstrate a policy, plan, procedure, or practice is in effect.

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 written 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, 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. Without limiting the foregoing, an investigation includes any governmental notice of regulatory or other noncompliance that requires submission of a written corrective action plan.

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.

Legal representative: An individual who is legally authorized to make decisions on behalf of the person served regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from jurisdiction to jurisdiction; e.g., healthcare power of attorney, power of attorney, and guardianship.

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 (ICF), etc.

Long-term withdrawal management: (Opioid Treatment Program) Withdrawal management for more than 30 days but no more than 180 days.

Maladaptive behavior: Behavior that is destructive to oneself, others, or the environment, demonstrating a reduction or lack of the ability necessary to adjust to environmental demands.

Manual skills: The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

Material litigation: A legal proceeding initiated by a third party concerning the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

Medical director: (Opioid Treatment Program) A physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program either by performing them directly or delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

Medical practitioner: (Opioid Treatment Program) A health care professional who is appropriately licensed by a State to prescribe and/or dispense medications for opioid use disorders and, as a result, is authorized to practice within an OTP. (Definition from SAMHSA, "practitioner" definition.)

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 con-

dition 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 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 for opioid use disorder: (Opioid Treatment Program) Medication for opioid use disorder (MOUD) means medications, including opioid agonist medications, approved by the Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), for use in the treatment of opioid use disorder. (Definition from SAMHSA)

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: Persons served are the primary consumers of services. They are the principal decision makers throughout the course of a program/service. Persons served have the right to choose whether members of the family, support system, or advocates may participate in that decision-making process. In circumstances when the person served is unable to exercise self-representation at any point in the decision-making process, person served is interpreted to also encompass those persons legally authorized to make decisions on behalf of the person served.

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: Workers involved in the delivery, oversight, and support of the programs/services seeking accreditation, regardless of employment status.

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 timeline, 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.

Polypharmacy: The use of multiple medications to treat different conditions.

Positive intervention: (Employment and Community Services) Positive intervention is an evidenced-based, proactive approach to facilitate behavioral change and promote alternative positive behaviors. Positive interventions use behavioral strategies to promote well-being and social acceptance, increase or accentuate positive behaviors, minimize maladaptive and/or unsafe behaviors, and prevent or reduce the use of restrictive interventions and practices.

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.

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 outcomes 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.

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 sample/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 (ICF), 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 event: 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 an event is called sentinel because it signals the need for immediate investigation and response. Without limiting the foregoing, a sentinel event includes any governmental notice of regulatory or other noncompliance that results in immediate jeopardy to the health or safety of any person (e.g., a Level 4 deficiency issued by the U.S. Centers for Medicare & Medicaid Services).

Service: Activities performed for the benefit of persons served.

Service access: The organization's capacity to provide services to those who desire or are in need of receiving 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 withdrawal management : (Opioid Treatment Program) Withdrawal management 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, payers, regulators, referral sources, personnel, employers, advocacy groups, contributors, supporters, landlords, business interests, and the community. In the context of any standard, "other stakeholders" refers to all stakeholders of any type not specifically identified in the standard.

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.

Withdrawal management: (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.

Youth: The time a person is young—generally referring to the time between childhood and adulthood.

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