Purpose

The organization's administrative and service environments are respectful, safe, and accessible and contribute to organizational effectiveness.

Introduction

The Administrative and Service Environment standards reflect the significant impact that accessibility; physical, psychological, and emotional safety; and personal dignity have on an organization's effectiveness. Specifically, these standards address how accessibility, facility maintenance, safety procedures both on- and off-site, a trauma-informed environment, and emergency response preparedness contribute to organizational productivity and effective service delivery.

ASE 1: Promotion of Health and Safety

In its daily operations, the organization ensures:

a. the health and safety of its personnel and the individuals and families it serves; and
b. that its administrative and service environments are respectful and promote the dignity of personnel.

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

No Self-Study Evidence
No Site Visit Evidence

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Observe facility

Rating Indicators:

1. The organization's practices reflect full implementation of the standard. The organization is proactive about health and safety.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement; e.g.,
    - Service quality or organizational functioning may be compromised and staff and/or stakeholders may be at risk.
4. Implementation of the standard is minimal or there is no evidence of implementation at all: e.g.,
    - Staff or stakeholders are at risk due to serious health or safety concerns that remain unaddressed.

ASE 2: Service Delivery Environment

The service delivery environment promotes respect, healing, and positive behavior of the service recipient.

Self-Study Evidence

*Behavior support and management policy, including whether restrictive behavior management interventions are prohibited	**File:** Behavior Support and Management Policy and Procedure
*Policy for prohibited interventions	prohibits all use of restrictive behavior management interventions.
*Procedures for monitoring and addressing the physical, psychological, and emotional safety needs of persons served	**File:** Behavior Support and Management Procedure
*Procedures that address harassment and violence towards service recipients and personnel	**File:** Harassment Policy
*Procedures for preventing the need for emergency interventions, including restrictive behavior management interventions	**File:** Behavior Support and Management Procedure

Site Visit Evidence

*Written information provided to service recipients and/or parents/legal guardians about how the organization promotes positive behavior

On-Site Activities

- Observe facility
- Interviews may include:
    1. Relevant personnel
    2. Persons served
    3. Parents/legal guardians

ASE 2.01
Personnel support positive behavior by:

a. developing positive relationships with service recipients;
b. being trauma-informed;
c. building on service recipients' strengths and reinforcing positive behavior; and
d. responding consistently to all incidents that challenge the safety of service recipients.

Related Standards: BSM 1.01, TS 2.07, TS 2.08

Interpretation: *Procedures for responding to incidents must address safety measures used in emergency situations, including whether restrictive behavior management interventions may be used to protect service recipients from harming themselves or others.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not fully addressed.
3. Practices are basically sound but there is room for improvement; e.g.,
    - Two of the elements are not fully implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - One of elements is not addressed at all.

ASE 2.02 (FP)
The organization:

a. monitors the service population for emerging physical, psychological, and emotional safety needs; and
b. modifies the service environment or procedures as necessary to respond to the safety needs of the population.

Examples: *Mechanisms that can be used to respond to the safety needs of the population include, but are not limited to:*

1. *monitoring interactions among service recipients and staff to ensure they remain respectful, calming, and empowering;*
2. *establishing and enforcing rules that promote a transparent and therapeutic service environment;*
3. *soliciting and responding to feedback from service recipients regarding their perceived safety in the service environment; and*
4. *staggering scheduling or providing separate entrances when survivors of violence or exploitation and individuals with histories of violent behavior are served in the same facility.*

Rating Indicators:

1. The organization monitors safety risks, responds to safety needs of service recipients and has implemented procedures for ensuring psychological, emotional, and physical safety as per the requirements of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Communications with service recipients about available protections and procedures could be improved at some locations, and the organization is working to address the issue.
3. Practice requires significant improvement; e.g.,
   - Safety needs are monitored inconsistently; or
   - Safety risks have been identified but protections are not yet fully in place in at least one program site; or
   - Safety procedures are vague because the organization has not paid sufficient attention to the safety needs of service recipients.
4. The organization does not monitor safety risks of service recipients and safety needs are not met as required by the standard.

ASE 2.03

The organization informs service recipients and parents or legal guardians about its procedures for:

a. maintaining a safe service environment, including procedures that address harassment and violence towards other service recipients and personnel; and
b. preventing the need for emergency interventions, including restrictive behavior management interventions.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Information provided needs minor clarification; or
   - One of the required elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - Neither of the two elements is fully addressed; or
   - One element is not addressed at all; or
   - Parents or legal guardians are frequently not notified.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 2.04(FP)
The organization maintains a work environment for its personnel that is conducive to effectively providing services to individuals and families in a private and confidential manner, as needed.

Related Standards: PRG 4.01

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some of the organization's facilities are cramped or in need of updating or expansion to better ensure confidentiality.
3. Practice requires significant improvement; e.g.,
   - Some of the organization's facilities lack sufficient space for confidential staff conferences or meetings where client cases are discussed; or
   - Some service delivery sites lack enough, or sufficiently private, interviewing space at peak periods.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The work environment in at least one service delivery site is wholly inadequate for effective, confidential service delivery; or
   - The organization makes no provision for confidential interactions with persons served; or
   - A number of sites lack adequate provisions for privacy for interviewing or for conducting the collective business of the organization such as meetings, case conferences, etc.

ASE 2.05

The environment promotes a non-threatening, welcoming, and inclusive approach that fosters trust and engagement for all people.

Interpretation: *Programs should provide a supportive, safe, and welcoming environment for all people. Programs can help to signal that they provide an environment that is safe and welcoming by posting "visual cues" of their commitment to equity, diversity, and inclusion in the reception or common area such as a copy of the nondiscrimination policy, a copy of the equity statement, culturally diverse décor, LGBTQ+ symbols, or posters and stickers promoting racial justice.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some visual cues are present in all the organization's facilities, but more could be done to reflect the diversity of staff and persons served; or
   - Visual cues are lacking in some of the organization's facilities, but staff and persons served report feeling welcome and safe in the service delivery environment.
3. Practice requires significant improvement; e.g.,
   - Some staff and persons served report feeling unwelcome or unsafe in the service delivery environment; or
   - Visual cues are lacking in several of the organization's facilities.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 2.06(FP)

Organization policy prohibits activities or interventions that are harassing, threatening, or otherwise harmful to an individual's well-being.

Interpretation: *The activities or interventions that will be prohibited by organization policy may vary based on service type, population served, and the service delivery setting but should include, as appropriate:*

1. *corporal punishment;*
2. *the use of aversive stimuli and/or therapies;*
3. *interventions that involve withholding nutrition or hydration, or that inflict physical or psychological pain;*
4. *the use of demeaning, shaming, degrading, or bullying language or activities;*
5. *forced physical exercise to eliminate behaviors;*
6. *unnecessarily punitive restrictions, including restricting family contact, celebrations, or prescribed treatment interventions as a disciplinary action;*
7. *unwarranted use of invasive procedures or activities as a disciplinary action;*
8. *punitive work assignments;*
9. *punishment by peers;*
10. *conversion or reparative therapies;*
11. *deliberate misgendering;*
12. *disciplinary room confinement; and*
13. *group punishment or discipline for individual behavior.*

ASE 3: Accessibility and Accommodation

Service and facilities are accessible and accommodate the needs of service recipients.

Self-Study Evidence

*Procedures for accommodating the diverse needs of persons served	**File:** Location.docx

Site Visit Evidence

*Client rights policy and procedures
*Community resource and referral list
*Sample eligibility criteria from across programs

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Persons served
- Observe facility

ASE 3.01

In planning the location and use of offices and branches, the organization considers:

a. accessibility, availability, and affordability of public transportation;
b. location of other relevant community resources; and
c. the special needs of the defined service population as well as the needs of persons with disabilities.

Interpretation: *If some of the organization's administrative or service facilities are not accessible to people with physical disabilities, the organization provides or arranges for equivalent services at an alternate, convenient, and accessible location.*

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not fully addressed, but the organization has taken steps to strengthen practice.
3. Practice requires significant improvement; e.g.,

- The organization does not consider the availability of public transportation nor does it formally review the distribution of persons within the service population in relation to facility locations; or
- Does not formally consider the needs of persons with special needs when planning and locating service delivery sites.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 3.02 (FP)

The organization designs and adapts its programs and services, as appropriate, to accommodate the visual, auditory, linguistic, and motor abilities of persons served.

Related Standards: RPM 1

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 3.03

The organization accommodates the written and oral communication needs of clients by:

a. communicating, in writing and orally, in the languages of the major population groups served;
b. providing, or arranging for, bilingual personnel or translators or arranging for the use of communication technology, as needed;
c. providing telephone amplification, sign language services, or other communication methods for deaf or hard of hearing persons;
d. providing, or arranging for, communication assistance for persons with special needs who have difficulty making their service needs known; and
e. considering the person's literacy level.'

Related Standards: TS 2.04

Examples: *Examples of ways the organization can demonstrate standard implementation include, but are not limited to:*

1. *providing basic program information in languages representative of consumer groups;*
2. *proactively reaching out to ensure that all individuals can use its services and fully participate in planning;*
3. *hiring sufficient numbers of bilingual personnel for all programs in which confidential interpersonal communication is necessary for adequate service delivery;*
4. *ensuring there is a bilingual worker on staff for each language group large enough to comprise an average-sized caseload;*
5. *offering trained translators or interpreters in non-counseling services when bilingual personnel are not available without depending upon children or other individuals unable to maintain the integrity of the client-provider relationship; and*
6. *using assistive technology, such as amplification for hard of hearing persons or a language telephone line, when appropriate.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization has been unable to secure the services of enough bilingual personnel or translators to cover its consumers' needs but efforts to do so are underway; or
   - Accommodations for one of the populations served needs some minor improvement; e.g. better access to communication assistance.
3. Practice requires significant improvement; e.g.,

- Accommodation is made for some, but not all primary groups served; or
- Little effort is made to address communication needs other than language barriers.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 3.04 (FP)

~~The organization supports equitable delivery of its programs and services to individuals with intellectual and developmental disabilities (IDD) by:~~

~~a. providing services to individuals based on assessed needs, individual and organization capacity, and the wishes of the person; and~~
~~b. connecting individuals and families to appropriate providers when specific needs cannot be met by the organization.~~

~~**Interpretation:** Regarding element (a), the decision to serve individuals with intellectual and developmental disabilities should be made based on how well the organization's services can meet the service requests and identified needs of the individual and not be made based solely on the presence or absence of an intellectual or developmental disability.~~

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 4: Facility Safety and Maintenance

The organization's facilities and grounds are safely maintained and are routinely monitored.

Related Standards: RPM 2.01

Self-Study Evidence

*Facility maintenance procedures	**File:** Facility Use Procedure
*Procedures for vehicle use including license validation, insurance coverage expectations, etc.	**File:** Vehicle Use Procedure

Site Visit Evidence

- Monthly maintenance inspection reports for the prior six months
- Documentation of corrective action where indicated
- Documentation of license, driving records, and insurance validation
- Contracts, including safety expectations, with any outside transportation providers, if applicable
- Contracts/agreements with any host sites

On-Site Activities

- Interviews may include:
    1. Relevant personnel
- Observe facilities
- Observe vehicles

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the ASE 4 Practice standards.

2. Practices are basically sound but there is room for improvement, as noted in the ratings for the ASE 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the ASE 4 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the ASE 4 Practice standards.

ASE 4.01 (FP)

All facilities in which the organization operates are properly maintained through:

a. monthly inspections to ensure the organization's facilities are safe and heating, lighting, and other systems are functioning properly;
b. preventive maintenance by a qualified professional; and
c. quick responses to emergency maintenance issues and potentially hazardous conditions.

Related Standards: RPM 2.01

Interpretation: *If the organization is a tenant in its facilities, some or all of the above activities may be conducted by the landlord. In such instances, the organization must be able to demonstrate that it monitors and documents the completion of elements (a) through (c) to provide a safe environment for people to work and receive services.*

Examples: *"Emergency maintenance issues" can include: overflowing toilets, flooded basements, defective heating systems, and other situations that can damage property, pose a threat to clients, or interfere with service delivery.*

Examples of "hazardous conditions" include: uncovered electrical outlets, improper storage of cleaning supplies and other hazardous materials, unsecured floor coverings or equipment, stairs without handrails, harmful water temperatures, inadequate lighting, improper ventilation, uncomfortable room temperatures, unscreened areas or unmarked glass doors, broken or malfunctioning tools or equipment, including electrical appliances, and unsafe drinking water.

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard. All administrative and service-delivery facilities are safe and well-maintained in accordance with comprehensive maintenance procedures as per the requirements of the standard.
2. Practices are basically sound and facilities are generally safe and well-maintained, but there is room for improvement; e.g.,
   - Inspections are conducted regularly on a timeframe established in procedures at all administrative and program sites, but non-emergency or non-hazardous issues identified as needing maintenance are not always resolved in a timely manner; or
   - The organization rarely reviews the need for, or conducts, preventive maintenance, instead making repairs on an "as needed" basis; or
   - Review of the physical plant at some programs or sites is conducted less than monthly but at least quarterly;
   - Maintenance records are not always up-to-date at rented facilities.
3. Practice requires significant improvement and potentially unsafe conditions exist at at least one administrative or service-delivery site; e.g.,
   - One of the standard's elements is not addressed at all; or
   - Poorly written or incomplete maintenance procedures, or use of unqualified staff have resulted in the failure to recognize critical problems needing attention; or
   - Maintenance procedures are implemented in a cursory or haphazard manner; or
   - Needed repairs are typically not made in a timely manner; or
   - There are ongoing problems with critical systems, like the hot water supply or heat, that the organization is attempting to remediate, thus far unsuccessfully; or

- There are deficiencies in regard to health, sanitation, and safety codes and regulations, and remedial action is being taken under direction from authorities; or
- Maintenance at rented facilities is not routinely monitored and/or documented.

4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - At least two of the standard's elements have not been addressed at all; or
   - Staff and/or clients are at risk due to the organization's failure to conduct routine inspections or maintenance, make critical repairs of emergency issues or hazardous conditions, or otherwise properly maintain at least one of its owned or rented facilities; or
   - Licensure or certification has been denied or revoked due to failure to meet applicable health and safety codes and regulations.

ASE 4.02 (FP)

An organization that permits or requires the use of agency- or privately-owned vehicles to transport clients requires:

a. the use of age-appropriate passenger restraint systems;
b. adequate passenger supervision, as mandated by statute or regulation;
c. proper maintenance of agency-owned vehicles;
d. current registration and inspection of vehicles;
e. annual validation of licenses and driving records for staff who are permitted to transport clients; and
f. motor vehicle insurance.

Related Standards: RPM 1, RPM 3.01

Interpretation: *This standard does not apply to vehicles owned by resource families, which are covered by FKC 18.05 and AS 10.06.*

Interpretation: *When state inspection is not available (d), the organization should establish alternate procedures for verifying proper maintenance of both privately- and organization-owned vehicles.*

Interpretation: *When the organization has a contract with an outside transportation provider, it must include relevant safety expectations in the contract.*

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - In rare instances routine vehicle maintenance or driver's license checks are delayed.
3. Practice requires significant improvement; e.g.,
   - The process for validating drivers licenses or driving records of staff currently using organization-owned vehicles to transport clients in their own vehicles is backlogged; or
   - Vehicle maintenance, insurance, or other records are poorly maintained resulting in confusion about how well the standard is being implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - One of the elements is not addressed at all.

ASE 4.03

When services are offered on a consistent and on-going basis, in a location that is not owned or leased by the organization, prior to using the facility, the organization develops a memorandum of understanding (MOU) or a contractual agreement with the host that includes:

a. space and equipment needs;
b. health and safety expectations; and

c. each group's responsibility for cleaning, maintenance, liability risk, and other costs (e.g., utilities, insurance, and repairs).

NA Taken in 2021: *The organization does not offer services on a consistent and on-going basis at locations it does not own or lease.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures need strengthening; or
   - One element has not been fully addressed.
3. Practice requires significant improvement; e.g.,
   - Agreements/contracts are often poorly executed and maintained, e.g., terms and conditions are general, nonspecific, or unclear; or
   - At least two of the elements have not been fully addressed; or
   - One element has not been addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

ASE 5: Safety and Security

The organization ensures that all buildings, grounds, and facilities promote the safety and security of persons served, personnel, and visitors.

Related Standards: RPM 2.01

Self-Study Evidence

*Results of most recent safety and security	**File:** Temple inspections **File:** Master Mason inspections **File:** Kimel inspections **File:** Jefcoat inspections **File:** Preventative maintenance checklist **File:** Alumni cottage inspections **File:** Eller cottage inspections **File:** Williams cottage inspections **File:** Risk Management Meeting_Minutes **File:** Security-Resource-Officer-position-summary **File:** bundy.pdf **File:** bemis.pdf **File:** alumni.pdf assessment**File:** alumni.pdf **File:** flowers.pdf **File:** eller.pdf **File:** EHI Demerit report 12-4-20.docx **File:** temple.pdf **File:** williams.pdf **File:** parham.pdf **File:** EHI Demerit report 9-19-19.docx **File:** jefcoat.pdf **File:** Buildings-Grounds-Assessment-Report-7-20.doc **File:** Risk-Assessment-Management-Plan-10-20.xls **File:** masters.pdf **File:** kimel.pdf
*Table of contents of training curricula	**File:** CPI curriculum contents.docx **File:** Crisis Response Part 9-23-2020.pptx **File:** Van driving curriculum.pdf **File:** VGCC First Aid Randy.ppt **File:** Bloodborne Pathogen Training 2021.ppt **File:** PhishingAwareness_Training 2020.pptx **File:** Med Administration Training 2020.pptx **File:** Food Safety and Preparation Review and Quiz Answer Guide.pptx

	File: Food Safety and Preparation Review and Quiz.pptx **File:** Pool operator table of contents.pdf

Site Visit Evidence

- Documentation of measures taken to promote safety (e.g. relevant policies, procedures, work orders, etc.)
- Training curricula
- Documentation tracking staff completion of training

On-Site Activities

- Interviews may include:
    1. Relevant personnel
    2. Persons served
- Observe facilities

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the ASE 5 Practice standards; health or safety concerns are promptly addressed.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the ASE 5 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the ASE 5 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the ASE 5 Practice standards.

ASE 5.01 (FP)

The organization assesses its safety and security needs and:

a. takes appropriate measures to protect the safety of all persons who are in its facilities or on its grounds; and
b. develops safety and communication protocols for staff, including staff that work off-site, as applicable.

Related Standards: GOV 5.05, RPM 2.01

Examples: *Appropriate measures can include procedures and protocols for public health emergencies, bars on windows, alarm systems, and written policies prohibiting the possession of weapons on the facilities premises except by qualified security and law enforcement personnel.*

Rating Indicators:

1. The organization regularly assesses the safety and security of its facilities and grounds as per the requirements of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Some non-critical recommendations of the safety assessment have not been addressed; or
    - Safety and communication protocols for off-site workers lack clarity or are somewhat outdated.
3. Practice requires significant improvement; e.g.,
    - The organization's approach to assessing safety and security of its facilities and grounds is inconsistent across programs and sites or not thorough, and as a result, appropriate measures are not in place, e.g., staff are not notified in advance when maintenance requires shutting off water, or staff report insufficient lighting in parking areas, or areas in need of repair are not cordoned; or
    - Communication protocols lack clarity or are outdated; or
    - Security systems for deterring break-ins are not in place in at least one site.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - The organization’s buildings, grounds and facilities are unsafe.

ASE 5.02 (FP)

The organization trains staff on:

a. safety procedures and protocols;
b. potential risks they may encounter on-site, in the community, or in service recipients' homes; and
c. self-protection techniques, as necessary.

Note: See ASE 6.04 for more information on training staff on the emergency response plan.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The training curriculum is not fully developed or lacks depth in some areas; or
   - Some personnel, such as new hires, are not yet trained.
3. Practice requires significant improvement; e.g.,
   - A number of staff have not yet been trained on risks they may encounter while working or on self-protection techniques; or
   - One of elements has not been addressed.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization's buildings, grounds and facilities are unsafe; or
   - Two of the elements have not been addressed.

ASE 6: Emergency Response Preparedness

The organization plans for and coordinates emergency response preparedness.

Self-Study Evidence

*Emergency Response Plan, including service continuity	**File:** Safety Procedure.pdf
*Emergency Response procedures	**File:** Safety Procedure.pdf
*Table of contents of training curricula	**File:** CPI curriculum contents.docx **File:** Crisis Response Part 9-23-2020.pptx **File:** Bloodborne Pathogen Training 2021.ppt **File:** First Aid Handbook.doc

On-Site Evidence

- Documentation of consultation with a health professional
- Emergency contact information
- Training curricula
- Documentation tracking staff completion of training
- Documentation tracking completion of training for persons served, as appropriate
- Fire drill logs

On-Site Activities

- Interviews may include:
  1. Program directors
  2. Relevant personnel
  3. Persons served
- Observe facility
- Review case records for individualized medication plans, as needed

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the ASE 6 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the ASE 6 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the ASE 6 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the ASE 6 Practice standards.

ASE 6.01 (FP)

The organization develops an emergency response plan that outlines its response to medical emergencies, facility and security-related emergencies, public health emergencies, and natural disasters, and addresses:

a. coordination with appropriate authorities and emergency responders;
b. communication with the governing body, personnel, service recipients and their families, community partners, and as appropriate, the public, and the media;
c. evacuation procedures including accounting for the whereabouts of staff and service recipients and the evacuation of persons with mobility challenges and other special needs; and
d. participation with community partners and stakeholders in community recovery efforts, as appropriate.

Related Standards: BSM 4.08, RPM 5.04

Interpretation: *It is critical that emergency response plans include arrangements for the provision of needed medications when applicable. Individuals that may require an individualized plan for providing medications in the event of an emergency include: individuals with psychiatric conditions, individuals taking opioid treatment medications, and older adults. Arrangements can include maintaining a list of service recipients likely to be effected and pre-arranging for services outside the area likely to be evacuated.*

Examples: *Emergency situations can include, but are not limited to, accidents, suicide, fire, medical emergencies, flooding, hostage situations, bomb threats, active shooter, unlawful intrusion, physical assault, and other life-threatening situations.*

Examples: The organization can help ensure preparedness to enact the emergency response plan by:

1. identifying the staff that will communicate with authorities and emergency responders at each program location;
2. testing the lines of communication to staff, board, persons served, community partners, and the public;
3. identifying staff who are responsible for people with mobility challenges and other special needs;
4. confirming availability of sufficient supplies at each site such as masks, gloves, hand sanitizer, first aid kits or supplies, a first aid manual, cleaning supplies, disinfectant, toilet paper, food, maintenance supplies, batteries, etc.;
5. maintaining up-to-date emergency contact information for all staff and service recipients;
6. ensuring availability of medications for people in residential facilities;
7. maintaining a readily available emergency response plan and procedures at all program sites;
8. developing plans for programs and administrative offices to operate with increased staff absences due to illness; and
9. developing plans for managing responsibilities performed by volunteers or contractors, in the event they are prohibited from entering the facility.

Examples: To ensure uninterrupted services to vulnerable populations in the event of an evacuation, arrangements can include maintaining a list of service recipients likely to be affected and pre-arranging for services outside the area likely to be evacuated.

Examples: Response plans in the event of a suicide can include:
1. procedures for managing information about the death;
2. coordination of internal or external resources;
3. supports for those affected by the death;
4. commemoration of the deceased; and
5. follow-up with anyone at elevated risk for suicide.

Examples: *Response plans in the event of a suicide can include:*

1. *procedures for managing information about the death;*
2. *coordination of internal or external resources;*
3. *supports for those affected by the death;*
4. *commemoration of the deceased; and*
5. *follow-up with anyone at elevated risk for suicide.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Plans or procedures related to one of the standard's elements could be more explicit or detailed, or have not been reviewed recently.
3. Practice requires significant improvement; e.g.,
   - Plans or procedures related to at least one of the standard's elements:
     - Are vague and/or confusing and as a result may pose a risk; or
     - Are outdated or have not been reviewed in more than two years; or
     - Do not designate responsibility for coordinating a response, or for taking actions identified as being critical; or
     - Are not readily available to staff who may need them immediately in the event of an emergency.
   - Emergency response plans or procedures are "one-size-fits-all" and are not appropriately tailored to:
     - The specific needs of different geographic locations or jurisdictions; or
     - The needs of different populations (e.g., foster children or the elderly) at different programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - One of the elements is not addressed at all.

ASE 6.02 (FP)

The emergency response plan includes provisions for service continuity that ensures ongoing mission-critical functions in the event of a disruption of normal services, and:
a. identifies temporary administrative and service delivery sites in the event of facility closure;
b. addresses the temporary delegation of decision-making authority when normal channels have been disrupted;
c. establishes alternative methods of communication with staff and stakeholders during periods of disruption;
d. ensures uninterrupted continuity of critical IT operations; and
e. is reviewed, tested, and updated at least annually.

Related Standards: RPM 5.04

Examples: *Continuity Plans allow flexible and scalable responses to emergencies and other events that could disrupt operations. "Mission-critical functions" include core services and operational functions that are necessary to the continued operation of the organization.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,

- Plans or procedures related to one of the standard's elements could be more explicit or detailed, or have not been reviewed recently.

3. Practice requires significant improvement, e.g.,
   - Plans or procedures related to at least one of the standard's elements:
     - Are vague and/or confusing and as a result may pose a risk; or
     - Are outdated or have not been reviewed in more than two years or;
     - Do not designate responsibility for coordinating a response, or for taking actions identified as being critical; or
     - Are not readily available to staff who may need them immediately in the event of an emergency.
   - Emergency response plans or procedures are "one-size-fits-all" and are not appropriately tailored to:
     - The specific needs of the different geographic locations or jurisdictions; or
     - The needs of different populations (e.g. foster children or the elderly) at different programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - One of the elements is not addressed at all.

ASE 6.03 (FP)

The organization is prepared to treat injuries and respond to medical emergencies by:

a. maintaining a readily available communication device, poison control information, and first aid supplies and manuals at all program sites and during off-site activities when applicable;
b. consulting with a health professional, as necessary, to develop procedures for such situations; and
c. maintaining emergency contact information for personnel and service recipients.

Interpretation: Organizations that maintain Naloxone or opioid antagonist kits to treat opioid overdose cases:

1. maintain at least two unexpired doses in accessible locations;
2. store personal protective equipment (PPE) close to the kit to facilitate quick response;
3. ensure staff trained in SAMHSA-approved protocols and procedures for reversing opioid drug crisis are available to administer these treatments;
4. have procedures and appropriate training in place to get affected individuals to medical care immediately following overdose treatment to preempt the reoccurrence or worsening of symptoms;
5. have procedures for documenting each incident where opioid antagonists were administered; and
6. have systems for maintaining and restocking opioid overdose equipment and medication to ensure availability of unexpired medication in an emergency.

Note: Please see the Case Record Checklist and Facility Observation Checklist for additional guidance on this standard.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - First aid supplies at one site were outdated.
3. Practice requires significant improvement, e.g., one or more of the following was not readily available at one of the organization's program sites:
   - A telephone or other communication device; or
   - Poison control information; or
   - First aid supplies and manuals.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - One of the elements is not addressed at all.

ASE 6.04 (FP)

Personnel from all the organization's programs and administrative offices, and persons served in residential or daytime group care settings when applicable, receive training on implementing the organization's emergency response plan that is tailored as appropriate to:

a. the specific types of emergencies faced by the organization;
b. the level of staff responsibility;
c. the needs, age, and developmental level of service recipients;
d. program type; and
e. geographic location.

Related Standards: PRG 4.04

Examples: *It may be appropriate for some staff to receive "gatekeeper training" on how to recognize, interpret, and respond to signs of suicide risk, and/or Mental Health First Aid training for recognizing and responding to signs of a mental health crisis.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Training is inconsistent across program sites; or
   - The curriculum related to one of the elements is not fully developed or lacks depth; or
   - A few personnel or service recipients have not yet been trained.
3. Practices are basically sound but there is room for improvement; e.g.,
   - Training is not provided at some programs; or
   - Training addresses some but not all of the types of potential emergencies likely to be encountered; or
   - A significant number of staff or service recipients have not been trained.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - One of the elements is not addressed at all

ASE 6.05 (FP)

Fire drills are conducted according to legal requirements, and held at least:

a. during periods of both activity and rest, as appropriate to the program or service;
b. once a month for every shift in Early Childhood Education (ECE) and Out of School Time Services (OST) settings; *(GLS/TLC/ILP: monthly /one overnight per quarter – licensing requirement)*
c. once a quarter for every shift in residential or daytime group care settings; and/or
d. annually for other services and at administrative offices.

Interpretation: *Residential programs for adults living independently in apartments, single-room-occupancy, or other independent living arrangements are not expected to conduct fire drills during evening and/or overnight shifts where staff do not have a continuous presence onsite. Such programs must still conduct fire drills at each program site during business hours.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Fire drills are conducted in accord with required timeframes, but drills during rest periods could be done more often; or
   - Procedures are vague or need clarifying, e.g., do not specify fire drill frequency for some non-residential or day programs.

3. Practice requires significant improvement; e.g.,
    - Quarterly fire drills are sometimes missed for some shifts, or are rarely conducted at night in residential facilities, or service recipients are not awakened during nighttime drills; or
    - Fire drill logs are poorly maintained or missing in some programs or sites; or
    - The organization has not recently reviewed current legal requirements; or
    - Fire drills are not conducted at some administrative sites; or
    - The staffing patterns for fire drills do not reflect the number of staff that would be present in the event of an actual emergency.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - The organization rarely conducts drills; or
    - The organization never conducts fire drills during rest periods or at night.

Service Delivery Administration Standards

Behavior Support and Management

Purpose

The organization's behavior support and management policies and practices promote positive behavior and protect the safety of service recipients and personnel.

Introduction

Effective behavior support and management practices center around preemptive interventions, such as identifying problem behaviors and working with the individual and their support systems to create practical solutions in order to minimize the need for restrictive interventions to the greatest extent possible.

A culture that promotes respect, healing, and positive behavior, and provides service recipients with the support they need to manage their own behaviors, can help prevent crisis situations and the need for restrictive interventions. Involving the individual and appropriate family members or support systems early on in identifying triggers and previous successes in coping with escalating behaviors creates a collaborative approach to behavior support and management and helps provide personnel and the individual with early insight into aggressive, harassing, or self-injurious behaviors.

Training prevents injuries and deaths in crisis situations, including those that warrant the use of restrictive interventions as a last resort. Organizations that maintain a process for reviewing incidents when they do occur have the opportunity to make changes in their practices to support the safest environment possible and further reduce the use of restrictive interventions.

NA: The organization's policy prohibits restrictive behavior management interventions.

Note: *Restrictive interventions are those that involuntarily restrict, limit, or curtail a person's freedom of movement and include manual restraint, mechanical restraint, and seclusion. Federal guidelines consider any restriction of an individual's movement a restrictive intervention. Related definitions can be found in COA's glossary.*

Timeout or isolation are colloquial terms that may or may not include restrictive interventions. For the purpose of these standards, any instance where an individual is placed in a room separate from others and they cannot voluntarily leave (whether the door is locked or personnel is preventing the individual from leaving) will be referred to as seclusion and considered a restrictive intervention.

Note: *Behavior Support and Management (BSM) will be NA when the policy referenced in ASE 2 prohibits restrictive interventions.*

Table of Evidence
No Self Study Evidence

BSM 1: Oversight of Restrictive Behavior Management Interventions

The organization employs restrictive behavior management interventions under the oversight of its management and governing body.

Self-Study Evidence

*BSM policy (see also ASE 2)	**File:** Behavior Support and Management Policy and Procedure
*BSM procedures including incident review procedures	**File:** Critical Incidents Procedure.pdf **File:** Behavior Support and Management Procedure.pdf

Site Visit Evidence

- Documentation of program director notification of restrictive behavior management interventions
- Documentation of committee and administrative reviews of restrictive behavior management interventions for the previous six months

On-Site Activities

- Interviews may include:
    1. Program directors
    2. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 1 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 1 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the BSM 1 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 1 Practice standards.

BSM 1.01 (FP)

Behavior support and management policies address:

a. safety measures to be taken when emergency situations arise, including which restrictive behavior management interventions may be used to protect service recipients from harming themselves or others;
b. other practices that may be used and under what circumstances; and
c. prohibited practices, including chemical restraint, corporal punishment, and behavior control methods that interfere with the individual's right to humane care.

Related Standards: ASE 2.01

Interpretation: *Medications are treatment for targeted symptomatology and should not be considered an intervention for challenging behaviors. In relation to element (c), chemical restraint does not include situations when a psychopharmacological drug:*

1. *is used according to the requirements for treatment authorized by a court;*
2. *is provided using specified criteria in a person's approved treatment plan as per a physician's order to provide medical treatment for a specific diagnosis and known progression of symptoms, such as in cases of a PRN; or*
3. *is administered when necessary (PRN) to prevent immediate, substantial, and irreversible deterioration of a person's mental status when prescribed by a physician or other qualified medical practitioner.*

Interpretation: *For organizations that have resource parents providing restrictive interventions, the organization needs to clearly outline in the behavior support and management policy the interventions resource parents are permitted to apply and under what circumstances.*

Examples: *Refer to COA's definition of restrictive behavior management interventions at the beginning of this section for a list of interventions that may be included in the behavior support and management policy.*

Note: *Refer to COA's glossary for a definition of chemical restraint.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements needs greater specificity or clarity in the policy.
3. Practice requires significant improvement; e.g.,
    - Two of the elements need greater specificity or clarity in the policy; or
    - The policy is too vague to provide guidance to personnel
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - One of the elements is not implemented.

BSM 1.02 (FP)

The organization prohibits the use of behavior management interventions:

a. by any person other than trained, qualified personnel;
b. as a substitute for appropriate staffing patterns, for the convenience of personnel or as punishment;
c. in response to property damage that does not involve imminent danger to self or others; and
d. when contraindicated in the individual's service or behavior plan.

Related Standards: PRG 5.02

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - There have been a few instances where behavior management interventions were used inappropriately, but corrective action was implemented immediately.
3. Practice requires significant improvement; e.g.,
    - There have been a few instances of prohibited interventions, and no evidence of immediate and appropriate corrective action.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

BSM 1.03

A committee comprised of all levels of personnel conducts regular reviews of the use of behavior support and management interventions and:

a. compares organization practices to current information and research on effective practice;
b. uses findings from quarterly risk management reviews of restrictive behavior management to inform personnel about current practice and the need for change;
c. revises policies and procedures when necessary;
d. determines whether additional resources are needed; and
e. supports efforts to minimize the use of restrictive behavior management interventions.

Related Standards: RPM 2.01

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not regularly included in the reviews.
3. Practice requires significant improvement; e.g.,
    - Two of the elements are not regularly included in the reviews; or
    - Reviews are not done sufficiently often to effectively monitor practices; or
    - The committee does not include personnel from all levels.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Three of the elements are not regularly included in the review; or
    - There is no committee, or participation is limited to management.

BSM 1.04

The program or clinical director is notified following each use of a restrictive behavior management intervention and each incident is administratively reviewed no later than one working day following an incident to:

a. review any preemptive measures taken to avoid the intervention;
b. determine whether or not the individual's behavior support and management plan was followed; and
c. assess the measures' effectiveness.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Notification and administrative review regularly occur, but procedures need clarifying; or
    - Notification has occasionally exceeded one working day.
3. Practice requires significant improvement; e.g.,
    - There have been instances where notification or administrative review did not occur; or
    - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Notification or review does not regularly occur.

BSM 2: Behavior Support and Management Practices

Behavior support and management practices promote respect, healing, and positive behavior and prevent the need for restrictive behavior management interventions.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Self-Study Evidence

*BSM procedures including procedures for: 1. obtaining consent 2. notifying parents/guardians of incidents involving restrictive interventions 3. conducting assessments and developing behavior management plans	**File:** Behavior Support and Management Policy and Procedure.pdf

Site Visit Evidence

- Copy of written behavior support and management philosophy and procedures provided to service recipients and/or parents/legal guardians

On-Site Activities

- Interviews may include:
    1. Program directors
    2. Relevant personnel
    3. Persons served
- Review case records

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 2 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 2 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the BSM 2 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 2 Practice standards.

BSM 2.01

The organization:

a. provides an explanation for and offers a copy of its written restrictive behavior support and management philosophy and procedures to service recipients or their parents/legal guardians at admission;
b. annually obtains the individual's and/or parent's/legal guardian's consent when restrictive behavior management interventions are part of the treatment modality;
c. informs the individual and/or parent/legal guardian of the service implications, if any, of refusing to sign; and
d. when the individual is a minor or has a legal guardian, notifies the parents/legal guardians promptly when the individual is involved in an incident involving a restrictive intervention.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need minor clarification; or
    - One of the required elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
    - Two of the elements are not fully addressed; or
    - One element is not addressed at all; or
    - Annual consents are not consistently obtained; or
    - Parents or legal guardians are frequently not notified.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Three or more of the elements are not fully addressed; or
    - Two of more of the elements are not addressed at all.

BSM 2.02 (FP)

The organization collaborates with the individual and/or parent/legal guardian to assess for:

a. the individual's perception of emotional and physical safety;
b. past experiences with restrictive behavior management interventions;
c. antecedents or emotional triggers and the resulting behaviors;
d. previous successes in utilizing strategies and coping skills to mitigate the need for restrictive behavior management interventions;
e. psychological and social factors that can influence use of such interventions, including trauma history; and
f. medical conditions or factors that could put the person at risk.

Examples: *Medical factors can include issues related to use of medications, such as an insulin imbalance. Psychological and social factors may include psychosis or claustrophobia.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need minor clarification; or
    - One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,

- Two of the elements are not fully addressed

4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - One of the elements are not addressed at all.

BSM 2.03 (FP)
A behavior support and management plan is based on assessment results and:

a. identifies proactive, strengths-based strategies that will help the person de-escalate their behavior and prevent harassing, violent, or out-of-control behavior;
b. specifies interventions that may or may not be used, taking the individual's trauma history into account;
c. is modified as necessary; and
d. is developed in collaboration with the individual and is signed by the person, their parent/legal guardian, and personnel, as appropriate.

Interpretation: *The behavior support and management plan, sometimes called a crisis plan, can be part of, and reviewed with, the overall service or treatment plan.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements needs strengthening; or
    - There are a few instances where signatures were missing.
3. Practice requires significant improvement; e.g.,
    - Two of the elements need strengthening; or
    - One of the elements is not addressed at all; or
    - There is no evidence that the plans, once developed, are reviewed or updated; or
    - Most plans are not signed.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

BSM 3: Restrictive Behavior Management Intervention Training

Personnel who use restrictive behavior management interventions, are trained and evaluated on an annual basis using a nationally recognized curriculum.

Examples: *Training on restrictive behavior management interventions can include:*

1. *proper and safe use of interventions, including when it is appropriate to use a restrictive intervention and time limits for use;*
2. *understanding the experience of being placed in seclusion or a restraint, including the medical and therapeutic risks related to restrictive interventions and the resulting consequences of the misuse of restrictive interventions, including trauma and re-traumatization;*
3. *response techniques to prevent and reduce injury;*
4. *evaluating and assessing physical and mental status, including signs of physical distress, vital indicators, and nutrition, hydration, and hygiene needs;*
5. *readiness to discontinue use of the intervention;*
6. *when medical or other emergency personnel are needed; and*
7. *documentation and debriefing.*

Self-Study Evidence

*Information about the nationally recognized curriculum used by the organization	**File:** Crisis Response Part 9-23-2020.pptx **File:** CPI curriculum contents.docx

Site Visit Evidence

- Documentation tracking staff completion of restrictive behavior management trainings and evaluations

On-Site Activities

- Interviews may include:
  1. Program directors
  2. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the BSM 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 3 Practice standards.

BSM 4: Restrictive Behavior Management Interventions

Restrictive behavior management interventions are used in a manner that protects the safety and well-being of persons served and personnel in crisis situations, when less-restrictive measures have proven ineffective.

Related Standards: RPM 1

Self-Study Evidence

*BSM procedures including procedures for: 1. authorization and reauthorization of restrictive interventions 2. continuous monitoring during a restrictive intervention 3. safely escorting service recipients 4. provision of food and water and use of bathrooms 5. time limits on use of restrictive interventions 6. evacuating individuals in seclusion or mechanical restraint during an emergency	**File:** Behavior Support and Management Policy and Procedure.pdf

Site Visit Evidence

- Documentation of training and qualifications for staff authorizing/reauthorizing interventions
- Restrictive behavior management intervention logs that include documentation of continuous monitoring

On-Site Evidence

- Interviews may include:
  1. Program directors
  2. Relevant personnel
  3. Persons served
- Seclusion room observation

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 4 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the BSM 4 Practice standards.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 4 Practice standards.

BSM 4.01
Personnel qualified through annual training and evaluation authorize each restrictive behavior management intervention in accordance with any applicable federal or state requirements.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Authorization procedures need clarifying.
3. Practice requires significant improvement; e.g.,
    - There have been instances of restrictive intervention without authorization by qualified personnel, but corrective action is occurring; or
    - Documentation is weak.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - There have been instances of restrictive intervention without authorization by qualified personnel and corrective action has not been initiated; or
    - Practices are in violation of applicable legal requirements; or
    - Written procedures do not address use of qualified personnel.

BSM 4.02 (FP)

Individuals are monitored continuously, face-to-face, and:
a. assessed at least every 15 minutes for any harmful health or psychological reactions; and
b. interventions are discontinued immediately if they produce adverse side effects such as illness, severe emotional or physical stress, or physical injury.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - In a few rare instances there was a lapse in monitoring or assessment, but corrective action was taken immediately.
3. Practice requires significant improvement; e.g.,
    - In more than a few instances there was a lapse in monitoring or assessment, but corrective action was taken immediately; or
    - Documentation is weak; or
    - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Lapses occur with some frequency and corrective action is not taken; or
    - There are no procedures; or
    - Procedures are not routinely followed.

BSM 4.03 (FP)

Procedures address safe methods for involuntarily escorting service recipients.

NA Taken in 2021: *The organization does not escort service recipients or use seclusion.*
Examples: *This includes methods such as the backwards escort.*

BSM 4.04 (FP)

Seclusion rooms:
a. conform to existing licensing and/or fire safety requirements;
b. are outfitted with a door that easily opens in case of emergency (e.g. spring lock door); and
c. are limited to one person at a time.

NA Taken in 2021: *The organization does not use seclusion.*
Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

BSM 4.05 (FP)

During a restrictive behavior management intervention personnel assess the individual's need for food, water, and use of bathroom facilities and provide access when safe and appropriate.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need clarifying.
3. Practice requires significant improvement; e.g.,
    - Procedures are inadequate; or
    - There have been instances where procedures were not followed, but corrective action has been initiated; or
    - Documentation needs significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - There are no procedures; or
    - Procedures are routinely not followed.

BSM 4.06 (FP)

Restrictive behavior management interventions are discontinued as soon as possible, and are limited to the following maximum time periods per episode:

a. 15 minutes for children aged nine and younger, for all restrictive behavior management interventions;
b. 30 minutes for individuals aged ten and older, undergoing manual or mechanical restraint;
c. 30 minutes for individuals aged ten to thirteen in seclusion; and
d. one hour for individuals aged fourteen and older in seclusion.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need clarifying.
3. Practice requires significant improvement; e.g.,
    - Procedures are inadequate; or
    - There have been instances where procedures were not followed, but corrective action has been initiated; or
    - Documentation needs significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - There are no procedures; or
    - Procedures are routinely not followed.

BSM 4.07(FP)

Reauthorization by qualified personnel is required for each instance of a restrictive intervention that exceeds the maximum time limit.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need clarifying.
3. Practice requires significant improvement; e.g.,
    - Procedures are inadequate; or

- There have been instances where procedures were not followed, but corrective action has been initiated; or
- Documentation needs significant strengthening.

4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - There are no procedures; or
   - Procedures are routinely not followed.

BSM 4.08
The organization has procedures to address the safe removal of individuals in seclusion or mechanical restraint in the event of an emergency evacuation.

NA Taken in 2021: *The organization does not use seclusion or mechanical restraint.*

Related Standards: ASE 6.01

BSM 5: Documentation and Debriefing

The organization assesses restrictive behavior management incidents and effects to reduce future preventable occurrences and untoward consequences.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Self-Study Evidence

*BSM procedures, including debriefing procedures	Behavior Support and Management Policy and Procedure

Site Visit Evidence

- Restrictive behavior management intervention logs
- Documentation of debriefing

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served
- Review case record

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the BSM 5 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the BSM 5 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the BSM 5 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the BSM 5 Practice standards.

BSM 5.01 (FP)

The use of restrictive behavior management interventions is documented, including:

a. the justification, use, circumstances, and length of application in the individual's case record;
b. all attempts made prior to the use of a restrictive behavior management intervention in order to preempt it, including the strategies identified in the individual's behavior management plan; and
c. names of the service recipient and personnel involved, reasons for the intervention, length of intervention, and verification of continuous visual observation in a log.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures need clarifying.
    - In a few instances documentation was not complete.
3. Practice requires significant improvement; e.g.,
    - Procedures are inadequate; or
    - Documentation problems are common but corrective action is being taken.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

BSM 5.02 (FP)

Debriefing occurs in a safe, confidential setting within 24 hours of the incident and includes the service recipient, frontline and clinical personnel, other appropriate personnel, and parents/legal guardians, when possible, to:

a. evaluate physical and emotional well-being;
b. identify the need for counseling, medical care, or other services related to the incident;
c. identify antecedent behaviors and modify the service plan as appropriate; and
d. facilitate the person's reentry into routine activities.

Related Standards: RPM 2.02

Interpretation: *The organization ensures the service recipient's participation in the debriefing process. In situations where the individual initially refuses to participate, the organization should make continued attempts to involve the individual.*

Interpretation: *If the parent or legal guardian is unable to be reached within the 24 hour period, all attempts to reach them should be documented and there should be continued outreach attempts past the 24 hour period to notify them of the incident.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not regularly addressed; or
    - In a few instances debriefing occurred after 24 hours; or
    - In a few instances one of the required attendees was absent.
3. Practice requires significant improvement; e.g.,
    - Two of the elements are not regularly addressed; or
    - In several instances debriefing occurred after 24 hours; or
    - In several instances one or two of the required attendees was absent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.
    - One of the elements is not addressed at all; or
    - Timeframes are routinely exceeded; or
    - One or more of the required attendees is routinely absent or excluded.

BSM 5.03

Personnel involved in the incident are debriefed to assess:
a. their current physical and emotional status;
b. the precipitating events; and
c. how the incident was handled and necessary changes to procedures and/or training to avoid future incidents.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,

- In a few instances one of the elements was not addressed.

3. Practice requires significant improvement; e.g.,
    - In several instances one of the elements was not addressed; or
    - In a few instances staff were not debriefed.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.
    - One of the elements is not addressed at all; or
    - Staff are frequently not debriefed.

BSM 5.04

Any other person involved in or witness to the incident is debriefed to assess their current physical and emotional status.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - In a few instances the debriefing did not occur.
3. Practice requires significant improvement; e.g.,
    - In several instances the debriefing did not occur.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

Client Rights (CR)

Purpose
The rights and dignity of clients are respected throughout the organization.

Introduction
COA's Client Rights (CR) standards are founded on the principle that organizational and program practices should reflect a profound respect for personal dignity, confidentiality, and privacy. In addition to addressing legally protected client rights, the standards in this section also center on the professional ethics of service delivery. This section promotes privacy, transparency, and mutual respect.

Interpretation: *COA recognizes that mandated clients and individuals receiving Adult Guardianship (AG) services may have a reduced level of rights. In addition, information provided to individuals who have been deemed incapacitated by the court, court order, and state law may vary based on an individual's assessed capacity to understand such information. Individuals should retain as much personal responsibility and self-determination as possible given their assessed capacity and individual rights may not be abridged unless superseded by legal mandate or court order.*

Self-Study Evidence *No self-study evidence*

Rating Indicators:
1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the CR 1 Practice standards.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the CR 1 Practice standards.
3. Practice requires significant improvement as noted in the ratings for the CR 1 Practice standard.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the CR 1 Practice standards.

CR 1: Client Rights and Responsibilities

The organization protects the legal and ethical rights of persons served by:
a. informing people of their rights and responsibilities;
b. providing ethical and equitable treatment; and
c. providing people with sufficient information to make an informed choice about using the organization and its services.

Self-Study Evidence

*Client rights policy	**File:** Resident Rights Policy and Procedure
*Client rights procedures	**File:** Resident Rights Policy and Procedure
*Grievance procedures	**File:** Stakeholder Grievance Policy and Procedure
*Policy for providing services to minors without the consent of the parent or legal guardian	
*Fee schedule	**File:** DSS Daily Board Rates

Site Visit Evidence
- Rights and responsibilities document provided to individuals and families at initial contact
- Grievance reports for the past six months

On-Site Activities
- Interviews may include:
  1. Relevant personnel
  2. Persons served
- Review case records
- Observe facility

CR 1.01 (FP)

All persons served receive, and are helped to understand, information about their rights and responsibilities that is:

a. provided in writing;
b. distributed during their initial contact;
c. available in the major languages of the defined service population;
d. effectively and appropriately communicated to persons with special needs; and
e. posted in the reception or common area of each service delivery site or residential facility.

Related Standards: GLS 15.02, GLS 15.03, GLS 16

Interpretation: *If an organization provides services remotely using technology, client rights and responsibilities should be made available on the organization's public website and the organization must implement a system for assuring and documenting that clients receive and understand their rights and responsibilities.*

Interpretation: *If a client is disoriented, suffering from impaired cognition, or in immediate crisis at initial contact, the summary of client rights and responsibilities should be provided at an appropriate time.*

Note: *Please see the Case Record Checklist and Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Information about rights is routinely provided; however, one of the required elements is not fully addressed;
   - Or all sites have postings but some of the postings could be larger or in a better location to increase client awareness of information and/or for easier reading.
3. Practice requires significant improvement; e.g.,
   - Two of the required elements are not fully addressed; or
   - One of the elements is not addressed at all; or
   - Information is not consistently provided at the initiation of services, but is provided upon request; or
   - At least one program does not provide client rights information; or
   - Not all reception sites or site locations have postings; or
   - Rights posters are missing important information; or
   - Rights posted on websites for services delivered remotely, using technology, are missing information.
4. The organization does not provide persons served with written rights and responsibilities.

CR 1.02 (FP)

Written rights and responsibilities include, but are not limited to:

a. basic expectations for use of the organization’s services including the responsibility to provide information needed to receive services;
b. hours in which services are available;
c. rules, behavioral expectations, and other factors that could result in discharge or termination;
d. the right of the person served to receive service in a manner that is non-coercive and that protects the person’s right to self-determination;
e. the right of the person served, families, and/or legal guardians to participate in decisions regarding the services provided; and
f. basic information about how to lodge complaints, grievances, or appeals.

Related Standards: GLS 15.02, GLS 15.03, GLS 15.04, GLS 16

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the required elements is not fully addressed.

3. Practice requires significant improvement; e.g.,
   - Two of the required elements are not fully addressed; or
   - One of the elements is not addressed at all.
4. The organization does not provide persons served with written rights and responsibilities.

CR 1.03 (FP)

Clients have the right to fair and equitable treatment including:

a. the right to receive services in a non-discriminatory manner;
b. the consistent enforcement of program rules and expectations; and
c. the right to receive services that are respectful of, and responsive to, cultural and linguistic diversity.

Related Standards: TS 2.04

Examples: *Fair and equitable treatment may include the provision of effective, equitable, understandable, and respectful services that are responsive to: diverse cultural beliefs and practices, such as the freedom to express and practice religious and spiritual beliefs; preferred languages; and other communication needs.*
Other categories that should be protected from discrimination and disrespect include, but are not limited to: race and ethnicity, military status, age, sexual orientation, gender identity, and developmental level.

One way organizations can be responsive to the unique, culturally-defined needs of persons and families being served is by ensuring that program information, signs, posters, printed material, electronic and multimedia communications, and trainings are available and presented:

1. *in the language(s) of the major population groups served; and*
2. *in a manner that is non-discriminatory and non-stigmatizing.*

Note: Refer to COA's glossary for definitions of equity, diversity, and inclusion.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   Two elements are not fully addressed; or
   One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 1.04 (FP)

Individuals provide consent prior to receiving services and have the right to:

a. participate in all service decisions;
b. be informed of the benefits, risks, side effects, and alternatives to planned services;
c. be offered the most appropriate and least restrictive or intrusive service alternative to meet their needs;
d. receive service in a manner that is free from harassment or coercion and that protects the person's right to self-determination;
e. refuse any service, treatment, or medication, unless mandated by law or court order; and
f. be informed about the consequences of such refusal, which can include discharge.

Related Standards: PRG 4.03

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not fully addressed; or
   - In a few instances evidence of consent was not found.
3. Practice requires significant improvement; e.g.,
   - Two of the elements are not fully addressed; or
   - One element is not addressed at all; or
   - In many instances, evidence of consent was not found.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 1.05 (FP)

The organization maintains a formal mechanism through which applicants, clients, and other stakeholders can express and resolve grievances, including denial of service, which includes:

a. the right to file a grievance without interference or retaliation;
b. timely written notification of the resolution and an explanation of any further appeal, rights or recourse; and
c. at least one level of review that does not involve the person about whom the complaint has been made or the person who reached the decision under review.

Related Standards: RPM 2.01

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   Procedure or documentation related to one of the elements needs strengthening.
3. Practice requires significant improvement; e.g.,
   Procedure or documentation related to two of the elements needs strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 1.06(FP)

The organization states in writing circumstances under which it will serve minors without consent from a parent or legal guardian, and provides this information upon request.

NA Taken in 2021: *The organization does not serve minors without consent from a parent or legal guardian.*

CR 1.07

Clients receive a schedule of any applicable fees and estimated or actual expenses, and are informed prior to service delivery about:

a. the amount that will be charged;
b. when fees or co-payments are charged, changed, refunded, waived, or reduced;
c. the manner and timing of payment; and
d. the consequences of nonpayment.

NA: The organization does not charge the client any fees, co-payments, or other forms of payment in exchange for services.

Related Standards: GLS 15.02

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,

- There have been a few instances when the information was not provided at the initiation of services; or
- One of the elements is not fully addressed.

3. Practice requires significant improvement; e.g.,
   - Information is not consistently provided at the initiation of services but is available upon request; or
   - Two of the elements are not fully addressed; or
   - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 2: Confidentiality and Privacy Protections

The organization protects the confidentiality of information about clients and assumes a protective role regarding the disclosure of confidential information.

Related Standards: PRG 2.01, RPM 1, RPM 5, TS 2.01

Self-Study Evidence

*Confidentiality policy	**File:** Confidentiality Policy
*Confidentiality procedures	**File:** Confidentiality Procedure
*Sample release form for disclosure of confidential information	**File:** DC forms packet under 12 yo **File:** ILP forms packet 18 yo and older **File:** DC forms packet 18 yo and older **File:** DC forms packet 12-18 yo

Site Visit Evidence *No site-visit evidence*

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served
- Review case records

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the CR 2 Practice standards.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the CR 2 Practice standards.
3. Practice requires significant improvement as noted in the ratings for the CR 2 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the CR 2 Practice standards.

CR 2.01 (FP)

When the organization receives a request for confidential information about a client, or when the release of confidential information is necessary for the provision of services, prior to releasing such information, the organization:

a. determines if the reason to release information is valid;
b. obtains informed, written authorization to release the information from the client and/or parent or legal guardian, as appropriate; and
c. maintains each authorization of consent in the case record and provides a copy to the client and/or parent or legal guardian.

Related Standards: PRG 1.02

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.

2. Practices are basically sound but there is room for improvement; e.g.,
   Written, informed consent is always obtained prior to releasing information, and there have been no instances where confidential information was inappropriately released, but procedures could be strengthened or clarified.
3. Practice requires significant improvement; e.g.,
   In a few rare instances information was inappropriately released or informed consent not obtained; or
   In a significant number of cases the information was not provided or there is no documentation that clients were offered a copy.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 2.02 (FP)

Prior to the disclosure of confidential or private information, the organization informs the client about circumstances when it may be legally or ethically permitted or required to release such information without his or her consent, and notifies the client of such a release when it occurs.

Examples: *When permitted or required by law, regulation, or court order, confidential information may be released without the authorization of the client and legal guardian. The organization may wish to seek legal counsel, as necessary, when others seek identifying information about an individual or family, or when the release of confidential information is necessary for the provision of services.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - There are a few instances where clients were not fully informed of the legal or ethical circumstances when confidential or private information may be released without consent, but corrective action was immediately implemented prior to the actual release of the private information.
3. Practice requires significant improvement; e.g.,
   - Written procedures do not provide sufficient guidance to personnel to reconcile when the organization may be legally or ethically permitted or required to release confidential or private information without prior notification of client.
   - There are instances where staff have released confidential or private information inappropriately.
4. Implementation of the standard is minimal or there is no evidence of implementation at all or the organization is facing legal action because of inappropriate release of information.

CR 2.03 (FP)

The organization obtains informed, written consent from the client or a legal guardian prior to recording, photographing, or filming, or the organization has a clear policy prohibiting recording, photographing, or filming.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Written, informed consent is always obtained prior to recording, photographing, or filming and there have been no instances where clients were recorded, photographed, or filmed without proper consent, but procedures could be strengthened or clarified.
3. Practice requires significant improvement; e.g.,
   - In a few rare instances, informed consent was not obtained prior to recording, photographing, or filming; or
   - The organization does not permit recording, photographing, or filming in practice but a clear policy does not exist or needs strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 2.04 (FP)

The release form for disclosure of confidential information includes the following elements:

a. the name of the person whose information will be released;
b. the signature of the person whose information will be released, or the parent or legal guardian of a person who is unable to provide authorization;
c. the specific information to be released;

d. the purpose for which the information is to be used;
e. the date the release takes effect;
f. the date, event, or condition upon which the consent expires in relation to the individual purpose for disclosure, not to exceed one year from when the release takes effect;
g. the name of the person(s) or organization(s) that will receive the disclosed information;
h. the name of the person or organization that is disclosing the confidential information; and
i. a statement that the person or family may withdraw their authorization at any time except to the extent that action has already been taken.

Interpretation: *Blanket release forms signed by clients when service is initiated do not meet the requirements of this standard except as put forth by federal regulation, for example, when making application to FEMA/DHS in a declared disaster.*

Interpretation: *When a release form is used to authorize the exchange of information between multiple parties, the form must comply with all elements of the standard. All relevant parties must be authorized to disclose and receive the information specified, for the purpose indicated, in the consent.*

Interpretation: *Elements (b) and (i) will not apply when law, regulation, or court order, permits confidential information to be released without the authorization of the person or legal guardian.*

Examples: *Examples of information that may also be included on release forms include a statement regarding the impact, if any, of refusing to sign the authorization, and rules regarding re-disclosure of information.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Consent forms are always completed and signed, but in a few instances information related to elements (c) or (d) is vague.
3. Practice requires significant improvement; e.g.,
   - Consent is always obtained and forms are signed, but a significant number of consent forms
     - Have missing or inadequately addressed components; or
     - Are overly broad or non-specific.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 3: Research Protections

An organization that participates in or permits research involving service recipients establishes the right of individuals to refuse to participate without penalty and guarantees participants' confidentiality.

NA: The organization does not permit research involving service recipients.

Interpretation: *For purposes of CR 3, research includes all forms of internal or external research involving service recipients except internal program evaluation and outcomes research, and educational projects carried out by students and interns as part of their professional training.*

Self-Study Evidence

*Human subject research policy	**File:** Human Subjects Research Policy
*Human subject research procedures	**File:** Human Subjects Research Policy
*Informed consent form template	**File:** DC forms packet 12-18 yo.docx **File:** DC forms packet under 12 yo.docx **File:** DC forms packet 18 yo and older.docx **File:** ILP forms packet 18 yo and older.docx

Site Visit Evidence

- Minutes from research proposal meetings for the previous six months
- Signed consent forms for research activities

On-Site Activities

- Interviews may include:
    1. CEO
    2. Governing body
    3. Relevant personnel
    4. Persons served

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the CR 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the CR 3 Practice Standards.
3. Practice requires significant improvement, as noted in the ratings for the CR 3 standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the CR 3 standards.

CR 3.01 (FP)

The identity and privacy of participants is safeguarded in all phases of research conducted by, or with the cooperation of, the organization including, but not limited to, masking the individual identity of research participants in all statistical analyses, reports, summaries, and case examples.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Procedures are somewhat general; or
    - Safeguards when working with external researchers need strengthening.
3. Practice requires significant improvement, e.g.,
    - In a few cases the names of persons served or other identifying data were not redacted from research materials.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 3.02

The organization has a mechanism to review research proposals involving service recipients, such as a human subjects committee or an internal review board that reports to the chief executive officer or governing body.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Proposals are not always reviewed in a timely manner.
3. Practice requires significant improvement; e.g.,
    - No committee exists and the governing body responds to proposal requests on a case-by-case basis with few established guidelines.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

CR 3.03 (FP)

Research participants, or a parent or legal guardian, sign a consent form that includes:

a. a statement that he or she voluntarily agrees to participate;
b. a statement that the organization will continue to provide services regardless of whether he or she agrees to participate;
c. an explanation of the nature and purpose of the research;
d. a clear description of possible risks or discomfort, as applicable; and
e. a guarantee of confidentiality.

Interpretation: The consent form should be presented to the participant in an accessible format, which takes into account language barriers as well as intellectual and developmental disabilities that could impact the participant's understanding.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - In a few cases one of the elements is not fully addressed; or
   - Consent is obtained, but the organization uses consent forms provided by external researchers which do not always contain the elements of the standard.
3. Practice requires significant improvement; e.g.,
   - In a few cases, consents are not obtained and forms are not signed; or
   - One elements is not addressed at all; or
   - Consent forms are overly broad or lack specificity.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

COUNCIL ON ACCREDITATION

CSE: Coaching, Support, and Education Services

Purpose
Individuals and families who participate in Coaching, Support, and Education Services identify and build on strengths, develop skills, gain experiential knowledge, access appropriate community and social supports and resources, and improve functioning in daily activities at home, at work, and in the community.

Definition

Coaching, Support, and Education Services are non-clinical, community-based programs and activities designed to support families and individuals of all ages. Services emphasize personal growth, development, wellness, and situational change and can be provided to individuals, families, or groups. Services must include at least one of the following supportive programs or activities:

Support Services for Individuals and Families, such as non-clinical supportive counseling, coaching, support, or guidance (see CSE 4);

Education and Support Groups, such as classes, support groups, workshops, health and wellness groups, and educational sessions (see CSE 5);

Information and Referral Services to connect individuals and families to appropriate community resources (see CSE 6); and

Peer Support Services delivered by individuals with lived experience, such as one-on-one coaching, peer recovery groups, family and youth support programs, and community building activities (see CSE 7).

Note: *Coaching, Support, and Education services can be offered in a variety of settings within the community, including schools, and may utilize electronic interventions to deliver services through technologies such as videoconferencing, online chat platforms, texting, and mobile applications.*

Note: *Organizations providing Support Services for Individuals and Families only will complete CSE 1, CSE 2, CSE 3, and CSE 4.*

Organizations providing Education and Support Groups only will complete CSE 1, CSE 2, CSE 3, and CSE 5.

Organizations providing Information and Referral Services only will complete CSE 1, CSE 2, CSE 3, and CSE 6.

When Coaching, Support, and Education services are delivered by peers, organizations will complete CSE 1, CSE 2, CSE 3, and CSE 7, as well as CSE 4, CSE 5, and/or CSE 6 depending on the population served (i.e. individuals, families, and/or groups) and the types of peer support provided.

Note: *CSE is assigned to programs in which services are provided by non-clinical personnel or peers, and while there is a screening and intake process, assessments and service plans are not required. Organizations that provide this service most likely will not be receiving third party reimbursement for their services.*

Examples of services that are reviewed under CSE include, but are not limited to:

- *life skills education programs;*
- *family life education programs;*
- *mental health and/or drug and alcohol education;*
- *health promotion and wellness activities;*
- *recovery management;*
- *family and/or intimate partner violence interventions;*
- *recovery coaching; and*

- *anger management programs.*

Supportive, non-clinical counseling programs reviewed under CSE 4 are distinct from clinical counseling programs reviewed under Mental Health and/or Substance Use Services (MHSU), which focus on treatment for diagnosable conditions. In clinical counseling programs, therapeutic evidence-based interventions are provided by appropriately trained and licensed/credentialed personnel.

Note: *Please see CSE Reference List for the research that informed the development of these standards.*

CSE 1: Person-Centered Logic Model

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Note: *Please see the Logic Model Template for additional guidance on this standard.*

Self-Study Evidence	On-Site Evidence	On-Site Activities
• See program description completed during intake • Program logic model that includes a list of client outcomes being measured	*No On-Site Evidence*	Interviews may include: Program director Relevant personnel

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
   Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - Logic models need improvement or clarification; or
   - Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
   - At least one client outcome has been identified for all of its programs; or
   - All but a few staff have been trained on use of therapeutic interventions and training is scheduled for the rest; or
   - With few exceptions the policy on prohibited interventions is understood by staff, or the written policy needs minor clarification.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Logic models need significant improvement; or
   - Logic models are still under development for a majority of programs; or
   - A logic model has not been developed for one or more high-risk programs; or
   - Outcomes have not been identified for one or more programs; or
   - Several staff have not been trained on the use of therapeutic interventions; or
   - There are gaps in monitoring of therapeutic interventions, as required; or
   - There is no process for identifying risks associated with use of therapeutic interventions; or
   - Policy on prohibited interventions does not include at least one of the required elements.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - Logic models have not been developed or implemented; or
   - Outcomes have not been identified for any programs; or
   - There is no written policy or procedures for the use of therapeutic interventions; or
   - Procedures are clearly inadequate or not being used; or
   - Documentation on therapeutic interventions is routinely incomplete and/or missing; or
   - There is evidence that clients have been harmed by inappropriate or unmonitored use of therapeutic interventions.

CSE 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes; (i.e. the changes you expect to see in individuals and families); and
f. expected long-term impact on the organization, community, and/or system.

Examples: Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA's PQI Tool Kit for more information on developing and using program logic models.

Examples: Information that may be used to inform the development of the program logic model includes, but is not limited to:

1. community needs assessments and periodic reassessments; and
2. the best available evidence of service effectiveness.

CSE 1.02

The logic model identifies individual or family outcomes in at least two of the following areas:

1. change in functional status;
2. health, welfare, and safety;
3. permanency of life situation;
4. quality of life;
5. achievement of individual service or recovery goals; and
6. other outcomes as appropriate to the program or service population.

Example: Outcomes data can be disaggregated by race or ethnicity to identify and monitor disparities in service provision or effectiveness.

NA: The organization provides information and referral services only.

CSE 2: Personnel

Program personnel have the competency and support needed to provide services and meet the needs of individuals and families.

Interpretation
Competency can be demonstrated through education, training, or experience, including lived experience when applicable. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.

Self-Study Evidence	On-Site Evidence	On-Site Activities
List of program personnel that includes: ○ Title ○ Name ○ Employee, volunteer, or independent contractor ○ Degree or other qualifications	• Sample job descriptions from across relevant job categories • Training curricula • Documentation tracking staff completion of required trainings and/or competencies	Interviews may include: Program director Relevant personnel Review personnel files

Self-Study Evidence	On-Site Evidence	On-Site Activities
○ Time in current position See organizational chart submitted during application Table of contents of training curricula	• Documentation tracking training and/or certification for peer support providers, as applicable • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker	

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required
   - qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
   - Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
   - Most staff who do not meet educational requirements are seeking to obtain them; or
   - With few exceptions, staff have received required training, including applicable specialized training; or
   - Training curricula are not fully developed or lack depth; or
   - Training documentation is consistently maintained and kept up-to-date with some exceptions; or
   - A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
   - With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
   - Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
   - Specialized services are obtained as required by the standards.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
   - Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
   - Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
   - A significant number of staff have not received required training, including applicable specialized training; or
   - Training documentation is poorly maintained; or
   - A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
   - There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
   - Workloads are excessive, and the integrity of the service may be compromised; or
   - Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
   - Specialized services are infrequently obtained as required by the standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

CSE 2.01

Direct service personnel are qualified by:

a. an associate’s degree in a human services field appropriate to the services being provided; or
b. appropriate training and experience.

Note: *Training and lived experience satisfies the requirements of this standard for peer support staff. See CSE 2.06 and CSE 2.07 for more information on competency and support expectations for peer support staff.*

CSE 2.02

Supervisors are qualified by:

a. at least two years of experience providing coaching, support, and/or education services;
b. a bachelor's degree in a human services field; and
c. training in staff supervision.

Interpretation
Appropriate experience and specialized training can compensate for a lack of a bachelor's degree depending on the program design.

CSE 2.03
Personnel are trained on, or demonstrate competency in:

a. procedures for making appropriate referrals or providing information;
b. recognizing and responding to signs and symptoms of trauma; and
c. recognizing and responding to signs of suicide risk.

CSE 2.04

Personnel leading education and support groups are trained on, or demonstrate competency in:

1. engaging and motivating group members;
2. understanding and managing group dynamics in order to maintain comfort and safety for participants;
3. leading discussions; and
4. facilitating group activities.

NA: The organization does not provide education or support groups.

CSE 2.05

Direct service personnel are trained on, or demonstrate competency in:

a. child development, and individual and family functioning;
b. evidence-based practices and relevant emerging bodies of knowledge as appropriate to the program design and service population;
c. ecological or person-in-environment perspectives; and
d. working with difficult to reach, traumatized, or disengaged individuals and families.

NA: The organization provides information and referral services only.

~~CSE 2.06~~
~~Personnel who provide peer support:~~

~~1. obtain certification, as defined by their state;~~
~~2. are willing to share their personal recovery stories;~~
~~3. have a job description and clearly understand the role of a peer support worker; and~~
~~4. have adequate support and appropriate supervision, including mentoring and/or coaching from more experienced peers when indicated.~~

NA *The organization does not provide peer support services.*

~~CSE 2.07~~
~~Personnel who provide peer support receive pre- and in-service training on:~~

1. ~~how to recognize the need for more intensive services;~~
2. ~~established ethical guidelines, including setting appropriate boundaries and protecting confidentiality and privacy;~~
3. ~~wellness support methods, trauma-informed care practices, and recovery resources;~~
4. ~~managing personal triggers that may occur during the course of their role as a peer support provider; and~~
5. ~~skills, concepts, and philosophies related to recovery and peer support.~~

NA *The organization does not provide peer support services.*

CSE 2.08

Employee workloads support the achievement of individual or family outcomes and are regularly reviewed.

Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

a. the qualifications, competencies, and experience of the worker, including level of supervision needed;
b. the work and time required to accomplish assigned tasks and job responsibilities; and
c. service volume, accounting for assessed level of needs of persons served.

CSE 3: Intake

The organization's intake practices ensure that individuals and families receive prompt and responsive access to appropriate services.

Self-Study Evidence	On-Site Evidence	On-Site Activities
Screening and intake procedures	Community resource and referral list	Interviews may include: • Program director • Relevant personnel • Individuals or families served Review logs, progress notes, or case records for documentation of services provided, as applicable

Rating Indicators:
1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service
- quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active client participation occurs to a considerable extent.

3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or

- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,

- There are no written procedures, or procedures are clearly inadequate or not being used; or
- Documentation is routinely incomplete and/or missing.

CSE 3.01

Individuals and families are screened and informed about:

a. how well their request matches the organization's services; and
b. what services will be available, and when.

CSE 3.02 (FP)
Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. give priority to urgent needs and emergency situations;
c. support timely initiation of services; and
d. provide for placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

CSE 3.03 (FP)

The organization has procedures in place to identify and respond to individuals and families at risk of suicide, self-injury, neglect, exploitation, and violence towards others.

Interpretation
If the program model does not necessitate individual risk screenings, organizations should, at a minimum, implement a program-wide screening to evaluate the potential risk of harm by or to persons served or others. Programs serving children, vulnerable adults, or individuals with a history of danger to self or others should conduct individual risk screenings.

Examples: *Organizations can respond to identified risk by connecting individuals and families to more intensive services; facilitating the development of a safety and/or crisis plan; and/or contacting emergency responders, 24-hour mobile crisis teams, emergency crisis intervention services, crisis stabilization, or 24-hour crisis hotlines, as appropriate.*

CSE 3.04
Case records, logs, or progress notes are maintained to document individual or group progress, as appropriate to the intervention.

Interpretation
A more formalized system of documentation may be necessary, depending on the service. For example, if the organization is establishing and tracking service goals, a service plan should be developed to monitor progress. Information that informs service delivery (e.g., screenings/assessments and service plans) should be maintained in the individual's case record.

Interpretation
For individuals in recovery, any assessment or recovery planning process that is in place should be driven by the individual and recovery plans should address their barriers to recovery, unmet service needs, and the accumulation of strengths and resources.

NA *The organization provides services to community members or groups on a one-time or occasional basis.*

NA *The organization provides information and referral services only.*

Examples: Unmet service needs can slow the growth of positive recovery capital for individuals in recovery. Examples of common service needs for individuals in recovery include:

1. mental health;
2. substance use;
3. legal, including criminal record expungement services;
4. crisis intervention;
5. primary care and dentistry;
6. education and vocational skill development; and
7. housing.

CSE 4: Support Services for Individuals and Families

The organization provides individuals and families with supportive services that:

a. recognize individual and family values and goals;
b. accommodate differences in lifestyles; and
c. emphasize personal growth, development, and situational change.

~~**NA** *The organization does not provide support services for individuals and families.*~~

~~**Examples:** Support services may be designed and delivered by peers, examples of which include peer mentoring/coaching, recovery management, and parent and family support services. When peers are delivering services, CSE 7 must also be implemented.~~

Self-Study Evidence	On-Site Evidence	On-Site Activities
Procedures for providing necessary care to trauma survivors or individuals at risk of suicide	*No On-Site Evidence*	Interviews may include: Program director Relevant personnel Individuals or families served Review logs, progress notes, or case records for documentation of services provided, as applicable

CSE 4.01

Services have an educational, supportive, or preventive focus to help individuals and families:

1. recover from crisis;
2. cope with life transitions;
3. set and/or work towards identified goals;
4. develop life skills and problem-solving techniques;
5. develop social support networks and build healthy, meaningful relationships with people of their choosing;
6. identify supportive resources;
7. better understand the patterns of community and family living;
8. anticipate and manage stresses of daily living;
9. improve role competency and family and social functioning; or
10. prevent relapse of symptoms, enhance health, and promote whole-person wellness.

Examples: Life skill development activities will be tailored to meet the needs of persons served but can include the development of life skills necessary to:

1. obtain safe and stable housing;
2. pursue educational, occupational, and volunteer opportunities;
3. manage finances;
4. access community resources;
5. access public assistance;
6. reduce risk-taking behaviors, including practice with decision making and anger management; and
7. participate in recreational activities and/or hobbies.

Examples: Social support networks can include mentors, community members, classmates, peers, mutual aid sponsors, siblings, and extended family members. For individuals in recovery from substance use disorder, the focus may be on building networks of sober individuals and identifying social activities that do not involve drugs and alcohol.

CSE 4.02

Personnel support individuals and families as they:

1. explore and clarify the reason for accessing services;
2. voice service goals;
3. identify successful coping or problem solving strategies based on identified strengths, formal and informal supports, and preferred solutions;
4. establish and evaluate progress towards achieving identified goals; and
5. realize ways of maintaining and generalizing gains.

Examples: The organization can encourage active participation of individuals and families by demonstrating:

1. sensitivity to the needs and personal goals of the individual or family;
2. a receptive manner;
3. respect for the person's autonomy, confidentiality, socio-cultural values, lifestyle choices, and complex family interactions;
4. flexibility; and
5. appropriate boundaries.

Fundamental Practice
CSE 4.03

When the individual is a victim of abuse, neglect, violence, or other known trauma, or at risk for suicide, the organization provides:

1. trauma-informed care;
2. education about the impact of trauma;
3. an appropriate safety plan;
4. resources to report domestic violence, sexual assault, abuse, or neglect if the individual elects to do so;
5. information on service options so the individual can actively participate in developing service goals and objectives;
6. more frequent monitoring of progress toward service or recovery goals; and/or
7. access to more intensive services.

Example: Organizational self-assessment is one way to evaluate the extent to which an organization's policies and practices are trauma-informed, as well as identify strengths and barriers in regards to trauma-informed service delivery.

For example, organizations can evaluate staff training and professional development opportunities and review supervision ratios to assess whether personnel are trained and supported on trauma-informed care practices. Organizations can also conduct an internal review of their service delivery processes to ensure that services are being delivered in a trauma-informed manner.

CSE 4.04
Individuals, and their families when possible and appropriate, are actively connected with self-help/mutual aid groups when desired and appropriate to their request or need for service.

Interpretation
Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting.

Organizations can support the individual's acclimation to a new group by, for example, discussing meeting protocols and what to expect prior to attending, accompanying them to their first meeting, and encouraging them to make connections with peers while at the meeting.

CSE 5: Education and Support Group Services
Education and support groups provide educational, supportive, and preventive services in a group setting to improve emotional well-being, and promote self-sufficiency, personal growth, development, resilience, and wellness.

~~**NA** *The organization does not provide education or support groups.*~~

Examples: Education and support group services may be designed and delivered by peers, such as peer recovery groups. When peers are delivering services, CSE 7 must also be implemented.

Self-Study Evidence	On-Site Evidence	On-Site Activities
No Self-Study Evidence	Education and support group schedule for the previous 12 months Curricula from education and support groups	Interviews may include: Program director Relevant personnel Individuals or families served Review logs, progress notes, or case records for documentation of services provided, as applicable

CSE 5.01
Services have an educational, supportive, or preventive focus to help individuals and families:

1. recover from crisis;
2. cope with life transitions;
3. set and/or work towards identified life goals;
4. develop life skills and problem-solving techniques;
5. develop social support networks and build healthy, meaningful relationships with people of their choosing;
6. identify supportive resources;
7. better understand the patterns of community and family living;
8. anticipate and manage stresses of daily living;
9. improve role competency and family and social functioning; or
10. prevent relapse of symptoms, enhance health, and promote whole-person wellness.

Examples: Education and support groups might focus on relapse prevention, job skills training, family relations, suicide loss and grief, and other topics related to personal recovery goals.
Examples: Life skill development activities will be tailored to meet the needs of persons served but can include the development of life skills necessary to:

1. obtain safe and stable housing;
2. pursue educational, occupational, and volunteer opportunities;
3. manage finances;
4. access community resources;
5. access public assistance;
6. reduce risk-taking behaviors, including practice with decision making and anger management; and
7. participate in recreational activities and/or hobbies.

Examples: Social support networks can include mentors, community members, classmates, peers, mutual aid sponsors, siblings, and extended family members. For individuals in recovery from substance use disorder, the focus may be on building networks of sober individuals and identifying social activities that do not involve drugs and alcohol.
CSE 5.02
Services provided in a group setting:

1. emphasize group learning and facilitate sharing in a safe, supportive environment;
2. are designed to respond flexibly to the changing needs of group members; and
3. are scheduled with participants' time commitments in mind.

CSE 5.03
Program activities promote the personal growth and independence of individuals and families through opportunities to:

1. share experiences with the group;
2. strengthen abilities to relate to those who are different from themselves;
3. develop satisfying relationships with other group participants;
4. assume responsibilities and develop leadership capacities; and
5. participate in activities of interest.

CSE 6: Information and Referral Services

The organization provides information about available community resources and makes referrals or connections as appropriate to the individual's or family's identified needs.
~~**NA** *The organization does not provide information or referral services.*~~

~~**Examples:** When peers are delivering information and referral services, CSE 7 must also be implemented.~~

Self-Study Evidence	On-Site Evidence	On-Site Activities
Procedures for referring individuals to services Crisis response procedures	Community resource and referral list	Interviews may include: Program director Relevant personnel Review contact logs or other documentation of information and referrals provided, when applicable

CSE 6.01

Individuals and families are promptly referred or connected to appropriate, culturally and linguistically responsive resources.

CSE 6.02

The organization maintains, or has access to, an up-to-date list of reliable community resources that include:

1. name, location, and telephone number;
2. contact person;
3. services offered;
4. languages offered;
5. fee structure; and
6. eligibility requirements.

Fundamental Practice

CSE 6.03

Written procedures address the provision of information and referral services in crisis situations including:

1. providing intervention and stabilization;
2. connecting the individual to more intensive services; and/or
3. contacting emergency responders as appropriate.

Examples: Crisis situations can include those involving victims of violence, individuals at risk for suicide, medical crises, child endangerment, and other emergency situations.

Examples of what may be outlined in crisis response procedures can include, but are not limited to:

1. protective measures or special precautions related to inquiries from individuals involved in cases of domestic violence or other endangerment situations;
2. how to address individuals who wish to remain anonymous yet require direct intervention and stabilization services;
3. protocols on how to connect individuals and families to appropriate formal crisis intervention services or emergency responders; and
4. guidance on mandatory reporting and the disclosure of suspected abuse or other criminal behavior.

~~CSE 7: Peer Support Services~~

The organization creates a safe, welcoming environment where individuals with lived experience can provide one another with emotional, informational, and practical support that is strengths-focused and person-driven.

NA *The organization does not provide peer support services.*

Self-Study Evidence	On-Site Evidence	On-Site Activities
No Self-Study Evidence	*No On-Site Evidence*	Interviews may include: Program director Relevant personnel Individuals or families served

CSE 7.01
Peer support services encourage:

1. resiliency;
2. recovery;
3. personal growth;
4. experiential learning;
5. wellness;
6. self-efficacy; and
7. personal choice.

CSE 7.02
Individuals and families are given the opportunity for meaningful voice and choice in program activities and decision making including:

1. participating in the development and enforcement of program rules;
2. contributing to program design and decision making; and
3. sharing feedback including dissatisfaction with aspects of the program.

Interpretation *The organization should have mechanisms in place to receive and respond to feedback to ensure contributions are meaningful. Individuals and families should be informed of how the organization will use their feedback and be made aware of any changes that were made in response to their input.*

CSE 7.03
Individuals are provided with:

1. opportunities to participate in and contribute to the recovery community, including giving and receiving peer support;
2. opportunities to engage with and contribute to the local community; and
3. opportunities to develop and enhance positive personal and interpersonal skills and behaviors.

Examples: In regard to element (b), ways that individuals can contribute to the local community can include school, work, volunteering, and recreation.

Administration and Management Standards

FIN: Financial Management

Purpose
The organization's ability to achieve its mission is based on sound financial management practices that ensure efficient, data-informed use of its resources.

Introduction

Sound financial management is the foundation for providing high quality services and achieving the organization's mission. Organizational leadership must foster a culture of accountability in all areas of organizational practice, including the management of the organization's finances. Accountability is established through clearly defined lines of authority and responsibility, adherence to internal control responsibilities, and by making the strategic connection between efficient and effective use of organization resources and improved outcomes. Effective financial management ensures that resources are being directed to those programs or interventions that have the strongest impact on persons served. Additionally, the attention and commitment of the governing body to their fiduciary responsibilities are essential to ensuring that the organization's financial practices enable it to achieve operational effectiveness and efficiency, accurate and reliable financial reporting, and compliance with applicable laws and regulations.

Table of Evidence
Self-Study Evidence *No Self Study Evidence*

FIN 1: Governing Body Financial Responsibilities

The organization's governing body or designated committee of the governing body, as appropriate:

a. approves the annual budget and any revisions to the budget;
b. reviews quarterly and annual financial statements/summaries provided by management;
c. reviews accounting policies and procedures;
d. reviews recommendations of the organization's auditors, and management's response to the recommendations;
e. annually evaluates the executive director's management of the organization's financial affairs; and
f. reviews and approves the IRS Form 990.

Related Standards: GOV 5.02, GOV 5.05

Interpretation: *Minutes of governing body and its committee meetings should reflect active oversight of the organization's finances.*

Self-Study Evidence *No Self Study Evidence*

Site Visit Evidence

- Governing Body minutes demonstrating active oversight of finances

On-Site Activities

- Interviews may include:
    1. Governing body members
    2. Governing body treasurer
    3. CEO
    4. CFO

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - Two elements are not fully addressed; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Three or more elements are not fully addressed;
   - Or at least two elements are not addressed at all.

FIN 2: Internal Control Environment

The organization establishes an internal control environment that promotes ethical financial management and includes mechanisms for:

a. conducting ongoing monitoring of the effectiveness of internal control policies and procedures;
b. management review by more than one individual;
c. assuring that management directives are carried out;
d. prevention of error, mismanagement, or fraud;
e. safeguarding and verification of assets; and
f. segregation of duties to the extent possible.

Self-Study Evidence

* Internal financial control manual that includes policies and procedures	**File:** Internal Financial Control Policy.pdf

Site Visit Evidence

- Governing body minutes where establishment of or compliance with internal controls were discussed

On-Site Evidence

- Interviews may include:
  1. Governing body
  2. Governing body treasurer
  3. CEO
  4. CFO

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements are not fully addressed.
3. Practice requires significant improvement; e.g.,
   - Two elements are not fully addressed;
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Fraudulent practices or serious financial mismanagement have occurred, and problems have not been remediated; or
   - Three or more elements are not fully addressed; or
   - Two elements are not addressed at all.

FIN 3: Revenue and Investments

The organization works to ensure its long-term financial viability and achievement of its mission through active pursuit of diverse sources of revenue and proper management of investments.

Self-Study Evidence

*Investment policy	**File:** Investments Policy.pdf
*Investment procedures	
*Results of most recent investment review	**File:** Edward-Jones-Investments **File:** Summary-of-Investments.pdf **File:** Investment-Activity.pdf **File:** MHCO-FOUNDATION-INVESTMENT-STATUS- **File:** Minutes 1-25.doc
*List of revenue sources with percentage of each to total budget	

Site Visit Evidence

*Governing Body minutes and/or committee meeting minutes where investments were reviewed

On-Site Activities

*Interviews may include:

1. Governing body
2. CEO
3. CFO

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the FIN 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the FIN 3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the FIN 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the FIN 3 Practice standards.

FIN 3.01

The organization pursues stable, predictable sources of revenue through diversification and balance in funding streams consistent with the organization's mission and programs.
Related Standards: GOV 5.02

Interpretation: *Organizations meet the intent of the standard if they can demonstrate that they are actively pursuing stable and predictable sources of revenue, even if they have not yet achieved that goal.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization makes active efforts to diversify or strengthen resources but still relies primarily on one or two major funding sources.
3. Practice requires significant improvement; e.g.,
   - Minimal efforts have been made to expand, diversify, or strengthen the organization's resource base.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization has no "fallback" position and has made little or no effort to protect itself from the consequences of dependence on a single source of revenue.

FIN 3.02

An organization that invests funds has controls to ensure the proper management of investments, including a committee established by the governing body, as appropriate, that:

a. follows, and biennially reviews, an investment policy that outlines acceptable levels of risk, criteria for contracting with investment advisors or firms, and protocols for making investment decisions;
b. oversees and reviews both the investment of funds and the management, purchase, or sale of real estate, securities, and other assets;
c. ensures practices conform to applicable legal and regulatory requirements; and
d. reports the status of investments and investment recommendations to the governing body.

Related Standards: RPM 1

Examples: *All nonprofit funds are invested and fall under the oversight of the governing body. This includes short-term investments like savings accounts, longer-term investments like stock, bonds, and mutual funds, as well as properties and other assets owned by the organization. The investment policy would, for example, specify how much of the organization's funds will be placed into savings accounts, which provide immediate access to those funds, versus longer term investments.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Investment policy was last reviewed and/or updated between two and three years ago.
3. Practice requires significant improvement; e.g.,
   - The investment policy has not been reviewed or updated within the last three years.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The governing body plays no role in investment oversight; or
   - There is no investment policy.

FIN 4: Financial Planning

Planning for the current fiscal cycle is data-driven, organization-wide, and involves key stakeholders.

Self-Study Evidence

Budget planning procedures	**File:** Budget Procedure.pdf
Annual Budget	**File:** Approved 2025 Budget.xls
Sample of monthly analysis of financial performance	**File:** 13 month printing income statement January 2025.pdf **File:** january 2025 print shop actual vs budget. **File:** 13 month income statement january 2025.pdf **File:** january 2025 actual vs budget.pdf **File:** Minutes 1-25. **File:** January_2025.xlsx **File:** january 2025 income statement.
Operating reserves policy	**File:** Operating Reserves Policy.pdf
Most recent executive report on organization finances	**File:** Notes-for-February-2025-Meeting.pdf **File:** Exec_Fin-Committee-minutes-December-2024.pdf **File:** Copy-of-4TH-QTR-2024-FINANCIAL-OPERATIONS.pdf **File:** Analysis-of-Financial-Operations-2024.pdf

Site Visit Evidence

*Governing body minutes reflecting budget planning and review of financial reports for the previous 12 months

On-Site Activities

*Interviews may include:

1. Governing body
2. CEO
3. CFO

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the FIN 4 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the FIN 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the FIN 4 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the FIN4 Practice standards.

FIN 4.01 (FP)

The annual planning and budget cycle includes participation of management, the governing body, program personnel, and other relevant stakeholders and is based on:

a. the organization's mission and strategic priorities;
b. performance improvement and outcomes data;
c. direct and indirect operating expenditures;
d. contractual requirements;
e. changing costs and conditions; and
f. anticipated revenue for the program year.

Related Standards: GOV 2.03

Examples: *Performance improvement and outcomes data in this context refers to the use of program and client outcomes data in planning and budgeting decisions. Such data may be used, for example, to direct available resources toward programs or interventions that have the strongest impact on individuals and families served.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Relevant parties participate in budget planning that considers strategic priorities, a realistic appraisal of funding, and costs, but the process could be made more comprehensive or changing conditions could be better addressed.
3. Practice requires significant improvement; e.g.,
   - The budget planning process is not comprehensive or formalized in one of the standard's elements; or
   - Either the governing body or management does not participate; or
   - There is no documentation of review by either the governing body or management team.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

FIN 4.02

The chief executive officer provides a quarterly executive report on the organization's finances to the governing body that includes:

a. current financial performance and any anticipated problems;
b. shifting strategic priorities and their financial implications;
c. a review of budget projections and areas of risk; and
d. discussion of other financial matters, as necessary.

Related Standards: GOV 5.05, GOV 6.01, RPM 4.03

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,

- Element (a) or (b) is not fully addressed.

3. Practice requires significant improvement; e.g.,
   - Element (a) or (b) is not addressed at all; or
   - Reports are provided less than quarterly.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

FIN 4.03 (FP)

Financial information is routinely analyzed and the information includes:

a. a monthly and annual analysis of financial performance against budget projection with budget-to-actual variance analyses performed on interim financial statements of activities;
b. cash reserves in alignment with an operating reserves policy;
c. service revenues and actual service delivery costs; and
d. an annual inventory of significant assets, including securities.

Related Standards: GOV 5.05, RPM 4.03

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization routinely analyzes financial information but is not always stringent about comparing it with data about actual service delivery costs; or
   - Financial analyses are conducted at least quarterly and annually.
3. Practice requires significant improvement; e.g.,
   - Analysis of financial performance is not performed at least quarterly; or
   - An annual analysis is not conducted; or
   - The organization does not analyze service revenue information and service delivery costs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization makes no attempt to either keep adequate service revenue information or to analyze it.

FIN 5: Financial Accountability

The organization receives an audit or review of its financial statements that is conducted within 180 days of the end of each fiscal year by an independent, certified public accountant.

Examples: *There are three levels of financial statement services offered by CPAs: audits, reviews, and compilations, each of which should be conducted by an independent CPA.*

An audit provides the highest level of assurance on an organization's financial statements. An audit provides assurance that an organization's financial statements are free of material misstatement and are fairly presented based upon the application of generally accepted accounting principles.

An audit includes:

1. *confirmation with outside parties;*
2. *testing selected transactions by examining supporting documents;*
3. *completing physical inspections and observations; and*
4. *considering and evaluating the internal control system of the organization.*

A review of financial statements provides limited assurance on an organization's financial statements. During a review, inquiries and analytical procedures present a reasonable basis for expressing limited assurance that no material modifications to the financial statements are necessary; they are in conformity with generally accepted accounting principles.

Following a review engagement, the CPA will issue a formal report that includes a conclusion as to whether, based on the review, the CPA is aware of any material modifications that should be made to the financial statements to bring them in accordance with the applicable financial reporting framework.

A compilation provides no assurance on an organization's financial statements and does not meet the requirements of the standard.

Self-Study Evidence *No Self Study Evidence*

Site Visit Evidence

- Most recent audit or review and the accompanying management letter
- Governing Body minutes reflecting review of the most recent audit or review

On Site Activities

- Interviews may include:
  1. Governing Body
  2. CEO
  3. CFO

Rating Indicators:

1. The organization's practices reflect full implementation of the standard. Organizations seeking reaccreditation have completed audits or reviews of financial statements for each intervening year since their last accreditation.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization undergoing reaccreditation completed an audit or review of financial statements for the most recent auditable fiscal year; however, it did not conduct one for any or all the intervening years since their last accreditation; or
   - The organization undergoing accreditation for the first time completed an audit or review of financial statements in the most recent auditable year; or
   - The organization completed the audit or review; however, it was not completed within eight months of the end of the fiscal year, but the organization implemented procedures to ensure timely completion for future audits.
3. Practice requires significant improvement; e.g.,
   - The audit or review for the most recent auditable year is scheduled but has not been completed; or
   - The most recent audit or review was completed more than eight months after the end of the fiscal year, and no plan is in place to ensure timely completion of future audits.
4. Implementation of the standard was minimal or there is no evidence of implementation at all; e.g.,
   - An audit or review for the most recent auditable year has not been completed nor has one been scheduled.

FIN 6: Financial Management System

Positive financial outcomes are achieved through a financial management system that receives, disburses, and accounts for funds consistent with sound financial practices.

Note: *See RPM 5: Security of Information for more information on appropriately limiting access to financial records to protect against destruction, modification, and unauthorized use.*

Self-Study Evidence

*Financial management and accounting procedures	**File:** Accounting Procedure.pdf
*Job description of the person responsible for managing financial accounts	**File:** Chief-Financial-Officer-Job-Description-
*Resume of the person responsible for managing financial accounts	**File:** CFO LuAnne Clark Resume
*Procedures regarding protection of client funds and assets	**File:** Accounting Procedure.pdf

Site Visit Evidence

- Documentation tracking staff completion of training on the accounting system

On-Site Activities

- Interviews may include:
    1. Governing body
    2. CEO
    3. CFO
    4. Relevant personnel
- Observe reporting and accounting system

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the FIN 6 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the FIN 6 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the FIN 6 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the FIN6 Practice standards.

FIN 6.01 (FP)

Accounting records are kept up-to-date and balanced on a monthly basis, as demonstrated by:

a. timely reconciliation of the bank statement and subsidiary records to the general ledger;
b. up-to-date posting of cash receipts and disbursements;
c. monthly updating of the general ledger; and
d. review of the bank reconciliation by a person other than the person who performs the reconciliation and is not authorized to sign checks.

Related Standards: RPM 4.03

Interpretation: *Subsidiary records include, but are not limited to: accounts receivable, accounts payable, and fixed assets.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - The organization has an occasional, minor problem in compliance such as short delays in posting receipts and disbursements or slightly overdue updates to the general ledger.
3. Practice requires significant improvement; e.g.,
    - Bank reconciliation is not regularly reviewed by two people as required.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

FIN 6.02

The organization uses the accrual method of accounting, at least at the end of the year.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

FIN 6.03

Oversight and management of the organization's accounting system require:

a. a financial officer or business manager to maintain the financial accounts who has prior accounting and bookkeeping experience or an accounting degree, C.P.A. credential, or other recognized accounting/financial certification, as appropriate to the size and complexity of the organization; and
b. all personnel who use the system to receive initial and ongoing training on its use.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   Ongoing staff training needs strengthening.
3. Practice requires significant improvement; e.g.,
   The organization has a qualified financial officer, but the system is deficient in some significant regard, such as lack of training for some personnel.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

FIN 6.04 (FP)

An organization that assumes fiduciary responsibility for, or disburses client funds:

a. segregates client funds from other organization funds; and
b. protects client assets.

Related Standards: RPM 1

Interpretation: *Organizations should manage client funds in accordance with applicable rules and regulations. This may include for example:*

1. *daily deposits of client funds;*
2. *credit balances on accounts;*
3. *uncashed checks;*
4. *funds left in client deposit accounts; and*
5. *trust account reconciliation.*

Interpretation: *Fiduciary responsibility refers to an individual's or organization's responsibility to act in good faith on behalf of another person. The fiduciary is legally or ethically trusted to make decisions in the best interest of the person and may not use their role to benefit themselves. Examples of fiduciary relationships include those of a guardian and ward or representative payee and beneficiary.*

Examples: *Examples of the types of funds that organizations may assume responsibility for or disburse to clients include:*

1. *allowances for children and youth in out-of-home care;*
2. *funds under the control of the organization in guardianship cases;*
3. *social security or SSI benefits when the organization serves as representative payee.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures for segregation of funds or protection of client assets need strengthening.
3. Practice requires significant improvement; e.g.,
   - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- The organization has no written procedures, and adequate protection and guidelines have not been developed to protect assets of persons served; or
- There have been instances in which funds for which the organization had a fiduciary responsibility appear to have been misused, e.g., assets or funds have been inappropriately co-mingled or disbursed inconsistently.

FIN 7: Fundraising

An organization that raises funds by individual solicitation from the general public conducts fundraising activities in an ethical, fiscally responsible manner.

Interpretation: *This section is applicable to organizations that solicit or receive money from private individuals, including, but not limited to, capital campaigns and contribution plans. This section is not applicable to money raised from private or public grants and contracts.*

Examples: *Organizations can reconcile fundraising practices with prevailing ethical practices of national bodies, such as the Association of Fundraising Professionals.*

Self-Study Evidence

*Fundraising policies	**File:** Fundraising Policy.pdf
*Fundraising procedures	**File:** Fundraising Policy.pdf

Site Visit Evidence

- Analysis of costs and benefits for sample of fundraising activities
- Financial statements/reports
- Annual Report
- Governing body meeting minutes where fundraising was discussed

On-Site Activities

- Interviews may include:
  1. CEO
  2. CFO
  3. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the FIN 7 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the FIN 7 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the FIN 7 Practice standards; e.g.,
   - Staff are unaware of the organization's fundraising policies and/or procedures; or
   - Fundraising practices may pose a risk to the organization.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the FIN7 Practice standards.

FIN 7.01 (FP)

The organization:

a. accurately describes the purpose for which solicitations are being made;
b. spends funds for the purposes they were solicited, with the exception of reasonable costs for administration of the fundraising program;
c. maintains accounting segregation for restricted funds; and
d. respects donor confidentiality requests, and ensures that such donors' names are not published in publicly available documents.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not fully addressed, but the organization has taken steps to strengthen practice; or
   - The organization has a system of controls that may need strengthening; however, contributions are appropriately recorded and acknowledged.
3. Practice requires significant improvement; e.g.,
   - There have been some violations of donor requests for confidentiality; or
   - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Unethical or deceptive practices regarding costs in relation to funds raised exist; or
   - The organization does not accurately describe the uses of the funds; or
   - Two or more of the standards' elements have not been addressed.

FIN 7.02

The organization collects and maintains data that supports sound fund-development decisions by its leadership and allows for the costs and benefits of each fundraising activity to be analyzed, including the reasonableness of fundraising costs in comparison to dollars raised.

Examples: *Factors that may affect the reasonableness of fundraising costs to dollars raised include, but are not limited to: the differential costs of donor solicitation, donor renewal, large bequests, or donations that would obscure true fundraising costs.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some fundraising costs are not sufficiently reviewed for full analysis.
3. Practices are basically sound but there is room for improvement; e.g.,
   - Some fundraising costs are not sufficiently reviewed for full analysis.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

Service Standards

GLS: Group Living Services

Purpose
Group Living Services allow individuals who need additional support to regain, maintain, and improve life skills and functioning in a safe, stable, community-based living

Definition

Group Living Services (GLS) provide trauma-informed, community-based care, treatment, rehabilitation and/or support and supervision on a short- or long-term basis to individuals living in a group setting.

Examples: *Individuals in a group living program can include:*

1. *children or youth from the child welfare, juvenile justice, mental health, or education systems;*
2. *children or adolescents who have been victims of human trafficking;*
3. *individuals who are pregnant or parenting;*
4. *adults or children transitioning from a more intensive setting;*
5. *adults or children with developmental and/or physical disabilities;*
6. *adults with serious and persistent mental health conditions;*
7. *unaccompanied alien children;*
8. *adults with substance use conditions; or*
9. *older adults who require a structured group living situation.*

Examples: *A trauma-informed program may be described as one that:*

1. *routinely screens for trauma exposure and related symptoms;*
2. *uses culturally and linguistically appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms;*
3. *makes resources available to children, families, and providers on trauma exposure, its impact, and treatment;*
4. *engages in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma;*
5. *addresses parent and caregiver trauma and its impact on the family system;*
6. *emphasizes continuity of care and collaboration across child-serving systems; and*
7. *maintains an environment of care and provides access to needed services for staff to address, minimize, and treat secondary traumatic stress, and increase staff resilience.*

Note: *Group Living Services are distinct from Residential Treatment Services (RTX), which provide an interdisciplinary, 24-hour-a-day structured program and therapeutic service array. The service needs of individuals in group living are not as intensive as those in residential treatment. As such, group living programs are less restrictive in nature. Transitional housing programs are separately reviewed under Shelter Services (SH).*

Note: *Though the term trafficking is used throughout this section, there are additional terms that may be utilized, including sex trafficking, commercial sexual exploitation of children (CSEC), domestic minor sex trafficking, and minor prostitution. The term victim is commonly used when referring to individuals who have been trafficked to emphasize that they have been coerced and exploited, though the term survivor may also be used.*

Note: *Please see the GLS Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see the GLS Crosswalk.*

Table of Evidence

Self-Study Evidence *No Self Study Evidence*

GLS 1: Person-Centered Logic Model

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Table of Evidence

Self-Study Evidence

* Program logic model that includes a list of client outcomes being measured	**File:** Logic Model for DC
See program description completed during intake	

Site Visit Evidence No Site Visit Evidence

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
   - Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Logic models need improvement or clarification; or
   - Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
   - At least one outcome has been identified for all of its programs.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Logic models need significant improvement; or
   - Logic models are still under development for a majority of programs; or
   - A logic model has not been developed for one or more high-risk programs; or
   - Outcomes have not been identified for one or more programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   Logic models have not been developed or implemented; or
   - Outcomes have not been identified for any programs.

GLS 1.01

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in service recipients); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA's PQI Tool Kit for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to:*

1. *needs assessments and periodic reassessments;*
2. *risks assessments conducted for specific interventions; and*
3. *the best available evidence of service effectiveness.*

GLS 1.02

The logic model identifies client outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. other outcomes as appropriate to the program or service population.

Interpretation: *Outcomes data should be disaggregated to identify patterns of disparity or inequity that can be masked by aggregate data reporting. See PQI 5.02 for more information on disaggregating data to track and monitor identified outcomes.*

Examples: *Common resident outcomes for recovery housing include:*

1. *housing stability;*
2. *decreased alcohol and illicit drug use;*
3. *lower rates of criminal justice involvement;*
4. *increased income;*
5. *increased employment over time;*
6. *improved psychological and emotional well-being;*
7. *increased social connectedness; and*
8. *improved family functioning.*

GLS 2: Personnel

Program personnel have the competency and support needed to provide services and meet the needs of residents and their families.

Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Table of Evidence

Self-Study Evidence

* *Table of contents of training curricula	**File:** Social Etiquette_April_26_2019.pptx **File:** April Newsletter.pdf Uploaded: 3/29/2021 **File:** 3-5 April (Lettuce)_final.pdf **File:** Summer Safety_July_2018.pptx Preparing_for_School_Good_Study_Habits_August_2018.pptx **File:** What's Growing On calendar.pdf **File:** CCW Self Care 2020.pdf **File:** COVID19-Vaccine-101-Deck-Final.pdf **File:** communciation&relationships.pdf **File**: DC Training - Interaction & Engagement --6 six months.pptx **File:** 2020 Resident Rights.pptx **File:** MHCO How Do I PQI and accreditation Training.ppt

	File: Ethical and Professional Standards of Conduct and Employee Rights 2020 with Answers.ppt **File:** FMLA & Leave Requests for Employees 2021.pptx **File:** attachment & belonging.pptx Uploaded: 3/25/2021 **File:** NCHumanTraffickingTaskForceManual.pdf
*Procedures or other documentation relevant to continuity of care and case assignment	**File:** DC Assessment and Service Planning Procedure.pdf

• List of program personnel that includes:
  • Title
  • Name
  • Employee, volunteer, or independent contractor
  • Degree or other qualifications
  • Time in current position	

• See organizational chart submitted during application	

Site Visit Evidence

- Sample job descriptions from across relevant job categories
- Documentation tracking staff completion of required trainings and/or competencies
- Training curricula
- Documentation tracking training and/or certification for peer support providers, as applicable
- Caseload size requirements set by policy, regulation, or contract, when applicable
- Documentation of current caseload size per worker

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Review personnel files

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
    - Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
    - Most staff who do not meet educational requirements are seeking to obtain them; or
    - With few exceptions, staff have received required training, including applicable specialized training; or
    - Training curricula are not fully developed or lack depth; or
    - Training documentation is consistently maintained and kept up-to-date with some exceptions; or
    - A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
    - With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
    - Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
    - Specialized services are obtained as required by the standards.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
- Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
- Supervisors do not typically provide additional support and oversight to staff without the listed qualifications; or
- A significant number of staff have not received required training, including applicable specialized training; or
- Training documentation is poorly maintained; or
- A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
- There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
- Workloads are excessive, and the integrity of the service may be compromised; or
- Specialized staff are typically not retained as required and/or many do not possess the required qualifications; or
- Specialized services are infrequently obtained as required by the standards.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

GLS 2.01

Residential counselors, house parents, adult care, and/or youth care workers have:

a. bachelor's degree or are actively, continuously pursuing a degree;
b. the personal characteristics and experience to collaborate with and provide appropriate care to residents and their families, gain their respect, guide their development, manage a home effectively, and participate in the overall treatment program; and
c. the temperament to work with, and care for, children, youth, adults, or families with special needs, as appropriate.

Interpretation: *The elements of the standard will be considered together to assess implementation. Recruitment of staff with demonstrated competence and with appropriate supervision and specialized training – sometimes available through national certification programs – can compensate for a lack of a bachelor's degree.*

Examples: *Experience per element (b) can include lived experience as residential programs can have peer support specialists, youth advocates, mentors, and/or family advocates on staff.*

GLS 2.02

Supervisors of direct service personnel are qualified by:

a. an advanced degree in social work or a comparable human service field and two years of relevant experience; or
b. a bachelor's degree in social work or a comparable human service field and four or more years of relevant experience.

GLS 2.03 (FP)

A physician or other qualified medical practitioner familiar with the needs of the resident population assumes 24-hour on-call medical oversight to ensure that residents' health needs are identified and promptly addressed.

NA: All service recipients have private physicians.

Interpretation: *The physician can provide services as an employee, contractor, or through another formal arrangement. There may be more than one physician fulfilling the role.*

Interpretation: *COA recognizes that geographic placement and resources can pose barriers. The use of an emergency room or urgent care facility is acceptable for overnight hours when protocols are established. Organizations can also leverage alternative service delivery methods such as telehealth when regional shortages of certain professional groups make in-person consultation impractical.*

GLS 2.04

Qualified professionals and specialists are available to provide services and support depending on the program model, population served, and specialized care needs.

Examples: *Examples of services and providers that may be on staff, or available through a formal arrangement, include:*

1. *mental health;*
2. *substance use;*
3. *crisis intervention;*
4. *medicine and dentistry;*
5. *psychological services, such as testing and evaluation;*
6. *prenatal and postnatal care, and the developmental needs of children;*
7. *prenatal and postpartum depression screenings and care;*
8. *nursing;*
9. *education and vocational skill development;*
10. *physical and developmental disabilities;*
11. *speech, occupational and physical therapy;*
12. *recreation and expressive therapy;*
13. *nutrition; and/or*
14. *religion and spirituality.*

Examples: *Examples of populations with specialized care needs include, but are not limited to:*

1. *older adults;*
2. *children and youth with pervasive developmental disorders;*
3. *children and youth who engage in fire setting;*
4. *individuals who exhibit sexually reactive behavior;*
5. *victims of physical, psychological, or sexual abuse;*
6. *LGBTQ population, especially those with gender identity issues;*
7. *individuals with eating disorders; and*
8. *individuals who have trouble communicating or being understood without special assistance.*

GLS 2.05

Personnel who provide peer support:

a. obtain certification, as defined by their state;
b. are willing to share their personal recovery stories;
c. have a job description and clearly understand the role of peer support worker; and
d. have adequate support and appropriate supervision, including mentoring and/or coaching from more experienced peers when indicated.

NA: The organization does not provide peer support services.

GLS 2.06

Personnel who provide peer support are trained on, or demonstrate competency in:

a. how to recognize the need for more intensive services and make an appropriate linkage;
b. established ethical guidelines, including setting appropriate boundaries and protecting confidentiality and privacy;

c. wellness support methods, trauma-informed care practices, and recovery resources;
d. managing personal triggers that may occur during the course of their role as a peer support provider; and
e. skills, concepts, and philosophies related to recovery and peer support.

NA: The organization does not provide peer support services.

GLS 2.07 (FP)

There is at least one person on duty at each program site any time the program is in operation that has received first aid and age-appropriate CPR training in the previous two years that included an in-person, hands-on CPR skills assessment conducted by a certified CPR instructor.

GLS 2.08

All direct service personnel are trained on, or demonstrate competency in:

a. understanding the definitions of human trafficking (both labor and sex trafficking) and sexual exploitation, and identifying potential victims;
b. procedures for responding to residents who run away;
c. interventions for addressing the acute needs of victims of trauma; and
d. collaborating with local law enforcement.

GLS 2.09

Recovery housing personnel are trained on, or demonstrate competency in:

a. medication assisted recovery and applicable policies and procedures;
b. how to identify and report unethical practices including patient brokering or excessive confirmation testing; and
c. emphasizing peer support and experiential learning in recovery.

NA: The organization does not provide recovery housing.

GLS 2.10

The organization minimizes the number of workers assigned to the family over the course of their contact with the organization by:

a. assigning a worker at intake or early in the contact; and
b. avoiding the arbitrary or indiscriminate reassignment of direct service personnel.

GLS 2.11

Caseloads support the achievement of client outcomes, are regularly reviewed, and generally do not exceed 15 residents.

Examples: *Factors that may be considered when determining caseloads include, but are not limited to:*

1. *the qualifications, competencies, and experience of the worker, including the level of supervision needed;*
2. *the needs of the population served;*
3. *special circumstances, such as multi-need residents;*
4. *the work and time required to accomplish assigned tasks and job responsibilities; and*
5. *service volume.*

GLS 3: Access to Service

The organization provides access to services for children, youth, and adults whose personal, social, developmental, or family situations preclude them from living at home or in a more independent setting.

Self-Study Evidence

*Admission procedures	**File:** DC Admissions Deferrals and Intake Procedure.pdf
*Eligibility criteria	**File:** DC Admissions Deferrals and Intake Procedure.pdf

Site Visit Evidence

- Criteria for making group assignments
- Materials outlining permitted and prohibited items

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents and their families
- Review case records

GLS 3.01

The organization defines in writing:

a. eligibility criteria, including age, developmental stage, and populations served;
b. scope of services, special areas of expertise, and the range of client issues addressed; and
c. how the facility promotes living-unit compatibility based on age, interests, and group composition.

Interpretation: *In regards to element (c), COA recognizes that organizations, particularly those that receive clients through referrals only, may have limited control of group composition. In these instances, the organization should identify the population(s) served, state how residents' diverse service needs will be met, and include strategies for promoting living-unit compatibility when possible.*

Characteristics and needs that should be considered can include age, necessary accommodations, ability to adjust to a group, gender, gender identity, and gender expression. Transgender and gender non-conforming individuals should be given access to sleeping quarters, bathroom facilities, and services based on their preferences and in accordance with applicable federal and state laws.

Examples: *Examples of ways that organizations can meet the grouping needs of transgender and gender non-conforming people can include, but are not limited to:*

1. *respecting the individual's name and pronouns;*
2. *providing gender neutral restrooms where facility structure allows;*
3. *having residents use restrooms one at a time;*
4. *allowing for single bedroom models; or*
5. *providing LGBTQ+ specific units.*

GLS 3.02

The resident and his or her family and/or legal guardian are engaged in the admission and placement process to prepare for admission, and are given the opportunity for a pre-admission visit, whenever possible.

GLS 3.03

The organization describes:

a. personal items residents may bring with them, consistent with a safe, therapeutic setting;
b. items that are discouraged or prohibited; and
c. any safety procedures the program follows, or consequences that can result, when prohibited items are brought to the program site.

Interpretation: *Given the rise in information and communication technologies, organizations must specify in their admission materials what electronic devices are permitted and prohibited.*

Examples: *Personal items residents may bring with them may include, for example, photos, books, cellphones, computers, or other electronics.*

GLS 4: Intake and Assessment

The organization's intake and assessment practices ensure that residents receive prompt and responsive access to appropriate services and supports.

Interpretation: *When the organization is working with an Indian family, tribal representatives or other tribal community members must be involved in the assessment process, as determined by the tribe and the family.*

Table of Evidence

Self-Study Evidence

*Screening and intake procedures	**File:** DC Admissions Deferrals and Intake Procedure.pdf
*Assessment and reassessment procedures	**File:** DC Assessment and Service Planning Procedure.pdf
*Copy of assessment tool(s)	**File:** Sample Resident assessment-choo.pdf **File:** CYW-ACE-Q-TEEN-1-copy.pdf **File:** CYW-ACE-Q-CHILD-copy.pdf **File:** WCC CSE-IT 2.0_12.21.18.pdf **File:** CLS_assessments_LifeSkills.pdf **File:** Finding-Your-Ace-Score.pdf

Site Visit Evidence

- Community resource and referral list

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - In a few rare instances, urgent needs were not prioritized; or
    - For the most part, established timeframes are met; or
    - Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Urgent needs are often not prioritized; or
    - Services are frequently not initiated in a timely manner; or
    - Applicants are not receiving referrals, as appropriate; or
    - Assessment and reassessment timeframes are often missed; or

- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several client records are missing important information; or
- Client participation is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - There are no written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

GLS 4.01

Residents are screened to determine whether they meet the program's eligibility criteria, and are informed about:

a. how well their request matches the organization's services;
b. what service options and levels of care will be available and when;
c. the effectiveness of treatment, when available; and
d. opportunities for active family participation and support, and involvement in community activities.

Interpretation: *Screenings will vary based on the program's target population and services offered, and can include information to identify any of the following: trauma history, substance use conditions, mental illness, and/or individual's risk of harm to self or others.*

GLS 4.02 (FP)

Prompt, responsive intake practices:

a. gather information necessary to identify critical service needs and/or determine when a more intensive service is necessary;
b. give priority to urgent needs and emergency situations;
c. support timely initiation of services; and
d. provide placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

GLS 4.03

Residents participate in a comprehensive, individualized, trauma-informed, strengths-based, culturally and linguistically responsive assessment that is:

a. completed within established timeframes; and
b. focused on information pertinent for meeting service requests and objectives.

Interpretation: *Standardized and evidence-based assessment tools should be used to support structured and consistent decision-making.*

GLS 4.04 (FP)

The assessment is conducted by clinical personnel, including a licensed psychiatrist, psychologist, or other qualified mental health professional, as appropriate to the program model and population served, and addresses:

a. behavioral and physical health;
b. a trauma screen and, when appropriate, a trauma assessment;

c. an evaluation of suicide risk, self-injury, neglect, exploitation, and violence towards others;
d. family strengths, risks, and protective factors;
e. community and social support, resources, and helping networks;
f. environmental, religious or spiritual, and cultural factors;
g. educational and vocational accomplishments;
h. social skills, recreational activities, hobbies, strengths and special interests;
i. factors related to successful group living;
j. additional tests and assessments needed; and
k. a summary of symptoms and diagnoses.

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

Interpretation: *Vulnerable populations, such as youth that are lesbian, gay, bisexual, transgender, and questioning (LGBTQ), are at high risk of violence and harassment while in residential care. The organization should consider these factors to ensure these youth are safe and welcomed by staff.*

Interpretation: *Personnel that conduct evaluations should be aware of the indicators of a potential trafficking victim, including, but not limited to:*

1. *evidence of mental, physical, or sexual abuse;*
2. *physical exhaustion;*
3. *working long hours;*
4. *living with employer or many people in confined area;*
5. *unclear family relationships;*
6. *heightened sense of fear or distrust of authority;*
7. *presence of older significant other or pimp;*
8. *loyalty or positive feelings towards an abuser;*
9. *inability or fear of making eye contact;*
10. *chronic running away or homelessness;*
11. *possession of excess amounts of cash or hotel keys; and*
12. *inability to provide a local address or information about parents.*

Several tools are available to help identify a potential victim of trafficking and determine next steps toward an appropriate course of treatment. Examples of these tools include, but are not limited to, the Rapid Screening Tool for Child Trafficking and the Comprehensive Screening and Safety Tool for Child Trafficking.

Examples: *Organizations serving young children can tailor the assessment process to meet the age and developmental level of the service population. Assessments may include an evaluation of factors that impact the child's social and emotional well-being (e.g., family characteristics), an observation of the child's behavior, and/or a thorough health and developmental history.*

Examples: *Factors that can impact group living success can include:*

1. *possible reciprocal individual and group effects;*
2. *the individual's ability to adjust to a group;*
3. *safety issues;*
4. *previous placements; and*
5. *trauma history.*

GLS 4.05 (FP)

When a resident's assessment indicates a substance use condition, the organization records a thorough alcohol and drug use history, including an evaluation of the effects of alcohol and other drug use on the resident's family, and:

a. provides an appropriate level of service and detoxification, as necessary; or
b. connects the resident and/or family members to appropriate services when the program does not serve individuals with substance use conditions.

GLS 4.06

Reassessments are conducted as needed, including at specific milestones in the treatment process including:

a. after significant treatment progress;
b. after a lack of significant treatment progress;
c. after new symptoms are identified;
d. when significant behavioral changes are observed;
e. when there are changes to a family situation or parental status;
f. when significant environmental changes occur; or
g. when a resident returns following an episode of running away.

Note: *For more information regarding residents that return after an episode of running away, refer to GLS 9.01 and GLS 16.03.*

GLS 5: Family Involvement

The organization works with the resident and his or her family to develop and maintain an optimal level of family involvement in all program activities.

Table of Evidence

Self-Study Evidence

*Procedures for facilitating family involvement	**File:** DC Daily Living.pdf

* **Site Visit Evidence** No Site Visit Evidence

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Residents and their families
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - For the most part, established timeframes are met; or
   - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or

- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

GLS 5.01

The organization helps every resident to:

a. express the nature of family involvement desired;
b. prevent, manage, and reduce family conflicts and develop problem-solving skills;
c. identify family strengths that help members meet challenges;
d. understand separation from family or significant others and grieve the loss of family;
e. maintain relationships with family members through time spent at home and shared activities, as often as possible;
f. participate in neighborhood activities; and
g. prepare for returning home or for living with another family, if appropriate.

Interpretation: *The organization should work with residents to identify individuals with whom they wish to maintain a relationship, especially when trafficking is suspected. Traffickers may pose as a significant other, older relative, or communicate through another individual and utilize visitation to continue the exploitation of the victim. In cases where the child is a victim of human trafficking, it is important to be aware that the child's parent or caregiver may be the trafficker or complicit in the trafficking. In such cases, determining appropriate family supports and level of involvement should include the input of the child, as well as child welfare and law enforcement systems.*

Interpretation: *Unless contraindicated by court-order or there are compelling reasons to limit contact, residents should have the opportunity to spend time with their family at home and receive visits from family and friends. For adults, and some young adults, every attempt should be made to include family members identified by the resident. In cases where adults do not want family involvement, they should receive help to identify friendship opportunities based on common interests, and for young adults efforts should be made to help them connect with a non-custodial parent and/or other extended family members.*

GLS 5.02

The organization supports family involvement and engagement by:

a. providing assistance or support, as needed;
b. encouraging the family's active participation in decision-making;
c. providing an environment conducive to family visits and activities; and
d. reestablishing parental and family care, or termination of parental rights, when in the best interest of or desired by the resident.

Examples: *Examples of ways to engage families and encourage their participation can include asking family members directly about their needs and having family advocates available to offer assistance.*

GLS 5.03

Residents are located close to their families and home communities to retain natural connections and allow for continued participation in community programs and when services are not available close to a resident's home or community, the organization attempts to maintain family ties and involve the family by:

a. assisting the family with travel arrangements;
b. coordinating or facilitating family services to be delivered in the community; and/or
c. employing methods for telecommunication through web-based or electronic systems.

Examples: *The organization can support family involvement and provide alternative services through cooperating local organizations. Transportation costs can be paid to facilitate frequent visiting and home visits, when possible.*

GLS 5.04

Family members receive information and support to help them understand the needs of the resident and promote successful reintegration with their family and community.

Interpretation: *Educating parents on sex trafficking is an important component to prevention, identification, and treatment. Information provided should address how parents can raise their children in an environment free of abuse, neglect, and exploitation, through information on topics such as internet safety, how to respond when a child runs away, and developing healthy relationships. Additionally, information for parents of trafficking victims should emphasize the issue of stigma associated with prostitution to help the family provide a healthy, nonjudgmental home environment, supportive of a successful reintegration.*

Examples: *Organizations can educate family members on important information related to the resident's treatment that will aid in their transition from care and offer supports to families, such as individual mentoring and family and/or parent coaching.*

GLS 6: Service Planning and Monitoring

Residents and their families participate in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and supports.

Interpretation: *While a service plan may conform to a uniform format, plan content should be individualized through collaboration with the resident and, as appropriate, a parent or guardian and/or legal advocate based on service needs and program model. Level of family involvement in the service planning process will vary by resident and/or program model.*

Interpretation: *When the organization is working with Indian children and families, tribal or local Indian representatives must be included in the service planning process and culturally relevant resources available through or recommended by the tribe or local Indian organizations should be considered when developing the service plan.*

Table of Evidence

Self-Study Evidence

*Service planning and monitoring procedures	**File:** DC Assessment and Service Planning Procedure

Site Visit Evidence *No On-Site Evidence*

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents and their families
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - For the most part, established timeframes are met; or
   - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   - In a few instances, client or staff signatures are missing and/or not dated; or
   - With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
   - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Timeframes are often missed; or
   - In several instances, client or staff signatures are missing and/or not dated; or
   - Quarterly reviews are not being done consistently; or
   - Level of care for some clients is clearly inappropriate; or
   - Service planning is often done without full client participation; or
   - Appropriate family involvement is not documented; or
   - Documentation is routinely incomplete and/or missing; or
   - Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

<u>GLS 6.01</u>

An assessment-based service plan is developed with the full participation of the resident, and their family when appropriate, and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. procedures for expedited service planning when crisis or urgent need is identified; and
d. the resident's and/or legal guardian's signature.

Interpretation: *Safety concerns for victims of human trafficking often do not end when they are admitted to residential settings. The organization should work with the victim to develop a safety plan that focuses on increasing physical safety by securing needed documents, property, and services; maintaining the residence's location in confidence or restricting access by certain individuals; and linking efficiently to law enforcement, if needed. Psychological safety should also be prioritized as the emotional effects of trauma – mistrust, anxiety, depression, panic disorder, etc. – can be persistent and overwhelming for victims.*

Examples: *When working with victims of trauma, the organization can facilitate the development of realistic goals in an empowering and trauma-informed manner by building rapport, establishing trust, and promoting physical and psychological safety.*

GLS 6.02

The organization works in active partnership with residents to:

a. assume a service coordination role, as appropriate, when the need has been identified and no other organization has assumed that responsibility;
b. ensure that they receive appropriate advocacy support;
c. assist with access to the full array of services to which they are eligible; and
d. mediate barriers to services within the service delivery system.

Interpretation: *Central coordination of services is one of the most important aspects of care for victims of human trafficking. It provides the opportunity to develop an important, consistent connection with the staff person while the complex myriad of needed services are accessed and coordinated.*

GLS 6.03

The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of the resident, to assess:

a. service plan implementation;
b. progress toward achieving service goals and desired outcomes; and
c. the continuing appropriateness of the agreed upon service goals.

Interpretation: *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

GLS 6.04

The worker and individual, and his or her family when appropriate:

a. review progress toward achievement of agreed upon service goals; and
b. sign revisions to service goals and plans.

Interpretation: *For children and youth, family members and/or legal guardians should always be involved in case conferences and advised of ongoing progress.*

GLS 7: Child Permanency

The organization participates in or facilitates permanency planning to promote physical, emotional, and legal permanence for children.

Interpretation: *When the organization is not responsible for facilitating permanency planning, it should document all participation in the process and any efforts to connect children to positive relationships with significant adults.*

In addition, organizations should demonstrate their role in supporting timely permanency planning through regular case record documentation and official reports provided to the local child welfare agency or the court which comment on children's and/or families' progress towards permanency goal(s).

Interpretation: *The permanency planning process for American Indian and Alaska Native children and families must always involve tribal representatives and service providers to ensure compliance with the Indian Child Welfare Act's placement preferences and support culturally responsive planning that recognizes and incorporates tribal definitions of permanency and tribal perspectives of the best interests of the child into the permanency plan. To facilitate full participation, the organization must ensure that the tribe or local Indian*

organization receives timely notification of court or administrative case reviews, and is informed of any changes made to the permanency plan.

Note: *Permanency planning often occurs in conjunction with service planning.*

Table of Evidence

Self-Study Evidence

*Procedures for permanency planning	**File:** DC Assessment and Service Planning Procedure
*Procedures for finding and engaging kin	**File:** DC Daily Living.pdf

Site Visit Evidence *No On-Site Evidence*

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents and their families
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

<u>GLS 7.01</u>

Permanency planning:

a. occurs with families and the team of people that support them, including out-of-home care providers, service providers, and extended family members or other supportive individuals identified by the family, as appropriate;
b. is scheduled at times when appropriate parties can attend; and
c. is child-driven, with children actively involved in every stage of the process as appropriate to their age and developmental level.

Examples: *Child-driven permanency planning can include, but is not limited to, involving children in:*

1. *conversations about what permanency means to them;*
2. *the discovery of extended family and other significant adults; and*
3. *the formation of a permanency team that will support their desired outcomes and have an ongoing role in their lives.*

GLS 7.02

The organization collaborates with children, parents, and the local child welfare agency to identify, notify, and engage relatives and other close, supportive adults that can be resources or supports for placement and permanency for children of all ages, regardless of whether or not they currently wish to be adopted.

Examples: *Procedures for identification of kin may include:*

1. *engaging children and family members in identification;*
2. *conducting a thorough review of the case record;*
3. *using technological resources for family-finding;*
4. *providing notification in family members' preferred languages; and*
5. *providing notifications in multiple forms, including written form.*

GLS 7.03

Concurrent planning is documented and includes:

a. early, preliminary, and reasoned assessment of the potential for reunification, the best interests of the child, and the need for an alternative plan;
b. full disclosure to involved parties of all permanency options, including expectations, implications, available supports, and legal timelines;
c. joining a resource family that is prepared to develop a life-long relationship with the child; and
d. counseling parents about relinquishment and alternative permanency options if needed.

Interpretation: *The age of a child should not limit the consideration of all permanency options.*

GLS 7.04

Permanency plans document:

a. permanency goals;
b. why goals are in the best interest of children and their well-being;
c. why other permanency options are not appropriate; and
d. how service plans and identified interventions support permanency and child well-being.

GLS 7.05

Case records document efforts made to support parents toward reunification, including:

a. involvement in assessment, service planning and service selection;
b. access to needed services and supports, including both formal and informal community resources;
c. ongoing, constructive, and progressive contact with their children; and
d. reduction of barriers to contact and involvement in the child's care.

Interpretation: *When the organization is working with American Indian and Alaska Native children and families, the Indian Child Welfare Act requires active efforts be provided to prevent family breakup. Active*

efforts require affirmative, thorough, timely, and culturally responsive engagement with families to satisfy the case plan by accessing resources and services and partnering with the tribe.

Early consultation with the child's tribe is critical to ensuring that a full range of resources have been made available to the family and that active effort requirements are fulfilled. Organizations may work with tribal leadership, elders, religious figures, or professionals with expertise concerning the given tribe to determine culturally responsive active efforts and identify culturally appropriate services for the family.

GLS 8: Group Living Program

Residents participate in the development of a group living program that is individually tailored to their age, developmental level, social and emotional needs, strengths, and interests.

Table of Evidence

Self-Study Evidence

*Sample of activity schedules	**File:** Feb8_JJCrowderChiliCookoff2020_.docx **File:** Feb_14_Valentines.docx **File:** Feb_13_148thMHCOBirthday.docx **File:** Feb_07_SuperbowlDinner.docx **File:** 2023 Calendar of Events. **File:** 2022 Calendar of Events.pdf **File:** Mar_17_StPattysRockHunt.docx **File:** 2024 Calendar of Events.pdf **File:** 2025 Calendar of Events.pdf **File:** Feb13_Black History Month-Troutmans.docx **File:** Feb25_Mardi Gras.docx **File:** Feb23_MarkIshmanFlagFootball.docx
*Procedures for involving residents in decision making	**File:** DC Assessment and Service Planning Procedure

Site Visit Evidence *No Site Visit Evidence*

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents
- Review case records
- Observe the program

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
5. Documentation is routinely incomplete and/or missing.

GLS 8.01

Group living services are integrated with the resident's daily living experience and include, as appropriate:

a. treatment for severe emotional disturbance or mental health and substance use conditions;
b. individual and group counseling;
c. family therapy;
d. educational and/or vocational programming;
e. linkages to needed services in the community;
f. life skills training;
g. recreational activities;
h. legal advocacy;
i. opportunities to participate in religious observances in a faith or spirituality of choice;
j. community cultural enrichment, shopping, volunteer and paid work activities; and
k. independent living preparation.

GLS 8.02

Residents, and family members when appropriate, are given the opportunity for meaningful voice and choice in program activities and governance including:

a. participating in the development and enforcement of program rules;
b. contributing to program design and decision making; and
c. sharing feedback including dissatisfaction with aspects of the program.

Interpretation: *The organization should have mechanisms in place to receive and respond to resident feedback to ensure their contributions are meaningful. Residents should be informed of how the organization will use their feedback and be made aware of any changes that were made in response to their input.*

Examples: *The establishment of resident councils is one way to involve individuals in decisions and program design and ensure that they have an opportunity to provide feedback on staff, activities, rules, food, their overall care experience, sense of safety and support, and the living environment. This type of activity can also provide opportunities for youth advocacy, self-efficacy, and leadership. For programs serving youth, family advisory councils can be established to involve families in the governance of the program.*

GLS 8.03

Program personnel provide residents with:

a. a variety of nutritious meals and snacks;
b. personal items such as clothing and an individual allowance;
c. companionship;
d. support and assistance needed to participate in group living and community activities; and

e. a flexible daily schedule to develop and enhance positive personal and interpersonal skills and behaviors.

Interpretation: *Special diets should be planned to meet the modified needs of individual residents.*

GLS 9: Healthcare Services

Residents receive comprehensive healthcare services to promote optimal physical, emotional, and developmental health.

Table of Evidence

Self-Study Evidence

Initial health screening procedures	**File:** Resident Health Services, Wellness, and Medication Management Procedure
Procedures for the coordination and provision of healthcare and dental examinations and services	**File:** Resident Health Services, Wellness, and Medication Management Procedure

Site Visit Evidence

- Informational health and wellness materials

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Residents
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - For the most part, established timeframes are met; or
   - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Timeframes are often missed; or
   - Several client records are missing important information; or
   - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

GLS 9.01 (FP)

An initial health screening is conducted by a qualified medical practitioner for all residents within 24 hours of admission to identify the need for immediate medical care and assess for communicable disease.

Interpretation: *Qualified medical practitioner refers to a licensed physician, registered nurse, nurse practitioner, physician's assistant, or other healthcare professional that is permitted by law and the organization to provide medical care and services without direction or supervision. For the purposes of this standard, qualified medical practitioners are distinct from other clinicians who are not permitted by law to provide medical care and services without direction or supervision (e.g., clinical social workers, licensed vocational/practical nurses, and medical assistants). To meet the standard, the initial medical screening must be administered by a qualified medical practitioner.*

If the organization does not have a qualified medical practitioner on staff, it should research community resources and consider creating a formal arrangement or a memorandum of understanding (MOU) with a local physicians group, local health department, federally-qualified health center, urgent care clinic, community-based health clinic, or telehealth providers.

When possible, the screening should be performed by the resident's primary care physician who has knowledge of the resident's medical history or a physician that can serve as the resident's medical home while in care. For children in foster care, the local child welfare agency may be responsible for ensuring the initial health screening is completed or may assist the organization to identify possible medical resources.

***Interpretation:** When a resident returns following a runaway episode, a health screen should be conducted within 24 hours of entry back into care to identify whether he or she was victimized or otherwise hurt or injured while on the run.*

Interpretation: *In situations where the resident is unable to receive an initial health screening by a qualified medical practitioner within 24 hours, the organization can receive a rating of 2 if it has procedures in place for accommodating exceptional circumstances and is able to provide evidence that the screening occurred within 72 hours of admission.*

Exceptional circumstances include, but are not limited to:

1. *weekend placements; and*
2. *when a client is transferring from the care of a public agency that has arranged for an initial health screening to be conducted within 72 hours of admission to the program.*

Examples: *Conditions that require immediate or prompt medical attention include, but are not limited to: signs of abuse or neglect, serious, accidental or unexplained injury, signs of infection or communicable diseases, hygiene or nutritional problems, pregnancy, and significant developmental or mental health disturbances.*

GLS 9.02 (FP)

The organization ensures that each resident receives:

a. a comprehensive medical examination within five days after admission, unless the resident has received a medical exam within the last year, and annually thereafter; and
b. a dental examination within six months prior to or one month after admission with appropriate follow-up thereafter.

Interpretation: *When records from the most recent medical and dental examinations are unavailable or examinations are incomplete, the organization must ensure that examinations are completed within the required timeframes.*

Interpretation: *The purpose of the medical examination is to identify and assess medical, developmental, and mental health conditions that require treatment, additional evaluation, and/or referrals to other healthcare professionals or specialists.*

The examination must be comprehensive, build on history gathered during the initial medical screening, and focus on specific assessments that are appropriate to the individual's age and developmental level. Findings from the exam should be used to develop individualized treatment plans, as well as inform follow-up assessments and services.

Interpretation: *In situations where resources are not available for preventive dental care to occur every six months, the organization can receive a rating of 2 if there is an annual preventive exam and evidence that recommendations from the dental practitioner indicate the child is not in need of more frequent care.*

Children with dental issues or at high risk of dental problems must be receiving the care they need. Families should be engaged in the process and solution for getting their child the needed dental care.

GLS 9.03 (FP)

The organization provides needed health services directly or by referral, and:

a. retains documentation of the resident's and his or her family's known medical history, including immunizations, operations, medications, and medical conditions and illnesses; and
b. provides the information to the resident and/or his or her legal guardian upon request.

GLS 9.04 (FP)

To promote their ability to maintain positive health practices, residents receive appropriate support and education regarding:

a. proper nutrition and exercise;
b. personal hygiene;
c. substance use and smoking;
d. sexual development;
e. safe and healthy relationships;
f. family planning and pregnancy options;
g. pregnancy, prenatal care, and effective parenting; and
h. prevention and treatment of diseases, including sexually transmitted infections/diseases and HIV/AIDS.

GLS 9.05

The organization provides or arranges specialized health services to meet the needs of the service population, as appropriate.

Examples: *Specialized health services may be needed by older adults, pregnant and parenting individuals, individuals with eating disorders, individuals with substance-use related conditions, or children with autism and pervasive developmental disorders. These services may include, for example:*

1. *tobacco cessation;*
2. *fetal alcohol syndrome screening;*
3. *speech, language, and occupational therapy;*
4. *prenatal care, well-baby care, and accessing child and infant health insurance programs;*
5. *gender identity counseling; and*
6. *screening for onset or existence of common cancers.*

GLS 10: Education Services

The organization provides or arranges for residents to receive education services and supports to help them achieve their educational and/or vocational goals.

Interpretation: *Organizations that do not offer educational services on-site should coordinate with community-based providers to meet the educational needs of all residents. When organizations do not directly provide or arrange education services, individual case records should indicate that education plans are integrated into treatment plans and document advocacy for areas of unmet educational need. Education services will vary depending on the population served.*

Table of Evidence

Self-Study Evidence

*Procedures for developing and/or integrating education plans	**File:** DC Assessment and Service Planning Procedure.pdf **File:** DC Daily Living.pdf
*Procedures for coordinating education services with community-based providers, if applicable	**File:** DC Assessment and Service Planning Procedure.pdf **File:** DC Daily Living.pdf

Site Visit Evidence

- Proof of certification, accreditation, or registration, as applicable

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

GLS 10.01

A comprehensive, coordinated education plan is developed for residents with educational goals, or vocational goals that include an educational component, and is integrated into their service plan.

Interpretation: *If the organization does not participate in the development of the education plan it is responsible for integrating each individual's education plan into their service plan.*

GLS 10.02

Residents pursuing educational goals are enrolled in an appropriate education program on-site or in the community that is approved, certified, accredited, registered, or operated by or in conjunction with the local school district.

GLS 10.03

The educational program incorporates effective instructional practices, quality curriculum design, and educational tools and supports for diverse learning needs of children and youth.

NA: The organization does not provide group living services to school-age children or youth.
The organization does not directly provide the educational program nor develop the education plans for children or youth.

Examples: *Diverse learning needs can include children who: require support due to a learning disability, are learning English as an additional language, or are intellectually gifted.*

GLS 10.04

The organization provides or arranges, as needed:

a. tutoring;
b. preparation for a high school equivalency diploma;
c. college preparation;
d. parent-teacher meetings;
e. vocational or continuing education opportunities; and/or
f. advocacy and support.

GLS 11: Community and Social Connections

Residents cultivate and sustain connections with their community and social support network to promote positive well-being.

Table of Evidence

Self-Study Evidence

*Procedures for facilitating community and social connections	**File:** DC Assessment and Service Planning Procedure.pdf **File:** DC Daily Living.pdf
*Policy that prohibits exploitation of individuals in employment-related training or jobs	**File:** Fair and Equitable Treatment Policy.docx **File:** DC Daily Living.pdf

Site Visit Evidence

- Community resource list
- Proof of accreditation, licensure, or certification for outside providers operating adventure-based activities

On-Site Activities

- Interviews may include:

1. Program director
2. Relevant personnel
3. Residents

- Review case records
- Observe a variety of activities

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - For the most part, established timeframes are met; or
   - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Timeframes are often missed; or
   - Several client records are missing important information; or
   - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

GLS 11.01

The organization facilitates residents' ability to access all available services and successfully reintegrate into their community by:

a. remaining knowledgeable about local, regional, and state resources, including networking and leadership opportunities; and
b. identifying opportunities for residents to develop positive ties to the community based on mutual interests and abilities.

GLS 11.02

Organizations create a normative environment for residents while they are in care and provide residents opportunities to participate in:

a. culturally and developmentally appropriate social, recreational, educational, or vocational activities in their community;
b. religious observances in the faith group or spirituality of choice; and
c. family and neighborhood activities consistent with their ethnic and cultural heritage and tribal affiliation.

Interpretation: *Individuals should have the right to choose whether they wish to participate in religious activities that take place at the program.*

Examples: *Activities in the community can include sports teams, drama, choir, and musical groups that promote pro-social behaviors and values.*

GLS 11.03

Residents, and their families when possible and appropriate, are:
helped to develop social support networks and build healthy, meaningful relationships with caring individuals of their choosing; and
actively connected with peer support services appropriate to their request or need for service.

Interpretation: *Connections to outside self-help/mutual aid groups should not be limited to providing the time and location for a meeting. Organizations can support the individual's acclimation to a new group by, for example, discussing meeting protocols and what to expect prior to attending, accompanying them to their first meeting, and encouraging them to make connections with peers while at the meeting.*

Examples: *"Caring individuals" may include mentors, community members, friends, classmates, peers, sponsors, siblings, cousins, grandparents, former foster parents, and extended family members.*

Examples: *Peer support services can help to promote resiliency and recovery and are provided by individuals who have shared, lived experience. They can include self-help/mutual aid recovery groups, peer-to-peer counseling, peer mentoring or coaching, family and youth peer support, or other consumer-run services.*

GLS 11.04

The organization encourages social and community integration through the development of life skills necessary to:

a. navigate the surrounding environment;
b. perform activities of daily living;
c. obtain safe and stable living;
d. manage a household;
e. pursue educational, occupational, and volunteer opportunities;
f. manage finances including credit and debt counseling when needed;
g. maintain personal safety;
h. access community resources;
i. access public assistance;
j. communicate effectively and avoid or resolve conflicts;
k. reduce risk-taking behaviors, including practice with decision making and anger management;
l. participate in recreational activities and/or hobbies; and
m. prepare for family reintegration, independent living, or another less restrictive setting, if applicable.

Interpretation: *This standard is applicable for all residents regardless of age. Organizations should tailor life skills training to meet the age and developmental level of the service population.*

GLS 11.05 (FP)

The organization evaluates residents for their ability to participate in athletic activities and obtains:

a. a written, signed permission slip from the resident's legal guardian;
b. a medical records release;
c. a signed document from a qualified medical professional stating that the resident is physically capable of participating; and/or
d. an adult waiver and release of liability.

NA Taken in 2021: *The organization does not offer athletic activities to residents.*

GLS 11.06

The organization offers employment opportunities or employment-related training to residents and:

a. makes reasonable efforts to match training and employment opportunities to the goals and interests of individual residents;
b. paid job opportunities are completely voluntary; and
c. a policy prohibiting exploitation of residents is maintained.

GLS 11.07 (FP)
Organizations that purchase services from providers that operate adventure-based activities with a significant degree of risk request proof of accreditation, licensure, or certification with a nationally recognized authority for the activity being conducted.

NA Taken in 2021: *The organization does not purchase services from providers that operate adventure-based activities.*

Examples: *Adventure-based activities with a significant degree of risk can include, white water rafting, climbing walls, or ropes courses.*

GLS 12: Services for Pregnant and Parenting Residents

NA Taken: *The organization does not serve pregnant and/or parenting residents.*

GLS 13: Substance Use Services

NA Taken: *The organization does not provide substance use services.*

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GLS 14: Residential Facilities

Residential facilities contribute to a physically and psychologically safe, healthy, non-institutional, homelike environment.

Interpretation: *"Homelike" settings are assessed within the context of an organization's location and environment.*

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Table of Evidence

Self-Study Evidence

*Procedures for maintaining a clean and safe environment	**File:** DC Daily Living.pdf **File:** Facility Use Procedure.pdf

Site Visit Evidence *No Site Visit Evidence*
On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Residents
- Observe facilities and outdoor area/grounds

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   - Procedures need strengthening; or
   - With few exceptions, procedures are understood by staff and are being used; or
   - For the most part, established timeframes are met; or
   - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Timeframes are often missed; or
   - Several client records are missing important information; or
   - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - No written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

GLS 14.01

Living quarters consist of separate cottages or units in a residential building that include:

a. a common room, dining and/or kitchen area, and space for indoor recreation;
b. private areas where residents can meet with family and friends; and
c. private facilities for bathing, toileting, and personal hygiene, that are developmentally appropriate.

GLS 14.02

Personal accommodations for residents are age, developmentally, gender, and culturally appropriate and include:

a. single rooms, rooms for groups of two to four residents, and/or accommodations for larger groups, if appropriate for therapeutic reasons;
b. adequately and attractively furnished rooms with a separate bed for each resident, including a clean, comfortable, covered mattress, pillow, sufficient linens, and blankets;
c. a non-stacking crib for each infant and toddler that is 24 months or younger that meets safety guidelines, as applicable; and
d. a safe place such as a locker to keep personal belongings and valuables.

Examples: *National advocacy standards suggest that single rooms have at least 100 square feet of floor space and rooms housing more than one individual have at least 80 square feet per person. Group assignments and room accommodations may be adjusted as appropriate to the service provided, therapeutic considerations, level of risk, or developmental appropriateness.*

Examples: *The Consumer Product Safety Commission (CPSC) provides standards to ensure safety for full-size and non-full-size cribs.*

GLS 14.03

Organizations that serve families or house families as a unit and keep sibling or family groups together, when possible.

NA Taken in 2021: *The program does not serve family units, or housing families as a unit is not possible or prohibited by law.*

Examples: *Allowing families to follow their schedules, routines, and rituals to the greatest extent possible can support family functioning, encourage stability, and minimize stress.*

GLS 14.04

Residents participate actively in:

a. decorating and personalizing their sleeping area;
b. choosing clothing based on their personal preferences;
c. food preparation and meal planning; and
d. contributing to decisions about how to make living areas inviting, comfortable, and reflective of their interests and diversity.

Interpretation: *Recognizing that there are communities where access to affordable, quality food is limited, it is important for personnel to take into consideration where residents will reside after they are discharged so healthy eating habits can continue long after they leave care.*

GLS 14.05

Facilities support quality therapeutic programs and settings accommodate:

a. individual, small, and large group activities;
b. activities that invite use of community resources;
c. a variety of after school, evening, weekend, holiday, and school break programs for use by residents, guests, family, and community members;
d. a variety of activities that are focused around the resident's home, community, and extended family and friends;
e. quiet reading, study hours, and help with school assignments;
f. individual hobbies and group projects that may be large and constructed over time; and
g. alternatives to watching television, such as art, photography, or other creative activities.

GLS 14.06

Residential facilities provide:

a. sufficient supplies and equipment to meet residents' needs;
b. access to a telephone, computer, and the internet as permitted, for use by residents and personnel;
c. adequate space for administrative support functions, food preparation, housekeeping, laundry, maintenance, and storage;
d. rooms for providing on-site services, as applicable;
e. accommodations for informal gathering of residents including during inclement weather;
f. at least one room suitably furnished for the use of on-duty personnel; and
g. private sleeping accommodations for personnel who sleep at the facility, if applicable.

GLS 14.07 (FP)

Indoor and outdoor settings are clean, maintained in good condition, and promote the health and safety of personnel and residents.

Interpretation: *The facility's outdoor area should contain sufficient space for recreational activities. Outdoor equipment should meet playground equipment safety standards and be appropriate for the*

number, age, and developmental level of residents. Programs serving children should have outdoor and indoor play spaces with adequate toys, books, and other recreational supplies.

GLS 15: Recovery Homes

NA: The organization does not operate recovery housing.

GLS 16: Privacy Provisions

The organization provides for resident comfort, dignity, privacy, and safety.

Related Standards: CR 1.01, CR 1.02

Table of Evidence

Self-Study Evidence

*Privacy policy	**File:** Confidentiality Policy.pdf **File:** Confidentiality Procedure.pdf
*Privacy procedures	**File:** Confidentiality Procedure.pdf

Site Visit Evidence

- Judicial order, law, or contract, as applicable

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents
- Review case records
- Observe facility

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

GLS 16.01 (FP)

The organization ensures residents' comfort, dignity, privacy, and safety by:

a. prohibiting the use of surveillance cameras or listening devices in bedrooms;
b. maintaining doors on sleeping areas and bathroom enclosures;
c. providing one- or two-person rooms to residents who need extra sleep, protection from sleep disturbance, or extra privacy for clinical reasons; and
d. requiring employees to knock before entering a resident's room unless there is an immediate health or safety concern.

Interpretation: *When organizations are required to employ alternate practices, documentation must be provided to justify the practice. Documentation may include a judicial order, law, contract, copy of the state's safety plan for a resident, or clear, clinical written justification for a resident.*
Sensitivity should always be taken to ensure that all service recipients, especially abuse or trauma survivors and the LGBTQ population, feel safe and not violated.

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

GLS 16.02 (FP)

Searches of residents or their property are conducted in a trauma-informed manner that respects client rights, dignity, and self-determination and include, as appropriate to the frequency and invasiveness of searches:

a. communicating to service recipients policies for searches of individuals or their property;
b. timely notification of a parent and/or legal guardian;
c. definition and documentation of reasonable cause and assessed risk of harm to self or others; d. trained, qualified staff; and
d. an administrative review process including documentation, notification, and the timetable for review.

Interpretation: *Search procedures should correspond directly to the invasiveness of the search to be conducted. For example, more invasive searches should be reserved for higher risk situations with reasonable cause, should only be conducted by highly qualified personnel, and always require an administrative review.*

GLS 16.03 (FP)

The organization communicates policies that respect residents' privacy for reviewing mail and only does so when a previous incident involving the resident indicates that:

a. the mail is suspected of containing unauthorized, dangerous, or illegal material or substances, in which case it may be opened by the resident in the presence of designated personnel; or
b. receipt or sending of unopened mail is contraindicated.

Examples: *Examples of mail include letters, packages, emails, and other forms of correspondence via social media and electronic communication.*

GLS 16.04 (FP)

All residents can have private telephone conversations, and any restriction is:
a. based on contraindications and/or a court order;
b. approved in advance by the program director or an appropriate designee;
c. documented in the case record; and
d. reauthorized weekly by the immediate supervisor of the direct service provider.

GLS 17: Care and Supervision

The organization provides 24-hour-a-day care and supervision that is respectful, supportive, and tailored to each resident's developmental, educational, clinical, and safety needs and attentive to effects of congregate living.

Table of Evidence

Self-Study Evidence

*Resident/personnel care and supervision ratios	**File:** Home Size.pdf
*Supervision and scheduling criteria	**File:** DC Daily Living.pdf
*Procedures for preventing and responding to missing and runaway children	**File:** Non-Critical Incidents Procedure.pdf **File:** Critical Incidents Procedure.pdf

Site Visit Evidence

- Educational or training materials provided to residents for skills development
- Resident/personnel care and supervision coverage schedules for the previous six months

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Residents
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
5. Documentation is routinely incomplete and/or missing.

GLS 17.01 (FP)

Individuals who provide direct care and supervision offer residents:

a. nurturance, structure, support, respect, and active involvement;
b. services provided in a safe, secure environment that prohibits weapons and gang activity;
c. predictable limit-setting;

d. flexibility, when appropriate and in the resident's best interest;
e. guided practice to learn effective communication, positive social interaction, and problem solving skills.

Examples: *This approach can help to anticipate, prevent, and reduce the occurrence of bullying and other unsafe or negative peer interactions.*

Examples: *Regarding element (d), being flexible with codified rules that contradict a resident's best interest can allow the organization to provide individualized care that is tailored to the resident's needs. For example, being flexible with bedtimes for a resident who may have experienced nighttime trauma rather than strictly enforcing a lights out time allows the organization to be responsive to the needs of residents.*

GLS 17.02 (FP)

Resident care and supervision is provided by:

a. personnel-to-participant ratios for daytime and overnight hours that are appropriate to the program model, length of treatment, population served, and their age, developmental and clinical needs;
b. enough additional personnel on-site that are qualified to meet special needs during busy/stressful periods, respond to
c. emergency/crisis situations, and carry out the organization's emergency response plan; an on-call, professional clinical staff member available on a 24-hour basis;
d. rotating after-hours and holiday coverage when needed; and
e. same-gender and cross gender supervision when indicated by individual treatment needs.

Interpretation: *The organization must demonstrate that based on their program model and the population served their staffing ratios for daytime and overnight coverage are addressing potential risks and meeting the needs of their clients.*

Interpretation: *The organization may use direct care workers or counselors to provide supervision to residents. Personnel must be awake at all times unless convincing evidence demonstrates the resident group does not need awake supervision during sleeping hours. Examples of reasons certain homes or programs might not have awake personnel are: care for a long-term, stable population; majority of unit residents are ready to move to a less restrictive setting; low runaway rates; and low rates of night-time incidents. Electronic supervision is not an acceptable alternative to supervision by personnel.*

Interpretation: *Regarding element (c) the professional clinical staff person is permitted to sleep during sleeping hours.*

Examples: *National recommendations for the supervision of children in residential care is that there are no more than four children per worker during waking hours and no more than eight children per worker during overnight hours.*

Note: *Organizations must also meet state licensing requirements for care ratios.*

GLS 17.03

The organization establishes procedures for preventing and responding to missing and runaway children that address:

a. creating an environment that provides a sense of safety, support, and community;
b. identifying risks or triggers that may indicate likeliness to run away from programs;
c. communication and reporting to relevant staff, authorities, and parents or legal guardians; and
d. welcoming, screening, and debriefing when children return to the program.

GLS 18: Transition from the Service System

Residents, and their families and/or legal guardians, as appropriate, participate in planning for transition to the community and are prepared with positive experiences and skills to make a successful move.
NA taken in 2021: The service is a long-term permanent housing setting.

GLS 18.03
NA taken in 2021: Residents are not transitioning to an independent living situation.
GLS 18.05
NA taken in 2021: Residents are not transitioning to an independent living situation.
GLS 18.06
NA taken in 2021: Residents are not transitioning to an independent living situation.
GLS 18.08
NA taken in 2021: Residents are not transitioning to an independent living situation.

GLS 19: Case Closing and Aftercare
The organization works with residents and family members, when appropriate, to plan for case closing and, when possible, to provide aftercare.
NA taken in 2021: The service is a long-term permanent housing setting.

Self-Study Evidence

Case closing procedures	
Aftercare and follow-up procedures	

On-Site Evidence
Relevant portions of contract with public authority, as applicable
On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Residents and their families
- Review case records

GLS 19.01
Planning for case closing:
a. is clearly defined and includes assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, the resident, family members or a legal guardian, and others, as appropriate to the needs and wishes of the resident.

GLS 19.02
Upon case closing, the organization notifies any collaborating service providers, as appropriate.
GLS 19.03
When an individual or family has to leave the program unexpectedly the organization makes every effort to identify other service options and link the person with appropriate services.
Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.*
GLS 19.04
As a continuing resource for information, crisis management, referral, and support, the organization provides each resident with:
a. a transition/aftercare plan summary, including the resident's options;
b. a list of emergency contacts; and
c. the organization's contact information.

GLS 19.05
The organization follows up on the transition/aftercare plan, as appropriate, when possible, and with the permission of persons served.
NA taken in 2021: The organization has a contract with a public authority that prohibits or does not include aftercare or transition planning follow-up.
Examples: *Reasons why follow-up may not be appropriate, include, but are not limited to, cases where the person's participation is involuntary, or where there may be a risk to the individual such as in cases of domestic violence.*

Administration and Management Standards

Governance

Purpose
The organization's governing body is sufficiently active, capable, and diverse to guide, plan, and support the achievement of the organization's mission and goals.

Introduction
COA's Governance standards reflect how excellence develops over time in non-profit organizations. The standards address several key concepts found in the literature on effective, non-profit leadership including, but not limited to, evidence of an association between the leadership and culture of a human service organization and the achievement of positive outcomes for the people and communities it serves. The standards outline the responsibilities of agency leadership to foster a culture of transparency, accountability, and community responsiveness.

Note: *Please see the GOV Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see GOV Crosswalk. See also ETH Private Crosswalk for Ethical Practice standards that are now found in GOV.*

Table of Evidence
Self-Study Evidence *No Self-Study Evidence*

GOV 1: Mission
The organization's mission:

a. is responsive to the needs and aspirations of the community;
b. guides the organization's administrative operations and delivery of services; and
c. serves as a benchmark of organizational effectiveness.

Related Standards: PQI 3.03

Table of Evidence
Self-Study Evidence Mission statement provided during application

Site Visit Evidence *No Site Visit Evidence*

On-Site Activities
* Interviews may include:
1. Governing body members
2. Relevant personnel

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement, e.g.,
   - The mission statement is in effect and is being used to guide decision making across the organization, but it needs updating and is currently under review by the organization's governing body.
3. Practice requires significant improvement, e.g.,
   - The mission statement is poorly written and as a result, it has limited use in setting the organization's strategic goals or guiding organizational decisions; or
   - Provision of human services are not identified as a major component or focus of the organization.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,

- There is no written mission statement or the organization's practices and services are at odds with its mission.

GOV 2: Strategic and Annual Planning

The organization engages in an inclusive long-term strategic planning process, and annually conducts short-term planning, in support of its mission.

Note: *Please see the Governance Standards Tool Kit - Strategic Plan Template for additional guidance on this standard.*

Table of Evidence

Self-Study Evidence

*Strategic and annual planning procedures	**File:** Public Relations
*Long-term strategic plan	**File:** MHCO Strategic Plan
*Review of service population demographics	**File:** Q4 2024 PQI Report
*Assessment of strengths and weaknesses	**File:** MHCO Organizational Assessment **File:** SWOT Analysis - MHCO
*Annual plans	**File:** MHCO Annual Plan 2024-2025 **File:** MHCO Annual Plan 2023-2024 **File:** MHCO Annual Plan 2022-2023 **File:** MHCO Annual Plan 2021-2022
*Equity Statement	

Site Visit Evidence

* BOD and/or committee meeting minutes where mission fulfillment and strategic planning were discussed

On-Site Activities

- Interviews may include:
    1. CEO
    2. CFO
    3. Governing body
    4. Senior management
    5. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the GOV 2 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the GOV 2 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the GOV 2 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the GOV 2 Practice standards.

GOV 2.01 (FP)

Long-term strategic planning responsibilities of the governing body include:

a. monitoring progress toward fulfilling the mission;
b. envisioning and setting the organization's strategic direction; and
c. supporting inclusive, management-directed, organization-wide, long-term planning every four years.

Interpretation: *Organizations may use a policy governance model to demonstrate that the governing body has developed the organization's broad vision and provided oversight to the operational planning activities conducted by management. The governing body need not conduct these planning activities itself.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not fully addressed.

3. Practice requires significant improvement; e.g.,
    - Governing body involvement in the planning process is minimal; however, it does review and approve the long-term plan; or
    - Long-term planning has not been done in more than four years; or
    - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - The governing body is not involved in the long-term planning process, nor does it review or approve the plan; or
    - Long-term planning has not been done for more than five years.
    - The strategic plan is wholly inadequate or nonexistent.

GOV 2.02 (FP)
The governing body reviews and approves the long-term strategic plan to ensure that it encompasses:

a. a review of the organization's mission, values, mandates, and strategic direction;
b. a review of the demographics of its defined service population;
c. an assessment of strengths and weaknesses;
d. measurable goals and objectives that support fulfillment of its mission and mandated responsibilities; and
e. appropriate strategies for meeting identified goals, including the need to redirect, eliminate, or expand services to respond to changing community demographics and the needs of persons served.

Related Standards: PQI 3.03

Examples: *To enhance its assessment, organizations can draw upon the findings of other external needs assessments, such as those conducted by the United Way, municipal planning boards, universities, or other organizations with a community-wide focus.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements is not fully addressed; or
    - The review of service population demographics did not include all populations served or geographic locations; or
    - The strategy (element (f)) for meeting one or two of the identified long-term goals needs greater specificity.
3. Practice requires significant improvement; e.g.,
    - One of the elements is not addressed at all; or
    - The mission has not been reviewed for more than four years; or
    - The organization did not review the demographics of its service population; or Identified goals and objectives are vague; or
    - Most identified goals and objectives are not measurable; or
    - Strategies for meeting identified goals are cursory and do not provide a sufficient framework for success or implementation; or
    - Governing body involvement in the planning process is minimal, however it does review and approve the long-term plan; or
    - Long-term planning has not been done in more than four years.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Two of the elements are not addressed at all; or
    - The governing body is not involved in the long-term planning nor does it review or approve the plan; or Long-term planning has not been done for more than five years; or
    - The strategic plan is wholly inadequate or nonexistent.

GOV 2.03 (FP)
The organization develops and implements an annual plan that supports its mission and integrates the priorities and objectives of each of its departments and programs, and:
a. operationalizes the goals and objectives of the long-term strategic plan;
b. reflects changing conditions and needs such as, resource allocation, funding, and regulatory changes;
c. responds to information from PQI activities.

Related Standards: FIN 4.01, HR 1, HR 3.01, PQI 3.03, RPM 4.01, TS 1.01

Examples: *Annual plans can also incorporate other regular planning processes, including:*

1. *HR planning;*
2. *evaluation of training needs;*
3. *budget planning;*
4. *technology and information management planning; and*
5. *PQI summary reports.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Departmental priorities and objectives could be better defined; or
   - While department and program plans are not integrated into an organization-wide annual plan, all but one or two departments or programs have developed a comprehensive annual plan.
3. Practice requires significant improvement, e.g.,
   - Management objectives are not included; or
   - Several departments or programs are not included in the most recent annual plan or have not done an annual plan; or
   - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Two of the elements are not addressed at all.

GOV 2.04
The organization develops an equity statement outlining its commitment to equity, diversity, and inclusion (EDI) that is shared with its stakeholders.

Interpretation: *The equity statement should reflect the organization's history, connect EDI to its mission, and outline how the organization demonstrates its commitment to EDI.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   The organization has an equity statement, but it has not been shared with its stakeholders.
3. Practice requires significant improvement; e.g.,
   The organization has begun the process of developing an equity statement, but the process is not yet complete.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   The organization does not have an equity statement and little to no work has begun to create one.

GOV 3: Community Involvement and Advocacy

The organization:
a. informs the public of its mission;
b. remains knowledgeable about community needs and strengths;
c. advocates for comprehensive and coordinated service delivery within the community; and
d. encourages the elimination of social and economic injustice.

Interpretation: *The standards in GOV 3 describe a variety of activities related to the organization's role within the community, including outreach and education, participation in community-wide advocacy efforts, and advocacy on behalf of service recipients who need help navigating the system. Given the broad range of activities outlined in GOV 3, activities conducted by "the organization" are the responsibility of the governing body, CEO, stakeholder advisory group, management, direct service personnel, and/or other personnel, as appropriate to the activity and their role.*

Table of Evidence

Self-Study Evidence

Community Demographic Profile	
See website URL and links to social media sites provided during application	
*A list of Governing Body members, with brief bios	**File:** MHCO BOARD OF DIRECTORS 2024 w bios

Site Visit Evidence

*Copies of PSAs, newspaper articles, other print media, or communication methods used within the past 12 months

*Documentation of participation in community advocacy efforts

On-Site Activities

*Interviews may include:

1. Governing body
2. Relevant personnel
3. Community stakeholders
4. Persons served

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the GOV3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the GOV3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the GOV 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the GOV3 Practice standards.

GOV 3.01

The organization provides the public with clear, timely, and accurate information about the organization's mission, programs, activities, service recipients, and finances.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - While social media or the website provides accurate information, some written materials that continue to be distributed are outdated; or
   - Some segments of the general public do not have access to accurate and timely information.
3. Practice requires significant improvement; e.g.,
   - Generally, public information is not current; or
   - Some important information is not available to the public.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 3.02

The organization conducts ongoing community outreach and education to:

a. communicate its mission, role, functions, capacities, and scope of services;
b. provide information about the strengths, needs, and challenges of the individuals, families, and groups it serves;

c. build community support and presence and maintain effective partnerships; and
d. elicit feedback as to unmet needs in the community.

Examples: *Examples of public outreach and education activities may include:*

1. *regular communication with the media and the general public;*
2. *informing the public of the positive impact the organization's programs are having on the community and its residents; and*
3. *fostering positive relationships with the local media.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not fully addressed; or
   - The organization has an ongoing program of community education, but it does not cover some of its programs or services.
3. Community outreach and education efforts need significant improvement; e.g.
   - Efforts are informal and infrequent; or
   - Efforts only address some of the organization's programs or services, or populations served; or
   - Element (a) or (b) is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 3.03

The organization collaborates with community members and persons served to address unmet needs in the community and advocate for issues of mutual concern consistent with the organization's mission, such as:

a. improvements to existing services;
b. filling gaps in service to offer a full array of community supports;
c. the full and appropriate implementation of applicable laws and regulations regarding issues concerning the service population;
d. improved support and accommodations for people with special needs;
e. improved access to needed services for underserved populations and marginalized communities;
f. solutions to community-specific needs including racial equity and cultural and linguistic diversity;
g. service coordination; and
h. a coordinated community response to public health emergencies.

Examples: *The organization can work at several levels to advocate with, and on behalf of, persons, groups, and families served. For example, direct service personnel can be given the time to carry out advocacy activities so they can support persons and families served to solve problems related to their individual cases. Advisory board members, management, and other personnel, along with persons served, can engage in legislative and other system-wide advocacy activities. They may also work collaboratively with other community organizations to monitor federal, state, and/or local activity that impacts the service population.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not addressed at all.
3. Practice requires significant improvement; e.g.,
   - Two of the elements are not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Little or no effort is made to collaborate with community members or persons served as described in the standard.

GOV 3.04

The governing body:

a. reflects the demographics of the community it serves;

b. represents the interests of the community it serves;
c. serves as a link between the organization and the public or community; and
d. is sufficiently diverse in strengths and capabilities to plan and deliver appropriate services to its defined community.

Interpretation: *COA recognizes that Board recruitment is a significant challenge for many organizations and that meeting the standard may be a long-term process. In the interim, an organization can establish a stakeholder advisory group that is representative of the community and include strategies for plan for strengthening its Board in its long-term or strategic plan.*

Examples: *The governing body should reflect a wide range of skills, abilities, community knowledge, and professions. Examples of board member strengths and capabilities may include:*

1. *governance expertise, including leadership ability and policy development skills;*
2. *relevant business experience;*
3. *financial expertise;*
4. *knowledge of consumer issues and trends;*
5. *familiarity with and access to community leaders, political representatives, and other relevant local organizations;*
6. *public recognition and respect; and*
7. *commitment and ability to fundraise or to connect the organization with potential resources, as applicable.*

Note: *Please see the Governance Standards Tool Kit - Board Skills Worksheet for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard. The organization's governing body reflects its community and possesses the skills and expertise necessary to effectively govern.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the standard's elements is not fully addressed; or
   - The governing body does not reflect its community, but a representative stakeholder advisory group is in place and there is a plan for diversifying the board.
3. Practice requires significant improvement; e.g.,
   - Two of the elements are not fully addressed; or
   - One element is not addressed at all; or
   - A stakeholder advisory group is in place to address lack of representativeness, but it is not very active, or there is no plan for long-term remediation.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 3.05

The organization provides persons served with meaningful opportunities to influence the design, delivery, and evaluation of its programs and services.

Examples: *Organizations can involve persons served by, for example (1) seeking input during house or community meetings, when applicable; (2) soliciting feedback through satisfaction surveys as required by PQI 3.02; (3) establishing advisory councils;(4) reserving seats on the board for individuals with lived experience and their families; (5) inviting persons served to play a role in orienting newcomers to the program; and (6) hiring former service recipients to serve as peer support workers.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements is not addressed at all.
3. Practice requires significant improvement; e.g.,
   - Two of the elements are not addressed at all.

4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - Little or no effort is made to provide meaningful opportunities to influence the design, delivery, and evaluation of programs and services as described in the standard.

GOV 4: Organization of the Governing Body

The governing body exercises leadership through a functional, effective structure.

Table of Evidence

Self-Study Evidence

*Bylaws	**File:** Charter **File:** Articles of Incorporation **File:** Bylaws/AMDENDED AND RESTATED BYLAWS
*Table of contents of governing body orientation and training curricula	

Site Visit Evidence

*BOD Manual
*BOD meeting minutes for the past 12 months
*Governing body orientation and training curricula
*Documentation tracking board member completion of required orientations and trainings

On-Site Activities

*Interviews may include:
1. BOD chair
2. BOD members

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the GOV 4 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the GOV 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the GOV 4 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the GOV4 Practice standards.

<u>GOV 4.01</u>

The governing body establishes in the organization’s charter, by-laws, or similar document:
a. the organization’s structure and scope;
b. its responsibilities, including number of meetings held per year and their quorum;
c. the body, typically its executive committee, to which it will delegate interim authority; and
d. a process for assessing and implementing responsibilities, such as establishing task forces/committees.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Documentation related to one of the elements is outdated or does not reflect current practice.
3. Practice requires significant improvement; e.g.,
    - Documentation related to two or more elements are outdated and do not reflect current practice; or
    - One of the elements is not addressed at all, e.g., no written delegation of authority.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 4.02

The governing body establishes in writing:

a. eligibility requirements for membership, including the prohibition of having staff and/or relatives of staff on board;
b. mechanisms for recruitment, selection, rotation, and duration of membership; and
c. mechanisms for election of officers and duration of terms.

Interpretation: *If the chief executive retains board privileges as a voting member, the organization's by-laws and/or conflict-of-interest policy must clearly define limits for the use of those privileges. The chief executive should be excused from deliberations on matters related to executive compensation, evaluation, and other areas that present apparent conflicts of interest.*

Note: *See GOV 7 for more information on establishing a Conflict of Interest policy.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation related to one of the standard's elements is outdated and does not reflect current practice.
3. Practice requires significant improvement; e.g.,
   - Written by-laws related to two or more elements are outdated and do not reflect current practice; or
   - One of the elements is not addressed at all; or
   - The executive director is a full voting member with no limits; or
   - Another staff member, or a relative of a staff member is a voting member of the board; or
   - The by-laws have not established terms of service on the board.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 4.03

Governing body members receive an orientation that addresses membership responsibilities and an overview of the organization and its mission.

Examples: *The board orientation may include: information on the organization's history, goals and objectives, governing body structure and procedures, ethics, programs and activities, introductions to staff, equity, diversity, and inclusion training; and facility and program tours.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 4.04

All governing body members participate in equity, diversity, and inclusion (EDI) training at least every two years.

Examples: *In order to best engage governing board members, organizations can connect EDI training to the mission of the organization and the desired outcomes of its programs.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g., EDI training is offered sporadically and has not been provided in the last two years.

3. Practice requires significant improvement; e.g., Multiple board members report never having received EDI training.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g., Board members have never received EDI training of any kind.

GOV 4.05 (FP)

The organization maintains a board manual that includes governing body-approved policies and up-to-date minutes and records of all meetings.

Note:*Please see the Governance Standards Tool Kit - Board Manual Table of Contents and Board Meeting Minutes Template for additional guidance on this standard.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Although up-to-date policies, minutes, etc. have been distributed to governing body members, they have not been incorporated into the manual.
3. Practice requires significant improvement; e.g.,
   - Governing body minutes and/or minutes of committee meetings are incomplete, or are too cursory to accurately reflect decisions or action taken, or are outdated; or
   - The manual is missing key policies; or
   - Policies have not been approved.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The governing body does not maintain a manual that meets the requirements of the standard or the manual is wholly inadequate.

GOV 5: Governing Body Responsibilities

The governing body actively fulfills its legal responsibilities, sets a tone of responsible stewardship, and ensures policies and performance uphold the public trust and support achievement of the organization's mission.

Self-Study Evidence

*Succession planning procedures	**File:** Governance **File:** MHCO Succession Policy
*Succession plan	**File:** MHCO Succession Policy

Site Visit Evidence

*Governing Body and/or committee meeting minutes from the previous 12 months addressing each of the GOV 5 practice standards

On-Site Activities

*Interviews may include:
1. Governing body chair
2. Governing body treasurer
3. Governing body members
4. CEO
5. CFO

GOV 5.01 (FP)
Policy development responsibilities of the governing body include:
a. adopting policies;
b. reviewing policies at least every four years and when legal requirements or regulations change;

c. adopting any changes to policies resulting from recommendations; and
d. evaluating management's implementation of policies.

Related Standards: RPM 1

Interpretation: *An organization that follows a policy governance model may not typically develop, ratify, and maintain statements known as "policies." However, distillations of the organization's principles, philosophies, practice, or "ends" may be considered policies for the purposes of this standard.*

For organizations with Boards that delegate the responsibilities for adopting, reviewing, changing, and/or evaluating implementation of policy to the Executive Director, evidence of presenting and discussing with the Board, any changes, additions, etc. related to policies should be reflected in the Board minutes to demonstrate Board involvement.

Rating Indicators:
1. The governing body actively exercises its policy-setting prerogatives as per the requirements of the standard, and policy decisions are reflected in comprehensive and up-to-date minutes of the governing body meetings. Policy setting is viewed as the board's major means of providing a framework and guidance for the organization's overall direction.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Governing body practice related to one or two of the elements could be strengthened in some minor way.
3. Practice requires significant improvement, e.g.,
   - A systematic review of policies has not been conducted for more than four years; or In some instances, organizational policies have been implemented prior to, or without, governing body review or approval; or
   - The governing body review of management implementation of policies is sporadic.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization's executive director approves policies without involvement of the governing body; or
   - One of the elements is not addressed at all.

GOV 5.02 (FP)

The governing body:

a. works with management to evaluate the organization's financial capacities and the resources needed to provide services;
b. works with the CEO to secure adequate resources to implement the organization's strategic planning and budgeting decisions; and
c. oversees fundraising activities including establishing fundraising targets and goals that flow from the strategic plan.

Related Standards: FIN 1, FIN 3.01

Examples: *Actively supporting work to secure funding that is aligned with the organization's planning and budgeting decisions is one way the governing body can support the achievement of mission and improved outcomes for persons served.*

Examples: *While not all organizations fundraise, it is a vital means to achieving a flexible revenue base and is a traditional role assumed by nonprofit governing bodies. Strategies for resource development can include, for example, fundraising, grants, contracts for service, and new business development opportunities.*

Rating Indicators:
1. The organization's governing body actively fulfills its resource development responsibilities as per the requirements of the standard.

2. Practices are basically sound but there is room for improvement; e.g.,
    - The link between resource development and strategic goals and objectives needs clarification.
3. Practice requires significant improvement; e.g.,
    - Management is largely responsible for resource development with the governing body taking a secondary role while providing limited oversight of management's activities.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - The governing body is not involved in resource development.

GOV 5.03

The governing body's responsibilities regarding the executive director include:

a. appointment of the executive director;
b. collaboration with the executive director;
c. delegation of the authority and responsibility for organization management and policy implementation to the executive director;
d. oversight and annual evaluation of the executive director's compensation and performance against the organization's strategic goals and additional responsibilities outlined in the CEO's job description;
e. approval of the executive director's employment activities outside of the organization to ensure they do not interfere with her/his administrative responsibilities; and
f. evaluation of the effectiveness of its partnership with the executive director, at least every two years.

Examples: *Organizations may use a performance review tool to help examine the many facets of the CEO's performance including, for example: leadership, management of the organization, working relationship with the board and staff, and management of the organization's finances.*

In addition, criteria for evaluating compensation may include, for example: compensation paid to other CEOs in similar positions, compliance with regulations and guidelines regarding reasonable compensation, cost of living considerations, and the total professional experience of the CEO including advanced degrees and other experiences and skills that uniquely contribute to the success of the organization.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - There is minor confusion or overlap as to the relative roles of the governing body and the executive director (e.g., resource development); or
    - The governing body annually reviews the executive director's compensation but could improve the quality of its analysis with industry practice and/or federal requirements.
3. Practice requires significant improvement, e.g.,
    - The governing body evaluates the executive director's performance less than annually; or
    - The evaluation of the executive director is informal (not written, dated, or signed); or
    - The evaluation of the executive director is not comprehensive or does not use specific performance criteria; or
    - The executive director is not involved in the evaluation process; or
    - The executive director has not received governing body approval for unrelated external business activities; or
    - The governing body does not evaluate its partnership with the executive director.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
    - At least two of the elements are not addressed at all.

GOV 5.04

To ensure continuity during transitions in leadership, the organization maintains succession planning procedures and a succession plan.

Examples: *Information included in a succession plan may include, for example:*

1. *critical positions within the organization and their key leadership and management functions;*
2. *under what conditions interim authority can be delegated for those positions, including unexpected leadership disruptions and planned departures, and the limitations of that authority;*
3. *to whom various leadership and management functions will be delegated;*
4. *governing body and staff responsibilities as they relate to transition planning;*
5. *how succession planning and leadership transitions will be communicated to the governing body, staff, and other relevant stakeholders; and*
6. *mechanisms for assessing readiness to assume leadership positions and for providing training, mentorship, and other leadership development opportunities to support readiness.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 5.05 (FP)

The governing body annually assesses overall risk to the organization, including the organization's continuing ability to pursue strategic goals and meet the needs of persons served.

Related Standards: ASE 5.01, FIN 1, FIN 4.02, FIN 4.03, HR 3, HR 5, HR 6, HR 7, RPM 1, RPM 3.01, RPM 4.01, RPM 6.01

Interpretation: Organization staff may be responsible for assessing different areas of risk throughout the year and sending the results of the assessments to the governing body to inform its annual review of overall risks.

Examples: *Areas of potential risk can include, for example:*

1. *compliance with legal requirements;*
2. *disruption of operations due to a public health emergency;*
3. *technology and information management;*
4. *insurance and liability;*
5. *health and safety of administrative and service environments;*
6. *human resources practices, including use of independent contractors and volunteers;*
7. *contracting practices and compliance;*
8. *client rights and confidentiality issues;*
9. *financial risks;*
10. *public relations, branding, and reputation; and*
11. *conflicts of interest.*

Financial risk assessment involves the identification of factors or conditions related to funding and financial health that may pose a threat to the achievement of an organization's objectives and mission including, for example, the effectiveness and efficiency of financial operations and the reliability of financial reporting. Areas of known financial risk include:

1. *fraud and misuse of funds;*
2. *investments;*
3. *tax liabilities;*
4. *physical assets and financial information;*
5. *fundraising practices;*
6. *funding of benefits, including health retirement benefits, pensions, etc.; and*
7. *deferred revenue.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,

- While the governing body assesses risk annually, risk related to different aspects of the organization are reviewed by the board at different times of the year, inhibiting its ability to comprehensively assess overall risk.

3. Practice requires significant improvement; e.g.,
   - The governing body has not conducted a risk assessment within the last two years; or
   - Documentation of the annual risk assessment in minutes is weak or missing.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - A comprehensive risk assessment has not been conducted for more than two years or did not involve the governing body.

GOV 6: Organization Leadership

The executive director effectively collaborates with the governing body to enunciate and achieve the organization's mission and vision, promote a healthy organizational culture, and oversee and manage the organization's operations.

Interpretation: *There are varying titles for the head of an organization, such as President/CEO and Executive Director. Depending upon the type of organization or service, the individual fulfilling this role may have other designations, such as Operating Manager, Program Director, or Program Officer. The standard requires that there is a clearly identified person to whom the governing body delegates the day-to-day management of the organization and whom it holds accountable for the organization's performance.*

Self-Study Evidence

CEO resume	**File:** Professional Resume ko MHCO
CEO job description	**File:** Administrator Job Description

Site Visit Evidence *No On-Site Evidence*

On-Site Activities

*Interviews may include:

1. CEO
2. BOD chair
3. BOD members

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the GOV 6 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the GOV 6 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the GOV 6 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the GOV6 Practice standards.

GOV 6.01

The executive director's primary responsibilities are:

a. management of the organization;
b. implementation of organization-wide, long-term strategic planning and periodic reviews;
c. development of policies governing the organization's program of services with the governing body;
d. attendance at all meetings of the governing body; and
e. provision of regular reports to the governing body on the organization's operations, finances, and implementation of the long-term plan.

Related Standards: FIN 4.02

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.

2. Practices are basically sound but there is room for improvement; e.g.,
   - The executive director does not attend, or have a representative at every board meeting; or
   - Minor communication problems exist; or
   - The executive director and governing body are actively working to improve their effectiveness as a team in response to a few identified issues; or
   - One of the elements is not fully addressed, e.g., executive director reports to the governing body sometimes lack depth.
3. Practice needs significant improvement; e.g.,
   - The executive director tightly controls information the board receives, so that the board frequently lacks the information needed to make informed decisions and effectively govern; or
   - The executive director does not attend or provide staff support for two or more governing body and/or committee meetings per year; or
   - The executive director often provides only verbal reports, or provides written reports that are cursory or otherwise do not provide timely or useful information; or
   - Two of the elements are not fully addressed; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The partnership between the executive director and governing body is completely ineffective or nonexistent; e.g.
   - The governing body is asked only to ratify decisions or is told of decisions after the fact; or
   - The executive is excluded by the governing body action from most committee activity; or
   - More than three of the elements of the standard are not fully addressed; or
   - Two or more elements are not addressed at all.

GOV 6.02

The executive director is qualified by:

a. an advanced degree from an accredited college or university in a field related to the organization's mission and services;
b. at least five years of related leadership experience;
c. experience administering services to families, adults, youth and/or children;
d. the skills to oversee human resources and financial management matters; and
e. the ability to work effectively and proactively with other providers, and local, state and federal entities.

Rating Indicators:

1. The organization's executive director is qualified as per the requirements of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The executive director does not meet element (a), however he/she is qualified as per elements (b) – (e); or
   - The executive director meets the advanced degree requirement but has less than five years of related leadership experience; or
   - The executive director has limited skills to oversee human resource and/or financial management matters but is receiving training to develop/enhance these skills or has consultants that provide support and advice.
3. Practice requires significant improvement; e.g.,
   - The executive director does not meet two of the standard's elements.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 7: Conflict of Interest

The organization prevents the enrichment of insiders and other abuses through the adoption and enforcement of a conflict-of-interest policy.

Note: *Please see the Conflict of Interest Policy and Procedures Template for additional guidance on this standard.*

Self-Study Evidence

*Ethical referral policy	**File:** Referrals for Family Support Services Procedure
*Policy prohibiting preferential treatment	**File:** Fair and Equitable Treatment Policy

	File: Nepotism Policy **File:** Employee Grievance Policy **File:** Conflict of Interest Policy
*Conflict of interest policy	**File:** Conflict of Interest Policy

Site Visit Evidence

- Governing body and/or committee meeting minutes documenting discussions of potential and apparent conflicts of interest from the previous 12 months

On-Site Activities

*Interviews may include:

1. CEO
2. Governing body
3. Advisory group
4. CFO
5. Relevant personnel
6. Persons served/community members

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the GOV 7 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the GOV 7 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the GOV 7 Practice standards; e.g.,
   - Conflict of interest policy provides minimal guidance to stakeholders due to lack of specificity, significant missing elements, or significant stakeholders not covered; or
   - Minor conflict of interest concerns are noted.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the GOV7 Practice standards; e.g.,
   - Significant conflict of interest concerns have been reported.

GOV 7.01 (FP)

A conflict-of-interest policy is tailored to the organization's specific needs and characteristics, and:

a. defines conflict of interest;
b. identifies groups of individuals within the organization covered by the policy;
c. addresses policy enforcement;
d. provides a framework for evaluating situations that may constitute a conflict; and
e. invests management with developing procedures that facilitate disclosure of information to prevent and manage potential and apparent conflicts of interest.

Rating Indicators:

1. The organization has implemented a conflict of interest policy as per the requirements of the standard.
2. Practices are basically sound, but there is room for improvement; e.g.,
   - One of standard's elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - The policy provides minimal guidance to stakeholders due to lack of specificity; or
   - Stakeholders are unaware of the policy; or
   - Two of the elements are not fully addressed; or
   - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - No policy exists; or
   - The policy is not enforced or is ignored in practice.

GOV 7.02 (FP)

The conflict-of-interest policy requires governing body members, advisory group members, personnel, and consultants who have a financial interest in the organization's assets, business transactions, leases, or professional services to:

a. disclose this information; and
b. not participate in any discussion or vote taken with respect to such interests.

Interpretation: *Governing body members who receive compensation for professional services they provide as consultants cannot be part of the organization's audit review process.*

Rating Indicators:

1. The organization's conflict of interest policy fully addresses the requirement for disclosure of conflicts of interest and for recusal from decisions related to such interests.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The policy related to one of the standard's elements needs clarifying.
3. Practice requires significant improvements; e.g.,
   - Applicable stakeholders are not clearly identified; or
   - The types of transactions that must be disclosed are not delineated; or
   - Safeguards regarding disclosure or recusal are insufficient; or
   - Governing body members or other important stakeholders are not aware of the policy.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Conflict of interest violations have occurred.

GOV 7.03

The conflict-of-interest policy addresses nepotism with regard to hiring, supervision, and promotion.

Interpretation: *This standard permits the hiring of relatives, provided that relatives are qualified and do not work within the same hierarchy of supervision.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspect of the policy requires clarification.
3. Practice requires significant improvement, e.g.,
   - Staff report that there have been instances of nepotism or preferential treatment; or
   - The organization chart indicates that at least one person is directly supervised by a relative.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

GOV 7.04

The organization prohibits:

a. making or accepting payment or other consideration in exchange for referrals;
b. preferential treatment of organization members, community partners, members of the organization's governing body, advisory groups, personnel, or consultants applying for and receiving the organization's services; and
c. steering or directing referrals to private practices in which personnel, consultants, or the immediate families of personnel and consultants are engaged.

Interpretation: *It is permissible to include on referral lists personnel and consultants with private practices, or family members of personnel and consultants, but the organization may not actively direct service recipients to the practices of these individuals and must clarify in writing the relationship between the private practitioners and the organization.*

Interpretation: *When private practice is permitted on the organization's premises persons served should receive information clarifying the relationship between the private practitioner and the organization.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspects of the policy are vaguely written, but there have been no ethical violations of the principles outlined in the standard.
3. Practice requires significant improvement, e.g.,
   - Significant aspects of the policy are vaguely written or confusing; or
   - The policy does not address at least one of the standards elements; or
   - The policy exists but enforcement is lax and there have been a few instances where it has been violated; or
   - The policy is generally understood but it is an unwritten expectation.
4. Implementation of the standard is minimal or there is no evidence of implementation at all: e.g.,
   - No policy exists; or
   - The policy is not enforced or is ignored in practice.

GOV 8: Protection of Reporters of Suspected Misconduct

The organization prohibits employment-related retaliation against employees, and others affiliated with the organization, who come forward with information about suspected misconduct or questionable practices, and provides an appropriate, confidential channel for reporting such information.

Note: *Please see the Whistleblower Policy Template for additional guidance on this standard.*

Self-Study Evidence

*Policy protecting reporters of suspected misconduct	**File:** Protection of Suspected Misconduct Reporting Policy
*Procedures for reporting suspected misconduct	**File:** Employee Grievance Procedure **File:** Protection of Suspected Misconduct Reporting Policy **File:** Stakeholder Grievance Policy

Site Visit Evidence

*Documentation of any grievances/incidents related to retaliation

On-Site Activities

*Interviews may include:

1. CEO
2. HR director
3. Relevant personnel

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The definition of what constitutes a reportable violation lacks specificity.
3. Practice requires significant improvement; e.g.,
   - There is a perception among staff that procedures do not adequately protect anonymity; or
   - Procedures are not readily available, or staff and board members are not aware they exist; or
   - Procedures do not adequately protect against retaliation.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Staff report feeling afraid or intimidated.

Administration and Management Standards

Human Resources

Purpose
The organization's human resources practices attract and retain a competent and qualified workforce that contributes to consumer satisfaction and positive service delivery results and supports the achievement of the organization's mission and strategic goals.

Introduction
Since an organization's workforce performs the tasks and provides the services that fulfill the organization's mission, its capacity to attract and retain a stable, competent, and qualified workforce is the foundation for achieving positive results for the people and communities it serves. As such, it is incumbent upon Human Resources Management to develop and implement strategies, plans, and programs necessary to attract, motivate, develop, reward, and retain the best people to meet the organization's goals and objectives.

Interpretation: *The HR standards apply to all "personnel" which includes both full-time and part-time employees. Standards that apply to direct service volunteers and independent contractors specifically note their inclusion. COA does not include non-direct service, occasional, or casual volunteers in evaluating an organization's human resources practices, but organizations should consider the benefits and risks associated with their role.*

Note: *Please see the HR Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see HR Crosswalk.*

Table of Evidence
Self-Study Evidence No Self Study Evidence

HR 1: Human Resources Planning

The organization assesses its workforce as part of annual planning and prepares for future needs by:

a. comparing the composition of its current workforce, including number of employees, skills, demographics, and cultural characteristics, with projected workforce needs; and
b. determining how to close gaps, when needed, through recruitment, training, leadership development, and/or outsourcing.

Related Standards: GOV 2.03, TS 1.01

Examples: *To address employment or leadership selection patterns that do not reflect the community served, organizations may establish a plan that includes:*

1. *targeted recruitment goals and strategies;*
2. *reviewing policies and criteria to identify factors that may pose systemic obstacles to employment or advancement; and*
3. *equitable leadership and personnel development programs.*

Leadership development programming can include, but is not limited to: trainings, degree or certificate programs, review of relevant professional literature or research, shadowing, additional assignments to develop new skills, leadership mentoring, and exposure to functions outside the individual's current role. Organizations can promote equitable access to leadership development programs by setting transparent, objective, performance-driven eligibility criteria and considering conflicts with job responsibilities when planning activities.

Note: *Please see the Workforce Assessment and Planning Tip Sheet for additional guidance on this standard.*

Self-Study Evidence

*Assessment of workforce needs	**File:** Staff-Qualifications-Workload-Report
*Community Demographic Profile	
*A list of administrative and management personnel by department that includes: 1. name 2. title 3. degrees held and/or other credentials 4. role (e.g. employee, volunteer, or contractor)	**File:** ILP Program Personnel **File:** DC Program Personnel

Site Visit Evidence

No On-Site Evidence

On-Site Activities

- Interviews may include:
    1. CEO
    2. HR Director
    3. Program/department directors

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - The workforce assessment is conducted but is not effectively integrated into annual planning; or
    - Strategies for closing identified gaps need improvement.
3. Practice requires significant improvement; e.g.,
    - The organization has not assessed workforce needs for more than two years; or
    - The assessment only addresses some of the programs or services; or
    - The assessment indicates significant gaps but the organization has not taken steps to address them.
4. Implementation of the standard is minimal or there is no evidence that an analysis has been conducted within the past four years.

HR 2: Recruitment and Selection

The organization hires appropriately qualified personnel to meet the demand for services and support the achievement of the organization's mission.

Note: *Please see the Personnel Records Checklist for additional guidance on this standard.*

Table of Evidence

Self Study Evidence

*Background check policy	**File:** Background Checks Policy
*Background check procedures	**File:** Background Checks Policy
*Recruitment and selection policies	**File:** Recruitment and Selection Policy and Procedure
*Recruitment and selection procedures	**File:** Recruitment and Selection Procedure

Site Visit Evidence

*Sample job descriptions from across job categories or positions
*Relevant portion of governing body minutes when HR selection policies were reviewed and approved

On-Site Activities

- Interviews may include:
    1. HR director
    2. Senior managers
    3. Supervisors
    4. Relevant personnel

- Review personnel records

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the HR 2 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the HR 2 Practice standards; e.g.,
    - With few exceptions, personnel possess the requisite qualifications; or
    - There are a few vacancies, but quality of service or organizational performance is not impacted in any observable way.
3. Practice requires significant improvement, as noted in the ratings for the HR 2 Practice standards; e.g.,
    - There is a pattern of personnel who lack the requisite qualifications, though few in number in any given service;
    - One or more organizational services cannot meet this standard; or
    - There are significant vacancies in some programs which affect service provision (i.e., high caseloads, or staff unable to meet job expectations).
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the HR 2 Practice standards; e.g.,
    - Personnel consistently do not meet the qualifications for the position and/or for their title.

HR 2.01 (FP)

Job descriptions and selection criteria:

a. state the credentials, job expectations, core competencies, essential functions, and responsibilities for each position or group of like positions;
b. include inclusive language and demonstrate the organization's commitment to equity, diversity and inclusion;
c. include sensitivity to the service population's cultural and socioeconomic characteristics; and
d. are reviewed and updated regularly to evaluate their continued relevancy against the needs and goals of the organization's programs and persons served.

Examples: *Credentials can include, for example:*

1. *education;*
2. *training;*

3. *relevant experience;*
4. *competence in required role;*
5. *recommendations of peers and former employers; and*
6. *any available state registration, licensing, or certification for the respective disciplines.*

Examples: *Examples of inclusive language in job descriptions can include:*
1. *language regarding accommodation for different abilities;*
2. *neutral language to eliminate age, cultural, racial, and gender biases; and*
3. *highlighting inclusive benefits that support a diverse workforce directly in the job description.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - All but a few job descriptions comply with the standard, e.g., are comprehensive and up-to-date; or
   - One of the standard's elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - One of the standard's elements has not been implemented at all;
   - In a significant percentage of cases, the organization does not comply with the standard, e.g., job descriptions are incomplete, vague, or omit qualifications; or
   - Several positions do not have job descriptions.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 2.02

Recruitment and selection procedures include:

a. notifying personnel of available positions;
b. verifying past employment and credentials;
c. providing applicants with a written job description;
d. giving final candidates the opportunity to speak with currently-employed personnel;
e. using standard interview questions that comply with employment and labor laws; and
f. using diverse interview panels.

Related Standards: RPM 1

Examples: Diverse panels with representatives from different backgrounds, departments, and seniority levels offer new perspectives, encourage organizations to think broadly and inclusively, and minimize bias.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures need greater clarity; or
   - Recruitment and selection procedures address the use of diverse interview panels, but staff report it is not always happening in practice; or
   - One of the standard's elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - Procedures are very general and/or do not provide useful guidance; or
   - Recruitment and selection procedures do not address using diverse interview panels at all; or
   - Two elements are not fully addressed or one of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 2.03 (FP)

Screening procedures include appropriate, legally permissible, and mandated reviews of state criminal history records and civil child abuse and neglect registries for new employees, contractors, volunteers, and student interns who will:

a. work in residential programs;
b. provide direct services to, or be alone with, children, the elderly, or other persons determined by the organization to be vulnerable or at risk; or
c. work with sensitive or confidential information such as personnel and client records.

Related Standards: RPM 1

Interpretation: *The organization is not required to conduct background checks for licensed staff if the organization has verified that background checks are conducted as part of the licensing process. The organization should assess whether there is any risk associated with not conducting background checks on staff not expressly addressed in the standard and consult with legal counsel, as needed. The requirements do not apply to current employees and contractors or to agencies with which the organization contracts for services.*

Interpretation: *The organization should not use criminal history records to deny employment to qualified individuals unless the nature of the conviction is related to the job duties. The organization should consult with legal counsel about any concerns regarding the appropriate use of background information.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard, e.g.,
   - Practice reflects that the organization understands the legal requirements regarding criminal records checks and review of civil child abuse and neglect registries, and conducts legally permissible reviews for new employees, contractors, volunteers, and student interns.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures for verifying background checks for licensed personnel need strengthening.
3. Practice requires significant improvement; e.g.,
   - In rare cases background checks are not completed prior to personnel being left alone with vulnerable populations or having access to sensitive or confidential information.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization consistently does not screen personnel per the requirements of the standard; or
   - Screening procedures violate applicable law; or
   - Procedures are vague or non-existent.

<u>HR 2.04</u>

An organization that recruits and selects employees with specific cultural traits or other characteristics establishes that such selectivity is:

a. legally permissible;
b. reviewed and approved by the organization's governing body, as applicable; and
c. appropriately considered a bona fide occupational qualification central to meeting the needs of persons served.

NA: The organization does not recruit and select personnel with specific cultural traits or other characteristics.

Related Standards: RPM 1

Examples: *An organization under religious auspices might seek legal advice to confirm that it may require employees to belong to a specific religious affiliation if knowledge of and commitment to the values of the religious tradition are necessary to accomplish the activities of the organization.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement; e.g.,
   - The organization has not verified that practices are legally permissible, e.g.,
     - Bona fide occupational qualification; and/or
     - Criteria based on religious affiliation.
   - Selection criteria have not been reviewed and approved by the organization's governing body.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 3: Satisfaction and Retention

Human resources practices are equitable and consistently applied and promote a high level of personnel satisfaction and retention.

Related Standards: GOV 5.05

Examples: *Factors that may contribute to staff satisfaction and retention include:*

1. *role clarity;*
2. *regular team, organizational, and divisional meetings to promote open communication and collaboration among disciplines and staff levels;*
3. *leadership that encourages initiative, creativity, and innovation;*
4. *leadership that rewards and recognizes employee contributions;*
5. *satisfaction with salary and benefits;*
6. *work-life policies and practices, such as flexible work options;*
7. *leadership that provides feedback to personnel about their suggestions and recommendations;*
8. *reasonable workload;*
9. *autonomy;*
10. *opportunities for advancement; and*
11. *opportunities for career development.*

Note: *Please see the Personnel Records Checklist for additional guidance on this standard.*

Self-Study Evidence

*Summary results of most recent staff satisfaction survey	**File:** PQI Report/Survey Results **File:** Masonic Home OSC Report
* Summary results of most recent staff retention analysis	**File:**
* Table of Contents for personnel policies and procedures manual	**File:** Manual Table of Contents.pdf
* Personnel grievance procedures	**File:** Employee Grievance Procedure

Site Visit Evidence

- Documentation of actions taken to address satisfaction and retention concerns
- Personnel policies and procedures manual
- Grievance reports for the past six months

On-Site Activities

- Interviews may include:
    1. CEO
    2. Governing Body
    3. HR Director
    4. Relevant personnel
- Review personnel records

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the HR 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the HR 3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the HR 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the HR 3 Practice standards.

HR 3.01

The organization annually measures personnel satisfaction and retention and takes action to address identified satisfaction and retention concerns.

Related Standards: GOV 2.03, PQI 3.03

Interpretation: *The aggregation of data reduces the risk of disclosing personal identifiable information in most instances; however, risk of disclosure still exists particularly when data is being disaggregated and unique or easily observable characteristics might allow someone to be identified in the data set. As such, data collection and reporting procedures should include mechanisms for avoiding such disclosure such as data suppression, rounding, reporting in ranges rather than exact counts, combining sub-groups into larger groups, etc.*

Examples: *Disaggregated data can be useful in addressing identified satisfaction, retention, turnover, hiring, and promotion concerns. Common characteristics used to disaggregate data include:*

1. *race and ethnicity/country of origin;*
2. *generation status;*
3. *immigration/refugee status;*
4. *age group;*
5. *sexual orientation; and*
6. *gender/gender identity*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Satisfaction and/or retention are not formally measured for a few departments and/or programs.
3. Practice requires significant improvement; e.g.,
    - Satisfaction and/or retention are not formally measured for a number of the organization's departments or programs;
    - Staff satisfaction and/or retention has not been formally measured for more than two years; or
    - The organization collects data on staff satisfaction and turnover but does not take action to address concerns; or

- Retention data has been aggregated but there is no indication of how it is used.

4. The organization does not measure staff satisfaction and/ or retention.

HR 3.02

All personnel confirm receipt of an up-to-date personnel policies and procedures manual that articulates current:

a. conditions of employment;
b. benefits;
c. rights and responsibilities of employees; and
d. other important employment-related information.

Examples: *Policies and procedures that are commonly addressed in a personnel manual include:*

1. *the organization's equity statement;*
2. *conditions and procedures for layoffs;*
3. *emergency and safety procedures;*
4. *equal employment policies;*
5. *harassment and discrimination;*
6. *nepotism and favoritism protections;*
7. *grievance process procedures;*
8. *insurance protections including unemployment, disability, medical care, and malpractice liability;*
9. *performance review system;*
10. *promotions;*
11. *professional development;*
12. *standards of conduct;*
13. *time-off policies;*
14. *wage policy;*
15. *working conditions;*
16. *technology/network security and usage policies; and*
17. *the use of social media, electronic communications, and mobile devices.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - A few of the organization’s procedures are vaguely written or incomplete; or
   - A few staff report not having a copy of, or access to, the manual.
3. Practice requires significant improvement; e.g.,
   - The manual does not include a few important policies or procedures; or
   - A significant number of staff did not confirm receipt of the manual.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 3.03

The organization reviews and updates the personnel policies and procedures manual every two years with an equity, diversity, and inclusion lens to ensure the manual remains up-to-date and promotes equity throughout the organization.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.

2. Practices are basically sound but there is room for improvement; e.g.,
    - Policies and/or procedures have not been reviewed in the past 2 years, but a review is underway; or
    - There is minimal evidence that the manual has been reviewed through an EDI lens.
3. Practice requires significant improvement; e.g.,
    - Policies and/or procedures have not been reviewed for more than three years; or
    - Evidence that the manual has been reviewed through an EDI lens is not present.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 3.04

The organization establishes personnel grievance procedures, which include:

a. the right to file a grievance without interference or retaliation;
b. a description of how grievances are filed, to whom, and who will make a final determination;
c. timely written notification of the resolution and an explanation of any further appeal, rights, or recourse;
d. processes for review including a third-party review of the final determination;
e. documenting responses and actions taken; and
f. maintaining a copy of the notification of resolution in the personnel record.

Interpretation: *Regarding element (d), the third-party review refers to at least one level of review that does not involve the person about whom the complaint has been made or the person who reached the decision under review. If a grievance is raised against the CEO, then the grievance will go directly to the governing body.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the required elements is not fully addressed; or
    - In a few instances staff were not aware of the procedures or did not know how to access them.
3. Practice requires significant improvement; e.g.,
    - Two or more of the required elements are not fully addressed; or one element is not addressed at all;
    - A significant number of staff members were not aware of the procedures or did not know how to access them.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 3.05

The organization provides all departing personnel with an opportunity to participate in an exit interview and documents their feedback or exit interview declination in the personnel record.

Examples: *This interview can provide an opportunity for personnel to share feedback such as administrative issues related to the transition or input on the organization's strengths and weaknesses.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Documentation of exit interviews is not comprehensive and/or used for performance improvement.
3. Practice requires significant improvement; e.g.,
    - Exit interviews are sporadic and/or occur only at the request of the employee.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 4: Performance Review

The performance review process tracks progress towards meeting performance goals, recognizes accomplishments, and emphasizes self-development and professional growth.

Related Standards: TS 3.01

Note: *Please see the Personnel Records Checklist for additional guidance on this standard.*

Self-Study Evidence

*Performance review procedures	**File:** Performance Appraisal Procedure
*Performance evaluation forms/templates	**File:** Performance Evaluation Form

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

- Interviews may include:
    1. HR Director
    2. Supervisors
    3. Relevant personnel
- Review personnel records

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the HR 4 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the HR 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the HR 4 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the HR 4Practice standards.

HR 4.01 (FP)

The organization provides every full-time and part-time employee with an annual, written performance review that involves the employee and the supervisor.

Related Standards: TS 3.02

Examples: *The organization can promote active participation by personnel in the performance review process by:*

1. *designating time to discuss the written review; and*
2. *soliciting the individuals' input on his or her accomplishments, challenges, and objectives for future performance and professional development.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some performance evaluations were not completed within stated timeframes; or
   - A few staff did not receive an evaluation within the most recent evaluation cycle.
3. Practice requires significant improvement; e.g.,
   - Performance evaluations have not been conducted within the last two years; or
   - Evaluations are poorly documented or missing in some personnel files; or
   - The process, including timeframes, differs significantly between departments or programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 4.02

Staff performance reviews emphasize self-development and professional growth and include:

a. specific expectations defined in the job description;
b. organization-wide expectations for personnel;
c. objectives established in the most recent review, accomplishments and challenges since the last review period, and objectives for future performance, including developmental and professional objectives;
d. strategies to continue developing cultural humility;
e. recommendations for training; and
e. an assessment of the staff member's knowledge and competence related to the characteristics and needs of service recipients, if applicable.

Related Standards: TS 1.01

Examples: *Organization-wide expectations for personnel can include attitudes, knowledge, and skills needed to effectively implement evidence-based practices with fidelity, when applicable.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - In a substantial percentage of cases, the organization complies with the standard; or
   - One of the required elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - In a significant percentage of cases, the organization does not address two of the required elements;
   - The organization does not consistently conduct evaluations across departments and/or programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 4.03

Personnel have the opportunity to sign, obtain a copy of, and provide comments on written performance reviews.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures need clarifying; or
   - A few staff report being unaware of their rights as per the requirements of the standard.
3. Practice requires significant improvement; e.g.,
   - Many staff report being unaware of their rights as per the requirements of the standard; or

- Practice is informal and has not been outlined in procedure; or
- The procedure is inconsistently applied across departments and/or programs.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 5: Personnel Records

The organization maintains a personnel record for each employee.

Related Standards: GOV 5.05

Note: *See RPM 5: Security of Information for more information on appropriately limiting access to personnel records to protect confidentiality.*

Note: *Please see the Personnel Records Checklist for additional guidance on this standard.*

Self-Study Evidence

*Procedures for maintaining personnel records	**File:** Employee Records Access Procedure
*Procedures regarding access to personnel records	**File:** Employee Records Access Procedure

Site Visit Evidence

Site Visit Evidence

On-Site Activities

- Interviews may include:
    1. HR Director
    2. Supervisors
    3. Relevant personnel
- Review personnel records

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the HR 5 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the HR 5 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the HR 5 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the HR 5 Practice standards.

HR 5.01 (FP)

Personnel records are updated regularly and contain:

a. identifying information and emergency contacts;
b. application for employment, hiring documents including job postings and interview notes, and reference verification;
c. job description signed by the employee;
d. compensation documentation, as appropriate;
e. pre-service and in-service training records;

f. health information or reports for annual physical examinations, appropriate to the job position or when required by law; and
g. performance reviews and all documentation relating to performance, including disciplinary actions and termination summaries if applicable.

Related Standards: RPM 1

Interpretation: *An organization may maintain records in separate files according to its own record keeping system as required by law or regulation. For example, EAP records, health benefits enrollment forms, documentation of a grievance/complaint and response documents, immigration status documentation, and EEOC-related records must be kept separately from other personnel records.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - With few exceptions, the organization complies with the standard, but a few records reviewed on newly hired personnel have not yet been completed; or
   - Documentation in a few records needs updating.
3. Practice requires significant improvement; e.g.,
   - Many personnel records did not include all the relevant elements; job descriptions, pre- and post-service training, interview notes, questions, etc.; or
   - Documents in many records are outdated or missing.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Personnel records are consistently incomplete or missing required documentation; or
   - There is evidence that personnel records are not appropriately maintained, e.g., different record components are not separated.

HR 5.02
Personnel may review, add, and correct information contained in their records.

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Personnel report that they are able to make additions or corrections, but procedures need some clarification.
3. Practice requires significant improvement; e.g.,
   - Personnel are uncertain about procedures, and there is no evidence of management's effort to clarify the issue.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 6: Volunteers

The organization recruits and retains a competent and qualified volunteer pool.

NA Taken in 2021: *The organization does not use direct service volunteers, student professionals, or interns.*

Related Standards: GOV 5.05

Self-Study Evidence

*Volunteer/intern supervision procedures	
*Procedures for developing and reviewing volunteer/intern assignments	

Site Visit Evidence

- Sample volunteer/intern assignments from across categories
- Documentation tracking volunteer/intern completion of required trainings

On-Site Activities

- Interview:
    1. Personnel responsible for recruitment and supervision of volunteers/interns
    2. Volunteers/Interns
- Review volunteer/intern records

HR 6.01

A written assignment is developed, and periodically reviewed, for each volunteer, student professional, and intern position that includes:

a. duties;
b. time commitment;
c. responsibilities and prohibited activities;
d. required skill sets, credentials, or trainings; and
e. lines of supervision and the process for providing ongoing feedback.

NA Taken in 2021: *The organization does not use direct service volunteers, student professionals, or interns.*

Interpretation: *Written assignments for student professional and interns should be provided by the placing organization.*

Examples: *Organizations can support appropriate assignments for prospective volunteers by using an interview process that includes, for example, consideration of their skills, interests, abilities, relevant experience, and availability; and matching those with the available volunteer opportunities at the organization.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Written volunteer/intern assignments require greater clarity; or
    - One of the standard's elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
    - For some volunteer/intern assignments roles and responsibilities are only communicated verbally; or
    - Two of the standard's elements are not fully addressed; or
    - One of the standard's elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 6.02

Direct service volunteers, student professionals, and interns are:

a. directly supervised by licensed or otherwise accountable professionals;
b. appropriately trained to fulfill their role; and
c. participate in regular discussions and receive feedback regarding their performance.

NA Taken in 2021: *The organization does not use direct service volunteers, student professionals, or interns.*

Examples: *When determining methods and timelines for providing regular feedback, the organization may consider the qualifications and experiences of the volunteer, educational requirements for students, and the complexity and intensity of the assignment.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - With few exceptions volunteers, etc. are supervised as per the standard.
3. Practice requires significant improvement; e.g.,
   - A significant number of volunteers, etc. are not appropriately supervised; or
   - Documentation of supervision is poorly maintained or nonexistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

HR 7: Independent Contractors

The organization:
a. exercises due diligence when contracting with independent contractors; and
b. routinely monitors compliance with contract requirements.

NA: The organization does not use independent contractors.

NA Taken in 2021: *The organization does not use independent contractors.*

Related Standards: GOV 5.05

Self-Study Evidence

*Procedures for contracting and monitoring contracts with independent contractors	
*Procedures for collecting quality data from contractors	
*Procedures for maintaining independent contractor records	
*Case record content and maintenance procedures that address contractor requirements	

Site Visit Evidence

- Sample contracts with independent contractors
- Documentation of contract compliance, including evidence of competencies/requirements associated with necessary qualifications and trainings

On-Site Activities

- Interviews may include:
  1. Relevant personnel
  2. Independent contractors
- Review independent contractor client records
- Review independent contractor records

HR 7.01 (FP)

Written contracts with independent contractors:
a. are time-limited with a specified end date;
b. define scope-of-work, expectations, and deliverables with specific timeframes;
c. specify competencies, including necessary qualifications and trainings;

d. describe protocols for routine communication of relevant information and data, including confidential information;
e. include requirements for maintaining client records, documentation of services, and organization access to client records;
f. describe expectations for contractor involvement in the organization's quality improvement process; and
g. include under what circumstances the contract can be terminated.

NA Taken in 2021: *The organization does not use independent contractors.*

Related Standards: PQI 1.02,

Interpretation: *Competencies for independent contractors providing direct services must include the relevant trainings and qualifications, as appropriate to their roles, listed in COA's Administration and Management, service Delivery Administration, and the applicable Service Standards. For example, if the organization is using contractors to deliver mental health services, then contracts must include the qualifications listed in the Personnel section of COA's Mental Health and/or Substance Use Services (MHSU) standards, as well as TS 2. Organizations should obtain documentation from contractors that verifies their competencies, such as degrees or trainings they have received, in order to demonstrate implementation needed to rate the standards within the appropriate sections.*

Examples: *Competencies may include education, training, experience, degree requirements, certifications, licenses, and pursuit of CEUs, as applicable.*

HR 7.02
Written contracts with independent contractors who provide direct services include criteria for:

a. service quality;
b. client satisfaction; and
c. outcomes that accord with the organization's expectations.

NA Taken in 2021: *The organization does not use independent contractors.*

Related Standards: PQI 3.01, PQI 3.02

HR 7.03 (FP)

Prior to entering into a contract, the organization verifies in writing that each contractor:
a. possesses the necessary qualifications;
b. is licensed and/or has certification, where applicable;
c. has relevant experience including experience delivering services to the service population, if providing direct services; and
d. carries professional liability insurance, as required by law or generally accepted business practices.

NA Taken: *The organization does not use independent contractors.*

HR 7.04 (FP)
The organization establishes procedures for how client records are maintained by independent contractors that address:

a. ownership of records;
b. information that must be recorded in client records;
c. organization access to client records for internal and external quality oversight, including review by Medicaid and/or other external funders or regulators, and accrediting bodies;
d. secure storage;
e. destruction of records;
f. whether copies of records may be retained by the contractor; and
g. maintaining client confidentiality.

NA Taken in 2021: *The organization does not use independent contractors to provide direct services to clients.*

Related Standards: PQI 4

HR 7.05

The organization has procedures to:
a. routinely monitor and document contractor progress toward fulfilling the terms of the contract; and
b. review contractor performance against identified deliverables prior to contract renewal.

NA Taken in 2021: *The organization does not use independent contractors to provide direct services to clients.*

Interpretation: *For standards that will be implemented by independent contractors (e.g., CR, BSM, and ASE), the organization must:*
1. *provide contractors with a comprehensive policy and procedure manual or include copies of relevant policies and procedures in contracts with independent contractors;*
2. *include contract language regarding a contractor's obligation to adhere to organization policies and procedures; and*
3. *routinely monitor and document compliance with organization policies and procedures.*

HR 7.06 (FP)

The organization maintains a record for each independent contractor that contains:
a. identifying and contact information;
b. application, resume, and documentation of qualifications;
c. IRS Form SS-8 or an internal assessment that the individual was properly classified as an independent contractor per Internal Revenue Service guidelines;
d. a completed IRS W-9 form;
e. documentation of reference checks;
f. documentation of qualifications per HR 7.03;
g. a background check per HR 2.03;
h. a copy of the contract;
i. a signed statement that the contractor will adhere to the organization's conflict of interest policies;
j. a signed confidentiality agreement; and
k. documentation of quality monitoring of contractor performance.

NA Taken: *The organization does not use independent contractors.*

Not Applicable Ratings

The Masonic Home for Children at Oxford, Inc. (#2599)

Overview

This document displays all of your Accreditation Standards that allow a rating of Not Applicable (NA) along with those which your organization or program has taken. Please review these NAs carefully prior to the submission of your Self-Study to ensure that they are correct and true. If any changes need to be made, log into your MyCOA portal and click on "Manage NAs" to make those changes. If you have any questions, contact your COA Coordinator.

Administration and Management Standards **FIN**		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
FIN 6.04	☐	The organization does not assume fiduciary responsibility for, or disburse client or non-fee-for-service funds to service recipients.
FIN 7	☐	The organization does not raise funds through solicitations or general funding events.

Administration and Management Standards **GOV**		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
GOV 2	☐	The organization is a network management entity.

Administration and Management Standards GOV		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
GOV 3	☐	The organization is a network management entity assigned the Network Administration (NET) standards that does not provide any direct services to individuals served by the network and is not being reviewed under any Service Standards.

Administration and Management Standards HR		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
HR 2.04	☐	The organization does not recruit and select personnel with specific cultural traits or other characteristics.
HR 6	☐	The organization does not use direct service volunteers, student professionals, or interns.
HR 7	☐	The organization does not use independent contractors.
HR 7.02	☐	The organization does not use independent contractors to provide direct services to clients.
HR 7.04	☐	The organization does not use independent contractors to provide direct services to clients.

Administration and Management Standards PQI		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
PQI 4	☐	The organization is a network management entity assigned the Network Administration (NET) standards that does not provide any direct services to individuals served by the network and is not being reviewed under any Service Standards. The organization is only assigned the Early Childhood Education (ECE) and/or Out-of-School Time Services (OST) standards. The organization provides only non-clinical group, crisis intervention, and/or information and referral services.

Administration and Management Standards RPM		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
RPM 5.05	☐	The organization does not electronically manage health records or protected health information.
RPM 6.03	☐	The organization does not enter into non-contractual service agreements.
RPM 7	☐	The organization does not purchase social and human services from other organizations.

Service Delivery Administration Standards ASE		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
ASE 2.01	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards.
ASE 2.02	☐	The organization is only assigned the Financial Education and Counseling (FEC), Early Childhood Education (ECE), and/or Out-of-School Time Services (OST) standards.

Service Delivery Administration Standards ASE		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
ASE 2.03	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards.
ASE 4.02	☐	The organization does not permit or require transporting clients in agency- or privately-owned vehicles.
ASE 4.03	☐	The organization does not offer services on a consistent and on-going basis at locations it does not own or lease.

Service Delivery Administration Standards BSM		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
BSM	☐	The organization's behavior support and management policy submitted as ASE 2 self-study evidence prohibits all use of restrictive behavior management interventions.
BSM 4.03	☐	The organization does not escort service recipients or use seclusion.
BSM 4.04	☐	The organization does not use seclusion.
BSM 4.08	☐	The organization does not use seclusion or mechanical restraint.

Service Delivery Administration Standards CR		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
CR 1.06	☐	The organization does not serve minors without consent from a parent or legal guardian.
CR 1.07	☐	The organization does not charge the client any fees, co-payments, or other forms of payment in exchange for services.
CR 3	☐	The organization does not permit research involving service recipients.

Service Delivery Administration Standards PRG		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
PRG 1	☐	The organization is only assigned the Early Childhood Education (ECE), Out-of-School Time Services (OST), and/or Community Change Initiatives (CCI) standards. The organization provides only non-clinical group, crisis intervention, and/or information and referral services.
PRG 1.03	☐	The organization does not obtain legal or medical information.
PRG 1.06	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards.
PRG 2	☐	The organization is only assigned the Early Childhood Education (ECE), Out-of-School Time Services (OST), and/or Community Change Initiatives (CCI) standards. The organization provides only non-clinical group, crisis intervention, and/or information and referral services.
PRG 2.03	☐	Applicable law prohibits limiting a person's access to their case record for any reason.

Service Delivery Administration Standards PRG		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
PRG 3	☐	The organization does not prescribe, dispense, administer, or store medication.
PRG 3.02	☐	The organization does not prescribe medication.
PRG 3.03	☐	The organization does not prescribe or administer medication.
PRG 3.04	☐	The organization does not dispense or administer medication.
PRG 3.05	☐	The organization does not store medication.
PRG 3.06	☐	The organization does not administer medication.
PRG 3.07	☐	The organization does not administer medication.
PRG 3.08	☐	The organization does not prescribe or administer psychotropic medication for children and youth.
PRG 4	☐	The organization does not engage service recipients in technology-based service delivery.
PRG 5	☐	The organization does not provide any programs or services focused on serving persons with intellectual and developmental disabilities. The organization is implementing the standards for Intellectual and Developmental Disabilities Services (IDDS).

Service Delivery Administration Standards PRG		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
PRG 5.02	☐	The organization does not use interventions that limit physical movement, diminish sensory experience, restrict personal freedoms, or cause personal discomfort.
PRG 6	☐	The organization does not provide any programs or services focused on serving persons with intellectual and developmental disabilities. The organization is implementing the standards for Intellectual and Developmental Disabilities Services (IDDS).
PRG 6.02	☐	The organization does not permit the use of restrictive interventions as part of behavior management.

Service Delivery Administration Standards TS		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
TS 2.03	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards.
TS 2.07	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards. The organization is only assigned the Employee Assistance Program (EAP) standards.
TS 2.08	☐	The organization is only assigned the Financial Education and Counseling (FEC) standards. The organization is only assigned the Employee Assistance Program (EAP) standards.

Service Standards CSE		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
CSE 1.02	☐	The organization provides information and referral services only.
CSE 2.04	☐	The organization does not provide education or support groups.
CSE 2.05	☐	The organization provides information and referral services only.
CSE 2.06	☐	The organization does not provide peer support services.
CSE 2.07	☐	The organization does not provide peer support services.
CSE 3.01	☐	Another organization is responsible for screening, as defined in a contract.
CSE 3.04	☐	The organization provides services to community members or groups on a one-time or occasional basis. The organization provides information and referral services only.
CSE 4	☐	The organization does not provide support services for individuals and families.
CSE 5	☐	The organization does not provide education or support groups.
CSE 6	☐	The organization does not provide information or referral services.
CSE 7	☐	The organization does not provide peer support services.

Service Standards GLS		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
GLS 2.03	☐	All residents have private physicians.
GLS 2.05	☐	The organization does not provide peer support services.
GLS 2.06	☐	The organization does not provide peer support services.
GLS 2.09	☐	The organization does not provide recovery housing.
GLS 4.01	☐	Another organization is responsible for screening, as defined in a contract.
GLS 7	☐	The organization does not provide out-of-home care for children in the custody of a public agency.
GLS 7.05	☐	The organization does not provide services to parents.
GLS 7.06	☐	The organization does not provide services to parents.
GLS 10.03	☐	The organization does not provide group living services to school-age children or youth. The organization does not directly provide the educational program nor develop the education plans for children or youth.
GLS 11	☐	The organization only serves residents with intellectual and developmental disabilities.
GLS 11.05	☐	The organization does not offer athletic activities to residents.

Service Standards GLS		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
GLS 11.06	☐	The organization does not provide employment-related training or jobs to residents.
GLS 11.07	☐	The organization does not purchase services from providers that operate adventure-based activities.
GLS 12	☐	The organization does not serve pregnant and/or parenting residents.
GLS 12.01	☐	The organization does not allow residents to bring their children to the program.
GLS 12.02	☐	The organization does not allow residents to bring their children to the program.
GLS 12.03	☐	The organization does not allow residents to bring their children to the program.
GLS 12.04	☐	The organization does not serve pregnant residents.
GLS 12.05	☐	The organization does not serve pregnant residents.
GLS 13	☐	The organization does not provide substance use services.
GLS 14.03	☐	The program does not serve family units, or housing families as a unit is not possible or prohibited by law.

Service Standards GLS		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
GLS 15	☐	The organization does not operate recovery housing.
GLS 17.03	☐	The organization does not serve children or families with children.
GLS 18	☐	The service is a long-term permanent housing setting.
GLS 18.03	☐	Residents are not transitioning to an independent living situation.
GLS 18.05	☐	Residents are not transitioning to an independent living situation.
GLS 18.06	☐	Residents are not transitioning to an independent living situation.
GLS 18.08	☐	Residents are not transitioning to an independent living situation.
GLS 19	☐	The service is a long-term permanent housing setting.
GLS 19.05	☐	The organization has a contract with a public authority that prohibits or does not include aftercare or transition planning follow-up.

Service Standards YIL		
Standard	**NA is True**	**Description – If the description reads true for your organization, check the box to select the NA.**
YIL 2.04	☐	The program is not designed to serve youth with special health or mental health needs.
YIL 3.02	☐	Another organization is responsible for screening, as defined in a contract.
YIL 5	☐	The organization does not serve youth with special needs.
YIL 6	☐	The organization does not provide supportive housing to youth in transition.
YIL 9.05	☐	The organization has a contract with a public authority that prohibits or does not include aftercare or transition planning follow-up.

Administration and Management Standards

PQI: Performance and Quality Improvement

Purpose
An organization-wide performance and quality improvement system uses data to promote efficient, effective service delivery and achievement of the organization's mission and strategic goals.

Introduction
COA's Performance and Quality Improvement (PQI) standards provide the framework for implementation of a sustainable, organization-wide PQI system that increases the organization's capacity to make data-informed decisions that support achievement of performance targets, program goals, positive client outcomes, and staff and client satisfaction. Building and sustaining a comprehensive, mission-driven PQI system is dependent upon the active engagement of staff from all departments of the organization, persons served, and other stakeholders throughout the improvement cycle.

Note: *Please see the PQI Toolkit for additional guidance on these standards.*

Note: *Please see the PQI Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see PQI Crosswalk.*

Table of Evidence

Self-Study Evidence *No Self Study Evidence*

PQI 1: Infrastructure

The organization's PQI system has the capacity to:
a. evaluate services at all regions and sites;
b. identify organization-wide and program-specific issues; and
c. implement solutions that improve overall effectiveness.

Self-Study Evidence

*PQI plan	**File:** MHCO PQI Plan 2024
*PQI operational procedures	**File:** PQI Operational Procedure
*Document or chart that describes the organization's PQI structure including committees, work groups, and member lists, as appropriate	**File:** MHCO PQI Plan 2024
*PQI meeting/activity schedule for the next 12 months	**File:** MHCO PQI Plan 2024

Site Visit Evidence
No Site Visit Evidence
On-Site Activities
- Interviews may include:
    1. CEO
    2. Senior management

3. PQI personnel
4. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the PQI 1 Practice standards. The PQI system has sufficient structure, defined procedures, and resources to ensure its long-term sustainability.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the PQI 1 Practice standards; e.g.,
   - The plan and procedures are sufficient to implement and sustain a PQI system.
3. Practice requires significant improvement as noted in the ratings for the PQI 1 Practice standards; e.g.,
   - A PQI plan and procedures have been developed but several areas outlined in the PQI Practice standards are not adequately addressed or a few are not addressed at all; or
   - The PQI system, as reflected in the plan and procedures, does not appear to be sustainable.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PQI 1 Practice standards; e.g.,
   - A PQI system has not been developed, or it is wholly inadequate.

PQI 1.01

A written PQI plan and procedures cover each program or service area and, if necessary, outline any variances between regions or sites, and:

a. articulate the organization's approach to quality improvement and methods used;
b. describe the PQI system's structure, functions, and activities;
c. define staff roles and assign responsibility for implementing and coordinating the PQI program (PQI 2);
d. identify what is being measured and why (PQI 3, PQI 4, Service Standards); and
e. include procedures for reporting findings and monitoring results (PQI 5).

Examples: *The PQI plan describes how the system is structured and functions, includes an overview of the organization's approach to quality improvement, and may include specific models and/or methodologies it may employ (e.g., Six-Sigma, CQI, Plan/Do/Check/Act, and TQM).*

PQI Structure: There are many ways to structure how information and data flow through an organization, mechanisms for review, and decision-making. Many organizations integrate PQI responsibilities into their existing decision-making and support structure, e.g., management teams, committees, or task forces. Others establish a separate, independent PQI committee to oversee and guide their PQI system.

Some small organizations may not have the resources to have a separate PQI structure or committee so they are diligent about including PQI as part of the agenda of regular staff meetings (see PQI 1.04). In effect, the entire staff serves as the PQI committee. Please note that it is especially important to thoroughly document PQI discussions in this scenario.

In regards to element (e), procedures for reporting findings and monitoring results can include:

1. *obtaining feedback about findings from stakeholders;*
2. *taking action in response to PQI findings and feedback;*
3. *monitoring improvement plans and corrective action plans; and*
4. *determining if an implemented change is an improvement.*

Note: *In regards to element (d), please see the Person-Centered Logic Model Core Concept in each assigned Service Standard for additional information on program outputs and client outcomes to be included in the PQI plan.*

Rating Indicators:

1. The written PQI plan provides the organization with a framework for operationalizing and implementing a comprehensive PQI system and includes all of the elements of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The PQI plan and procedures do not cover one or two of the organization's programs or one of its service delivery sites, divisions, or departments, but the organization is actively working to integrate these into their plan and procedures; or
   - One of the elements is not fully addressed.
3. Practice needs significant improvement, e.g.,
   - More than two of the organization's programs or service delivery sites, regions, or divisions are not integrated into the organization-wide plan and procedures; or
   - Two of the elements are not fully addressed; or
   - The PQI plan lacks specificity and it is unclear what is being measured for each program or service area; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 1.02

The PQI plan:

a. defines the organization's stakeholders; and
b. specifies how important internal and external stakeholder groups will be involved in the PQI process.

Related Standards: HR 7.01

Interpretation: *Stakeholder involvement is fundamental to a well-designed, useful PQI system. Ideally, a broad range of internal and external stakeholders including staff from all levels of the organization, the organization's governing body, persons served, and other external stakeholders have a role in the organization's PQI system.*

Examples: *Examples of stakeholders include:*

1. *staff;*
2. *governing body members;*
3. *persons served, including families, as appropriate;*
4. *volunteers;*
5. *licensing authorities;*
6. *consumer advocates;*
7. *funders; and*
8. *contractors and partners.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   Most of the important internal and external stakeholders have been identified; or
   Procedures for involving stakeholders lack specificity regarding how some stakeholder groups will be meaningfully involved.
3. Practice needs significant improvement; e.g.,
   Written documentation does not address involving clients or other external stakeholders; or
   Written documentation provides only minimal guidance about how stakeholders will be involved.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 1.03
The PQI plan describes how:

a. staff and their supervisors have timely access to the information they need to clarify expectations and implement practice improvements; and
b. staff at all levels receive relevant information on PQI findings.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Plan/procedures lack specificity regarding the flow of information.
3. Practice needs significant improvement; e.g.,
   - Plan/procedures provide only minimal guidance.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 1.04

Organization leaders, senior managers, program directors, and supervisors:

a. keep PQI on the agenda of board, management, and staff meetings;
b. regularly evaluate the need for and uses of data; and
c. evaluate the PQI system, infrastructure, processes, and procedures.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Leaders, senior managers, etc. are committed to maintaining a sustainable PQI system, but practice related to one of the standard's elements needs improvement.
3. Practice requires significant improvement; e.g.,
   - Leaders, senior managers, etc. do not consistently put in the effort and attention needed to sustain the organization's PQI system, as indicated by limited implementation of two of the standard's elements.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 2: Roles and Responsibilities

The organization has sufficient qualified staff, representing different departments and levels of the organization, to conduct and sustain its PQI system.

Interpretation: *COA does not expect all staff to be involved in PQI.*

Self-Study Evidence

*Job description of staff member(s) responsible for oversight and coordination of the PQI system	**File:** PQI Director Job Description
*Tables of contents of PQI training curricula	**File:** MHCO How Do I PQI and accreditation Training.ppt

Site Visit Evidence

- Job descriptions of staff with ongoing PQI responsibilities
- Documentation tracking staff completion of PQI training
- PQI Training curricula

On-Site Activities

- Interviews may include:
    1. PQI personnel
    2. Managers and program directors
    3. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the PQI 2 Practice Standards. Staff have the knowledge and experience needed to implement and coordinate the PQI system, including the ability to implement evaluation methods, as per the requirements of the standard.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the PQI 2 Practice standards; e.g.,
    - Identified staffing and training deficiencies do not significantly compromise the organization's ability to implement its PQI system or sustain it over time; or
    - Job descriptions reflect the required competences, and the organization seeks to hire and/or assign or train people with the requisite skills.
3. Practice requires significant improvement as noted in the ratings for the PQI 2 Practice standards; e.g.,
    - The organization's inability to hire or train staff is presenting a serious challenge to its ability to implement and sustain a PQI system.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PQI 2 Practice standards.

PQI 2.01

Staff responsible for implementing and coordinating the organization's PQI system are competent to:

a. identify indicators of quality practice;
b. implement internal and external evaluation methods, such as benchmarking, as appropriate to the programs being evaluated;
c. ensure proper data entry and data integrity;
d. collect, analyze, and interpret data; and
e. communicate evidence and findings to staff in a manner that facilitates their active engagement.

Interpretation: *PQI may be a shared responsibility as opposed to being under the leadership of a single staff position.*

Examples: *Organizations that have limited resources or are new to measuring performance can partner with colleges or universities or other organizations to gain access to knowledge and expertise related to setting up and sustaining their PQI system, collecting and analyzing data, etc.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - PQI staff have the competency and/or support needed to implement and coordinate the PQI system, but one of the elements is not fully addressed.
3. Practice needs significant improvement; e.g.,
    - PQI staff are not sufficiently competent and/or supported to implement and coordinate the PQI system, e.g., one element is not addressed at all, or two of the elements are not fully addressed.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 2.02

Staff receive support, as appropriate to their responsibilities, on:

a. inputting data into the data management system;
b. using data collection tools and forms;
c. reading and interpreting reports; and
d. using data to improve performance.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Most staff receive the support they need.
3. Practice needs significant improvement, e.g.,
   - Staff support is insufficient for at least two of the standard's elements; or
   - Support is not being provided for either element (a) or (b); or
   - The integrity of the data may be compromised due to insufficient staff support.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Staff are not supported and cannot demonstrate competence, and further support is not being provided.

PQI 3: Performance and Outcomes Measures

The organization identifies measures and outcomes related to:

a. the impact of services on clients;
b. quality of service delivery; and
c. management and operations performance.

Examples: *Organizations providing child welfare services are encouraged to integrate the Federal Child and Family Service Review (CFSR) Outcomes measures and Systemic Factors, particularly those identified in Performance Improvement Plans, into their overall PQI system.*

Self-Study Evidence

See PQI plan (PQI 1) for a description of what is being measured. Response must address PQI 3.01, PQI 3.02, and PQI 3.03, and include: 1. outcomes 2. outputs 3. data sources 4. indicators 5. targets	
*See PQI outcomes documentation provided in the Person-Centered Logic Model Core Concept in each service standard	**File:** Logic Model for Direct Care l.pdf **File:** Logic Model for Independent Living Program
*Organizations Seeking Re-Accreditation Only • Most recent Final Accreditation Report (FAR)	**File:** 2021 Final Accreditation Report.pdf

Site Visit Evidence

- Regulatory/licensing or other external reviews/reports
- Documentation that COA Stakeholder Surveys were distributed (e.g. email chains, Stakeholder Survey Recipient Reporting Form, etc.)

On-Site Activities

- Interviews may include:
  1. PQI personnel
  2. Relevant personnel

PQI 3.01

The organization identifies key outputs and outcomes, and related:

a. measurement indicators;
b. performance targets; and
c. data sources including data collection tools or instruments for each identified output and outcome.

Related Standards: HR 7.02

Interpretation: *Organizations are encouraged to use standardized or recognized outcomes evaluation tools when such tools are available and appropriate.*

Interpretation: *Program outputs and client outcomes must be identified in the logic model submitted in the Person-Centered Logic Model Core Concept in each assigned Service Standard.*

Examples:

Outputs are what the program delivers. Examples of program outputs include:

1. *number of educational or clinical sessions provided;*
2. *total number of clients served over a specified period of time; and*
3. *number of housing placements made.*

Outcomes are the observable and measurable effects of a program's activities on its service recipients.

Examples include:

1. *improved functioning as measured by the Children's Functional Assessment Rating Scale (CFARS);*
2. *number/percent of homeless and runaway youth that are reunited with family during past quarter;*
3. *reduction in criminal justice system involvement; and*
4. *improved family/community involvement.*

For some programs, outcomes, outputs, indicators, tools, etc. may be established by contractual and/or funding requirements.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization has not developed indicators or performance targets for some of its programs.
3. Practice needs significant improvement; e.g.,
   - At least one of the standard's elements are not being addressed at all; or
   - Outputs and outcomes have not yet been identified for one of its high-risk programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 3.02

The organization surveys clients annually to assess program quality.

Related Standards: HR 7.02

Examples: *Types of information that the program may collect from clients can include client satisfaction or outcome information.*

According to the Urban Institute, client surveys can be an indispensable source of outcome information. They provide a systematic means of gathering data on service outcomes from all or a portion of clients. Client surveys help organizations learn whether services are producing anticipated or desired results and, if not, provide clues for how to improve them.

Issues covered by a client survey should correspond to the key service outcomes an organization wishes to track. Because survey length generally affects response rates, issues not pertinent to improving outcomes should probably be limited. The goal is to develop the shortest possible list of questions consistent with the survey's objective of assessing outcomes.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice needs significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 3.03

The organization identifies measures for management and operational performance to:

a. measure progress toward achieving its mission and strategic and annual goals;
b. evaluate operational functions that influence the capacity to deliver services and meet the needs of persons served; and
c. identify and mitigate risk.

Related Standards: GOV 1, GOV 2.02, GOV 2.03, HR 3.01, TS 1.03

Examples: *Examples of operations and management performance measures can include:*

1. *efficiency in the allocation and utilization of its human and financial resources to further the achievement of organizational objectives;*
2. *effectiveness of risk prevention measures;*
3. *effectiveness at retaining a competent and qualified workforce through staff retention/turnover and satisfaction;*
4. *costs versus benefits of fundraising efforts;*
5. *achievement of budgetary objectives ;*
6. *effectiveness of community education and outreach; and*
7. *efforts to diversify the governing body. leadership, or workforce..*

Organizations may consider if any data is currently being collected related to these elements. Then, the organization may identify an outcome or goal in some of these areas.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization has identified performance measures related to two of the three elements of the standard.
3. Practice needs significant improvement; e.g.,
   - The organization has identified performance measures related to only one of the standard's elements.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 3.04

Findings and recommendations from external review processes are integrated into the organization's PQI system.

Examples: *External reviews can include:*

1. *licensing and other reviews related to federal, state, and local requirements;*
2. *government and other funder audits;*
3. *accreditation reviews; and*
4. *other reviews, where appropriate.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The process for review of findings and recommendations can be improved, e.g., while findings are reviewed by management, they are not integrated into the PQI improvement cycle when appropriate.
3. Practice needs significant improvement; e.g.,
   - There is evidence that the organization has not adequately addressed the findings or recommendations of at least one key external review; or
   - It does not review or address findings in a timely manner and thus may be putting itself at risk of sanction.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 4: Case Record Review

The organization conducts case record reviews at least quarterly for each of its services to:

a. minimize the risks associated with poorly maintained case records;
b. document the quality of the services being delivered; and
c. identify barriers and opportunities for improving services.

Related Standards: HR 7.04, PRG 1

Interpretation: *COA is not prescriptive about who can conduct case record reviews. While a peer review model is recommended, it is acceptable for PQI staff, a consultant, or another person or combination of persons to conduct the reviews. Please note that, regarding PQI 4.03, persons with clinical or service delivery experience may be needed to obtain the relevant qualitative data from the case records.*

Self-Study Evidence

*Case record review procedures, including sampling methodology	**File:** Case Record Review Procedure.pdf

*Sample of case record review data collection tool(s)	**File:** DC Medical File Review form.docx **File:** Notice of Correction form.pdf **File:** DC File Review for Quality Performance.xls **File:** IL File Review for Quality Performance.xls **File:** File Review and scanning record updated
*Most recent quarterly report from the case record review process	**File:** Q4 2024 PQI Report.

On-Site Evidence

*Results of external case record audits, if applicable

On-Site Activities

*Interviews may include:

1. PQI personnel
2. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the PQI 4 Practice standards.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the PQI 4 Practice standards.
3. Practice requires significant improvement as noted in the ratings for the PQI 4 Practice standards; e.g.,
   - Case records may pose a risk to the organization and corrective action has not been implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PQI 4 Practice standards.

PQI 4.01

The quarterly case record review process:

a. includes a random sample of both open and recently closed cases;
b. uses uniform data collection tools to ensure consistency and permit comparison of data across similar programs and services; and
c. maintains objectivity by ensuring that reviewers do not review cases in which they have been directly involved as a service provider or supervisor.

Interpretation: *Sampling: See recommended sampling guidelines. Organizations may choose a different sampling method as long as a rationale is provided.*

Closed Cases: COA does not define the percentage of closed cases that must be included in the sample. The majority of cases the organization reviews should be open, but the organization must include a sample of closed cases to evaluate documentation related to discharge planning, case closing, aftercare, and the condition of the case record including whether or not records have been expunged as required by PRG 1.06.

Examples: *Organizations can get more from the case record review process by stratifying the random sample of open cases to account for length of service. For example, a program that serves clients for up to six months could divide the sample proportionally between cases that have been open less than one month, one to three months, three to six months, and more than six months.*

For generating random numbers, the Research Randomizer is an easy to use tool that is made available for free by the Social Psychology Network and includes short tutorials.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the standard's elements is not sufficiently developed, e.g., cases are not selected randomly for more than half of the organization's programs or services but includes both open and closed cases.
3. Practice needs significant improvement; e.g.,
   - At least two of the standard's elements are not sufficiently developed, e.g., sample size is insufficient to enable the organization to draw conclusions from the data; or
   - The organization only reviews open cases; or
   - Little effort is being made to ensure objectivity, e.g., supervisors frequently were the sole reviewers of supervisee cases.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 4.02

Quarterly reviews of case records evaluate the presence, clarity, quality, continuity, and completeness of required documents.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One or two important documents are not included in the review; or
   - Procedures need strengthening.
3. Practice needs significant improvement; e.g.,
   - A number of important documents are not included in the review; or
   - Reviews are conducted no more than three times per year; or
   - Reviews are not conducted for one of the organization's services; or
   - The review process is poorly designed or haphazardly conducted; or
   - Case records may pose a risk to the organization and corrective action has not been implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 4.03

The organization identifies indicators and measures the quality of services for each of its programs or services in its quarterly case record review process.

Examples: *Quality of services is a very broad category and varies according to the program, service population, service mandates, and any number of other factors and can include criteria for evaluating the appropriateness and/or effectiveness of the services provided to persons served.*

Examples of common qualitative measures include:

1. *timeliness and comprehensiveness of individualized assessments;*
2. *length of service;*
3. *need for continued service;*
4. *family involvement; and*
5. *achievement of service goals, etc.*

Some organizations take a utilization management approach to case record review and, rather than review case records quarterly, conduct more frequent or ongoing reviews.

A utilization management approach looks at the key decisions and process milestones including, for example:

1. *appropriateness of admissions and authorization decisions;*
2. *intake and referral processes;*
3. *service planning and service delivery milestones;*
4. *need for continued service; and*
5. *discharge decisions.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Indicators for one program need strengthening; or
   - Data is aggregated and used to monitor service quality for 75% of the organization's programs/services including all high risk programs.
3. Practice needs significant improvement; e.g.,
   - Data is not consistently collected, or is collected and aggregated but not used to monitor service quality; or
   - Service quality data is collected for less than 75% of the organization's programs; or
   - Service quality data is not being collected for at least one high-risk program.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 5: Analyzing and Reporting Information

The organization systematically collects, aggregates, analyzes, and maintains data.

Self-Study Evidence

Procedures for collecting, reviewing, and aggregating PQI data	**File:** Data Management Procedure
Data analysis/reports related to the elements in PQI 5.02	**File:** Q4 2024 PQI Report.pdf **File:** Q4 2023 PQI Report.pdf **File:** Q4 2022 PQI Report.pdf **File:** Q4 2021 PQI Report.pdf **File:** Q3 2024 PQI Report **File:** Q3 2023 PQI Report.pdf **File:** Q3 2022 PQI Report.pdf **File:** Q3 2021 PQI Report.pdf **File:** Q2 2024 PQI Report.pdf **File:** Q2 2023 PQI Report.pdf **File:** Q2 2022 PQI Report.pdf **File:** Q2 2025 PQI Report.pdf **File:** Q1 2025 PQI Report.pdf **File:** Q1 2024 PQI Report.pdf **File:** Q1 2023 PQI Report.pdf **File:** Q1 2022 PQI Report.pdf
Most recent summary documents or reports provided to internal and external stakeholder	**File:** Q4 2024 PQI Report.pdf **File:** Q4 2023 PQI Report.pdf **File:** Q4 2022 PQI Report.pdf **File:** Q4 2021 PQI Report.pdf **File:** Q3 2024 PQI Report **File:** Q3 2023 PQI Report.pdf **File:** Q3 2022 PQI Report.pdf **File:** Q3 2021 PQI Report.pdf **File:** Q2 2024 PQI Report.pdf

	File: Q2 2023 PQI Report.pdf **File:** Q2 2022 PQI Report.pdf **File:** Q2 2025 PQI Report.pdf **File:** Q1 2025 PQI Report.pdf **File:** Q1 2024 PQI Report.pdf **File:** Q1 2023 PQI Report.pdf **File:** Q1 2022 PQI Report.pdf
Procedures for sharing and reviewing reports and findings with staff and stakeholders	**File:** PQI Operational Procedure.pdf **File:** Data Management Procedure.pdf

Site Visit Evidence

- PQI committee/work group minutes for analyzing PQI information
- Documentation of stakeholder review and discussion of PQI results, including meeting minutes and agendas
- Governing body meeting minutes regarding review of PQI data
- Documentation of improvements made from the analysis and use of PQI data, including any related corrective action/improvement plans

On-Site Activities

- Interviews may include:
  1. PQI personnel
  2. Relevant personnel
- Observe system for collecting, aggregating, analyzing, and maintaining data

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the PQI 5 Practice standards. Comprehensive PQI data management procedures support the organization's ability to systematically collect, aggregate, analyze and maintain data.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the PQI 5 Practice standards.
3. Practice requires significant improvement as noted in the ratings for the PQI 5 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PQI 5 Practice standards.

PQI 5.01

Procedures for collecting, reviewing, and aggregating data include:

a. cleaning data to ensure data integrity including accuracy, completeness, timeliness, uniqueness, and outliers;
b. protecting personal identifiable information (PII) in data reports;
b. quarterly aggregation of data; and
c. developing reports for analysis and interpretation.

Interpretation: *Data should be collected, aggregated, and reviewed at least quarterly at all three levels of performance measurement as addressed in PQI 3.03, PQI 4, and the Person-Centered Logic Model Core Concept in each assigned Service Standard.*

Examples: *Cleaning data, also known as data cleansing, means checking for errors and inconsistencies in order to improve the quality of your data prior to aggregating and analyzing it. Common things to check for include:*

1. *accuracy - making sure the data was recorded correctly including misspellings, correct numbers, addresses, etc.;*

2. *completeness - making sure all the data was recorded and none is missing;*
3. *timeliness - ensuring that the data is current and/or relevant to the current time frame;*
4. *uniqueness - ensuring that data was recorded only once and not multiple times; and*
5. *outliers - look for data that is unexpected (Note: This could mean you have a PQI issue that warrants attention but sometimes a single extreme result, even if it is legitimate, can tip the results so they are not truly representative).*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures for ensuring data integrity and reliability are sufficient for sustaining the PQI system but need some improvement, e.g., formats for reports are not consistently useful for analysis; or
   - In a few instances, data was not aggregated and reviewed quarterly.
3. Practice needs significant improvement; e.g.,
   - Procedures are insufficient to sustain consistent data review or do not address one of the standard's elements; or
   - Only some of the collected data is reviewed and/or aggregated for review; or
   - Data is rarely aggregated into a form that permits analysis.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 5.02

The organization analyzes PQI data to:

a. track and monitor identified measures;
b. identify patterns and trends; and
c. compare performance over time.

Related Standards: RPM 4.03

Interpretation: *Organizations should disaggregate data to identify patterns of disparity or inequity that can be masked by aggregate data reporting. Common characteristics used to disaggregate data include:*
race and ethnicity/country of origin;

1. *generation status;*
2. *immigrant/refugee status;*
3. *age group;*
4. *sexual orientation; and*
5. *gender/gender identity.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard. The organization analyzes PQI data per the requirements of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Data from across the organization is analyzed, but data is not analyzed for one of the organization's programs; or
   - Data from across the organization is analyzed, but only some of the data has been disaggregated to identify patterns of disparate outcomes; or
   - Data analysis does not include one of the elements of the standard.
3. Practice needs significant improvement; e.g.,
   - Data from across the organization is analyzed, but no data has been disaggregated to identify patterns of disparate outcomes; or
   - Most of the organization's PQI data has not been analyzed; or
   - Data analysis is not performed for most of the organization's programs or services; or
   - Data related to management and operational performance is not analyzed.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 5.03

Reports of PQI findings are:

a. shared and discussed with board members, staff, and stakeholders; and
b. distributed in timeframes and formats that facilitate review, analysis, interpretation, and timely corrective action.

Examples: *Discussions with board members, staff, and stakeholders about PQI findings can include:*

1. *areas of strength and quality practice;*
2. *areas for improvement; and*
3. *how to prioritize targeted areas, identify interventions, and monitor the effectiveness of interventions over time.*

In order to engage in meaningful discussions about the data being collected, organizations should decide how results will be communicated to staff and stakeholders. Organizations can start by determining who needs what data, with what frequency, and how best to share the information.

Methods for sharing findings include:

1. *performance dashboards, report cards, or other types of summary reports;*
2. *discussion at board, staff, and departmental meetings;*
3. *using monthly reports of key service delivery outputs and outcomes in staff supervision activities;*
4. *conducting focus groups and presentations at community meetings;*
5. *soliciting feedback via interviews or surveys;*
6. *providing quarterly reports to oversight entities, stakeholder advisory groups, and leaders on important data related to key operations and management functions; and*
7. *quality review activities that engage community providers.*

Graphic presentation of data is very useful in communicating results of PQI activities. Data visualization techniques can facilitate understanding of complex information and reveal underlying patterns and relationships within the data that may otherwise go unnoticed.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Summary reports are created and distributed, but practice could be improved; or
   - Stakeholders have complained about reports that are hard to read or understand; or
   - Summary reports are not always distributed in a useful timeframe.
3. Practice requires significant improvement, e.g.,
   - There are many examples of relevant PQI data not being provided to stakeholders for review; or
   - Data is not formatted into reports; or
   - The format of reports is unclear and confusing; or
   - Confidentiality concerns have been raised or noted.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PQI 5.04

The organization:

a. reviews PQI findings and stakeholder feedback and takes action, when indicated; and
b. monitors the effectiveness of actions taken and modifies implemented improvements, as needed.

Examples: *Organizations can use PQI findings and feedback to:*

1. *improve services;*
2. *eliminate or reduce identified problems;*
3. *replicate good practice;*
4. *recognize and motivate staff; and*
5. *improve organizational systems, processes, policies, and procedures.*

Examples: *Information generated by the PQI system can be used to:*

1. *monitor progress toward achieving its mission and strategic and annual goals;*
2. *meet funder requirements; and*
3. *promote the organization and its services throughout the community.*

Examples: *Corrective Action Plans or Improvement Plans can be implemented when issues have been identified that will involve ongoing effort and monitoring.*

Improvement Plans formally lay out the actions that will be taken to address areas in need of improvement that are identified by staff and stakeholders as crucial to meeting the organization's goals and delivering quality services. Improvement plans should be implemented when it is necessary to monitor and address the issue over time.

Corrective Action Plans are implemented to correct problems or deficiencies, including those related to compliance with regulatory requirements (e.g., Medicaid documentation requirements). The need for a Corrective Action Plan suggests that the issue has moved beyond program improvement to the level of oversight by the organization's leadership.

Organizations may also wish to create an annual summary report for oversight entities, stakeholders, and staff that includes:

1. *key PQI activities that are ongoing, have been resolved, or that need further intervention;*
2. *issues that require continued monitoring within the PQI system; and*
3. *PQI priorities and goals for the coming year.*

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization uses PQI data to improve programs; however, some available findings and recommendations are not being used; or
   - Actions made in response to findings and feedback are being monitored, and modifications are made when needed, but practice could be improved, e.g., the data is not being reviewed in a timely manner.
3. Practice requires significant improvement, e.g.,
   - PQI data is not routinely used; or
   - Except for a few examples, the organization does not generate enough usable data to take meaningful action, or does not routinely use data in either of the ways listed in the standard; or
   - Important modifications are often not made despite evidence that they are needed.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

Service Delivery Administration Standards

PRG: Program Administration

Purpose
Service delivery practices guide the administration of safe, effective programs that respect personal dignity and self-determination.

Introduction

COA's Program Administration (PRG) standards promote the development of safe, effective, and respectful programs through the implementation of practices for maintaining complete, organized, and confidential case records; establishing safe, uniform practices for prescribing, dispensing, storing, and administering medication; effectively harnessing technology-based service delivery to better meet the needs of service recipients; and providing services that promote integration and self-determination for individuals with intellectual and developmental disabilities.

Note: *Please see the PRG Reference List for the research that informed the development of these standards.*

Note: *Program Administration is a new section in the 2020 Edition that includes content previously contained in other sections. Please see the RPM Crosswalk, the CR Crosswalk, and the TS Crosswalk for more information.*

Table of Evidence

Self-Study Evidence *No Self Study Evidence*

PRG 1: Case Records

Case records contain sufficient, accurate information to:

a. identify the individual or family being served;
b. support decisions about interventions or services; and
c. document the delivery of services.

NA: The organization provides only non-clinical group, crisis intervention, and/or information and referral services.

Related Standards: PQI 4, TS 2.02

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Self-Study Evidence

*Case record content and maintenance procedures	**File:** Resident Records Access Procedure.pdf **File:** Resident Records Access Policy.pdf

Site Visit Evidence

* Mock case record, table of contents, or case record outline for each service

On-Site Activities

*Review case records
*Interviews may include:

1. Program directors
2. Relevant Personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the PRG 1 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the PRG 1 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the PRG 1 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PRG1 Practice standards.

PRG 1.01 (FP)

The organization maintains a case record for each individual or family.

PRG 1.02(FP)

Case records contain information necessary to provide services including:

a. demographic and contact information;
b. the reason for requesting or being referred for services;
c. up-to-date assessments;
d. the service plan including mutually developed goals and objectives;
e. copies of all signed consent forms;
f. a description of services provided directly or by referral;
g. routine documentation of ongoing services;
h. documentation of routine supervisory review;
i. discharge or aftercare plan;
j. recommendations for ongoing and/or future service needs and assignment of aftercare or follow-up responsibility, if needed; and
k. a closing summary entered within 30 days of termination of service.

Related Standards: CR 2.01

Interpretation: *This standard describes the basic elements to be included in individual case records. COA recognizes that in some cases not all listed information is obtainable for an individual or family. In these cases, an explanation should be placed in the case record. Additionally, the listed information may not be routinely available due to the nature of the service, e.g., a low demand shelter or drop-in center.*

Interpretation: *Regarding element (h),"documentation of routine supervisory review" refers to the quarterly review of individual cases that is found in the Service Planning and Monitoring sections of most Service Standards. This review is unrelated to Supervision between the supervisor and personnel addressed in TS 3.*

Interpretation: *Case records and signatures can be paper, electronic, or a combination of paper and electronic.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record content and maintenance procedures need strengthening; or
   - In all but a few cases, the organization complies with the standard; or
   - One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - In a significant percentage of cases, the organization does not comply with the standard; or
   - Two of the required elements are not fully addressed; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Three or more of the required elements are not fully addressed, or
   - Two or more elements are not addressed at all.

PRG 1.03 (FP)
The case record contains essential medical and legal information including, as applicable:

a. orders for and results of psychological, medical, toxicological, diagnostic, or other evaluations;
b. documentation of all prescribed and over-the-counter medications including copies of all written orders for medications, when applicable;
c. special treatment procedures, allergies, or adverse treatment responses; and
d. court reports, documents of guardianship or legal custody, birth or marriage certificates, and any legal directives related to the service being provided.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record content and maintenance procedures need strengthening; or
   - With a few exceptions records contain necessary and required information.
3. Practice requires significant improvement; e.g.,
   - Procedures require significant strengthening; or
   - Many records do not have the necessary or required information; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Two or more elements are not addressed at all.

PRG 1.04 (FP)
Case record entries are made by authorized personnel only, and are:

a. specific, factual, relevant, and legible;
b. kept up to date from intake through case closing;
c. completed, signed, and dated by the person who provided the service; and
d. signed and dated by supervisors, where appropriate.

Examples: *When selecting an electronic record keeping system, the organization may consider, among other things, whether or not the system has the capacity to:*

1. *verify the individual's identity and ensure that each electronic signature is unique to the individual; and*
2. *ensure that the signature will remain tied or connected to the content being signed for as long as the record is maintained.*

Examples of ways to verify the authenticity of digital signatures when using electronic records include, but are not limited to: a digitalized signature via tablet or two identifying components such as a user identification code (ID) and password/personal identification number (PIN).

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record content and maintenance procedures need strengthening; or
   - In a substantial percentage of cases reviewed, the organization complies with the standard; or
   - One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - In a significant percentage of cases, the organization does not comply with the standard; or
   - Two of the required elements are not fully addressed; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Three or more of the required elements are not fully addressed; or
   - Two or more elements are not addressed at all.

PRG 1.05 (FP)
Progress notes comply with legal requirements and are entered:

a. at least quarterly; or
b. monthly for individuals receiving protective services, out-of-home care, day treatment, or frequent or intensive counseling or treatment.

Related Standards: RPM 1

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record content and maintenance procedures need strengthening; or
   - Progress notes in most case records are up to date and reflect the progress of the client; or
   - One of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - In a significant percentage of cases progress notes have not been kept up to date; or
   - In a significant percentage of cases progress notes are lacking in content and do not reflect the progress of the client; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 1.06
At case closing, case records are reviewed and unsummarized notes, personal observations, and impressions are expunged.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Most case records are reviewed prior to closure and unnecessary information is removed.
3. Practice requires significant improvement; e.g.,
   - Many closed records contain worker notes and/or unnecessary material.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 1.07
Unless otherwise mandated by law, the organization maintains case records as follows:

a. for at least seven years after case closing for adults;
b. until the age of majority or seven years after case closing, whichever is longer, for minors; and
c. disposes of case records in a manner that protects privacy and confidentiality in the event of the organization's dissolution.

Related Standards: RPM 1

Examples: *Proper disposal of paper and electronic records can include, but is not limited to, shredding paper records, clearing electronic files when computers are replaced or reassigned, and destroying electronic media such as flash drives.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - One of the elements needs strengthening; or
   - With few exceptions procedures are understood by staff and are being used.
3. Practice requires significant improvement; e.g.,
   - One of the elements has not been addressed at all; or
   - Procedures are not well-understood or used appropriately.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 2: Access to Case Records

Access to case records is appropriately limited.

Related Standards: RPM 1

Self-Study Evidence

*Case record access policies	**File:** Resident Records Access Policy.pdf
*Case record access procedures	**File:** Resident Records Access Procedure.pdf

Site Visit Evidence *No On-Site Evidence*

On-Site Activities

*Interviews may include:
1. Information systems manager
2. Program directors
3. Relevant personnel

*Observe case record room/files and information systems accessibility observation

Rating Indicators:

1. The organization's practices fully meet the standard as indicated by full implementation of the practices outlined in the PRG 2 Practice standards.
2. Practices are basically sound but there is room for improvement as noted in the ratings for the PRG 2 Practice standards.
3. Practice requires significant improvement as noted in the ratings for the PRG 2 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PRG 2 Practice standards.

PRG 2.01 (FP)

Access to confidential case records is limited to:

a. the service recipient or, as appropriate, a parent or legal guardian;
b. personnel authorized to access specific information on a “need-to-know” basis;
c. former service recipients;
d. individuals requesting records of deceased service recipients; and
e. auditors, contractors, and licensing or accrediting personnel consistent with the organization’s confidentiality policy.

Related Standards: CR 2, RPM 5, TS 2.01, TS 2.02

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record access policy or procedure needs strengthening.
3. Practice requires significant improvement; e.g.,
   - Record access policy or procedure needs significant strengthening; or
   - In a few instances the organization does not comply with the standard.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 2.02
Service recipients may review and, when desired, add a statement to their files in accordance with applicable laws and regulations, and:

a. reviews are conducted in the presence of professional personnel on the organization's premises;
b. reviews are carried out in a manner that protects the confidentiality of family members and others whose information may be contained in the record;
c. any personnel responses to service recipient additions are added with the service recipient's knowledge; and
d. the service recipient is given the opportunity to review and comment on personnel responses.

Examples: *Organizations using electronic record keeping systems can provide safe access to case records by, for example, creating a separate user portal or printing the case record.*

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record access policy or procedure needs strengthening.
3. Practice requires significant improvement; e.g.,
   - Record access policy or procedure needs significant strengthening; or
   - In a few instances the organization does not comply with the standard.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 2.03 (FP)

If the organization determines that serious harm would likely ensue if an individual were to review their case record, and applicable law provides no guidance on case record access, then:

a. senior management reviews, approves in writing, and enters into the case record the reasons for refusal; and
b. procedures permit a qualified professional to review records on behalf of service recipients, provided the professional signs a statement that information determined to be harmful will be withheld.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Record access policy or procedure needs strengthening.
3. Practice requires significant improvement; e.g.,
   - Record access policy or procedure needs significant strengthening; or
   - In a few instances the organization does not comply with the standard.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3: Medication Control and Administration

The organization ensures safe, uniform medication control and administration.

Related Standards: GLS 2.09, RPM 1

Self-Study Evidence

*Medication management procedures	**File:** Resident Health Services, Wellness, and Medication Management Procedure.pdf

Site Visit Evidence

- Resumes and job descriptions from relevant job categories
- Documentation tracking staff completion of medication management training
- Medication logs
- Aggregate reports of psychotropic medication use in children and youth for the past six months

On-Site Activities

- Interviews may include: Relevant personnel
- Review case records
- Facility observation

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the PRG 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the PRG 3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the PRG 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the PRG3 Practice standards.

PRG 3.01 (FP)

Personnel directly involved in medication control and administration are qualified by license or training in accordance with law and regulation.

Interpretation: *When applicable to the organization or program, all personnel who are responsible for administering opioid antagonists, such as Naloxone, for emergency overdose treatment are trained in SAMHSA-approved protocols and procedures for reversing opioid drug crises.*

Interpretation: *Programs, such as shelters and safe homes, that allow service recipients to store medications in a safe, lockable personal space (e.g., individual lock boxes or private use lockers) should train staff in the organization's medication management procedures, including the proper handling and disposal of medications.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - With few exceptions, staff possess the required qualifications.
3. Practice requires significant improvement; e.g.,
   - A significant number of staff do not possess the required qualifications, and as a result the integrity of the service may be compromised.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.02 (FP)

When medication is initially prescribed, the prescribing clinician provides education to service recipients about the medication including:

a. medication name;
b. dose;
c. reason for use;
d. how to administer;
e. desired effects; and
f. potential side effects.

NA Taken in 2021: *The organization does not prescribe medication.*

Interpretation: *Written, detailed information regarding specific medications may be provided by the pharmacy responsible for filling a prescription.*

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

PRG 3.03 (FP)

When individuals are receiving prescription medication:

a. qualified personnel obtain and/or update information about the medications the individual is taking at each visit; and
b. the prescribing clinician compares current medications the individual is taking at each visit, including vitamins or other non-prescription medications, with new or changed medication orders to identify possible adverse interaction of medications.

NA: The organization does not prescribe or administer medication.

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The required assessments do not happen at each visit; however, reviews are conducted regularly and when new medications are prescribed.
3. Practice requires significant improvement; e.g.,
   - One of the elements is not consistently addressed as required; or
   - Assessments are not regularly conducted.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.04 (FP)

Procedures for the proper administration of medication address:

a. maintaining a record of who received medications, what medications were dispensed or administered, and when and by whom medications were dispensed or administered;
b. administration of over-the-counter medications; and
c. safe dispensing or administering of sample medications, in accordance with law and regulation.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation needs minor improvement; or
   - Procedures need strengthening.
3. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation is inconsistent, or some documentation is missing or incomplete; or
   - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.05 (FP)
Procedures for the proper administration and storage of medication address:

a. locked, supervised storage with access limited to authorized personnel and in accordance with law, regulation, and manufacturer's instruction;
b. maintaining medication in original packaging and labeling with the name of the service recipient, medication name, dosage, prescribing physician name, and number or code identifying the written order; and
c. appropriate disposal of expired or unused medication, syringes, medical waste, or medication prescribed to former service recipients.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation needs minor improvement; or
   - Procedures need strengthening.
3. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation is inconsistent, or some documentation is missing or incomplete; or
   - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.05 (FP)

Immediately prior to administration, qualified personnel review with the individual the medication to be administered and its purpose, and verify:

a. the identity of the individual and the medication ordered;
b. that the medication to be administered matches the medication order; and
c. the integrity of the medication through visual inspection.

Interpretation: *Storage of medication in a secure, central location with access by authorized personnel only is an effective risk management measure and best practice. However, COA recognizes that some programs, such as shelters and safe homes, allow service recipients to store medications in a safe, lockable personal space (e.g., individual lock boxes or private use lockers). In these instances, organizations can demonstrate implementation of the standard by providing protocols, procedures or other documents that demonstrate that they have acknowledged the potential risks of this method and subsequently taken appropriate measures to minimize those risks.*

Organizations also need to clearly communicate that service recipients are personally responsible for administering and storing their own medications. Intake processes should stipulate what service recipients are allowed to store in their secure, personal space and assign responsibility of the space to the client to support this approach to storing medication.

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement;e.g.,
   - There are minor problems with storage or labeling but safety has not been compromised; or
   - Procedures need strengthening.
3. Practice requires significant improvement;e.g.,
   - There are problems with storage or labeling that raise concerns about safety;or
   - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.06 (FP)

Immediately prior to administration, qualified personnel review with the individual the medication to be administered and its purpose, and verify:

a. the identity of the individual and the medication ordered;
b. that the medication to be administered matches the medication order; and
c. the integrity of the medication through visual inspection.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures are consistently followed with minor exceptions; or
   - Documentation needs strengthening.
3. Practice requires significant improvement; e.g.,
   - Procedures are not consistently followed; or
   - Documentation needs significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.07 (FP)

Following administration of medication, personnel observe and assess the effects of medication on the individual and consult with medical professionals, as necessary.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Documentation of observed effects needs minor improvement; or
   - Procedures need strengthening.
3. Practice requires significant improvement; e.g.,
   - Documentation of observed effects is inconsistent, or some documentation is missing or incomplete; or
   - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 3.08 (FP)

The organization tracks the use of psychotropic medications in children and youth at the individual and program level and:

a. engages prescribers and other partnering providers in corrective action when concerns are noted; and
b. advocates for increased availability and use of non-pharmacological interventions.

Examples: *Measures to prevent inappropriate or unnecessary use of psychotropic medications can include:*

1. *ensuring prescribing providers are familiar with child and adolescent trauma symptoms; and*
2. *establishing a team- or peer-based prescribing model.*

Note: *See PRG 1.03 for more information on tracking pharmacological interventions at the individual case level.*

Please see the Case Record Checklist for additional guidance on this standard.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.
   - Documentation and/or monitoring of corrective actions could be strengthened.
3. Practice requires significant improvement; e.g.,
   - The organization tracks psychotropic medication use but findings and recommendations are not being used;
   - Procedures need significant strengthening.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

PRG 4: Technology-based Service Delivery
When engaging service recipients in technology-based service delivery, services are based on the needs of the service population and are provided by appropriately trained and licensed personnel.

NA Taken in 2021: *The organization does not engage service recipients in technology-based service delivery.*
Examples: *Examples of different technologies that may be used include, but are not limited to: telephones/mobile phones, computers, tablets, videoconferencing, interactive messaging systems, or any other tool that allows personnel to see, hear, and/or interact with service recipients from a remote location and provide services at a distance.*

Terms that are often used to refer to the delivery of services via technologies include, but are not limited to: telehealth, teleservices, telepractice, telemental health, telepsychiatry, mHealth, online therapy, distance counseling, internet- or web-based interventions, telephonic services, and digital services.

Self Study Evidence

List of services being provided via technology	
Technology-based services policies	
Technology-based services procedures	
Criteria for assessing the appropriateness of technology-based services for individuals	

PRG 4.01
The organization develops policies and procedures to guide technology-based service delivery that address:
a. privacy and security measures specific to the service delivery model;
b. the use of acceptable technologies including personnel-owned devices, if applicable; and
c. collecting, storing, tracking, and transmitting information gathered electronically.

NA Taken: *The organization does not engage service recipients in technology-based service delivery.*

Related Standards: ASE 2.04, RPM 5.01, RPM 5.02, RPM 5.03

PRG 4.02 (FP)
For each individual, the organization:
a. assesses the appropriateness of technology-based service delivery based on established criteria and suitability factors; b. monitors whether or not the service delivery model is effective; and
c. arranges for services to be delivered in-person when necessary.

NA Taken: *The organization does not engage service recipients in technology-based service delivery.*

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

PRG 4.03 (FP)
Prior to engaging in technology-based service delivery, service recipients receive information needed to make an informed decision about engaging in the service including:
a. the service provider's physical location, contact information, and credentials;
b. alternate methods of service delivery, including access to other service providers, in the event of a technological failure;
c. privacy and confidentiality limitations associated with electronic communication;
d. instructions on how to access services and use the technologies;
e. risks and benefits associated with the service delivery model;
f. emergency response procedures including verifying the person's current location for the purposes of emergency management;
g. how personal information and data will be documented, stored, protected, and used; and
h. under what conditions a referral for face-to-face services may be made.

NA Taken: *The organization does not engage service recipients in technology-based service delivery.*

PRG 4.04
Personnel are trained on, or demonstrate competency in:
a. use of equipment and software as appropriate to their position and the services provided;
b. privacy and confidentiality issues specific to the service delivery model;
c. recognizing and responding to emergency or crisis situations from a remote location; and
d. engaging and building rapport with service recipients when communicating electronically.

NA Taken: *The organization does not engage service recipients in technology-based service delivery.*

Related Standards: ASE 6.03, TS 2.01, TS 2.02, TS 2.03, TS 2.04
Examples: *Examples of equipment and software training topics include, but are not limited to:*
1. *set up;*
2. *features;*
3. *maintenance;*
4. *safety and security measures; and*

5. *responding to technical matters (e.g., maintenance issues and troubleshooting) directly or by contacting the appropriate parties for assistance.*

Examples: *Regarding element (c), in the event of a medical emergency personnel would need to know how and when to contact local emergency responders (e.g., 911) and/or service recipients' emergency contacts.*

PRG 4.05 (FP)

Personnel only provide technology-based services to service recipients located in states where they are appropriately licensed, if required.

NA Taken: *The organization does not engage service recipients in technology-based service delivery.*

PRG 5: Services for Persons with Intellectual and Developmental Disabilities

Children, youth, and adults with intellectual and developmental disabilities receive services that help them achieve full integration and inclusion, make choices, exert control over their lives, and fully participate in, and contribute to, their communities.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Interpretation: *Throughout these standards the term "person" is defined to include children, youth, and adults with intellectual and developmental disabilities. In instances where the person cannot make his or her own decisions, sign documents, or is otherwise limited in his/her ability to provide informed consent, the term, "person" may be understood to also include an advocate or legal guardian, as in "...the person, his/her advocate, or legal guardian."*

Note: *Please see the Case Record Checklist for additional guidance on this standard.*

Self Study Evidence

See service planning procedures with the service planning and monitoring evidence of each applicable service section	
Procedures for helping persons access and use assistive technology	
Procedures for providing or making referrals for family support services	
Procedures for use of interventions that limit movement, diminish sensory experience, limit personal freedom, or cause personal discomfort	

On-Site Evidence

Training curricula and/or educational materials provided to support familie

Training curricula and/or educational materials provided to service recipients regarding sexuality and relationships

On-Site Activities

*

- Interviews may include:
  1. Program director
  2. Relevant personnel
  3. Persons served
- Review case records

PRG 5.01 (FP)

The organization works in partnership with the person, and his or her team according to the wishes of the person, to develop and implement a service plan that promotes self-determination and enables the fullest and most independent life possible in the community.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Examples: *Individuals that may be members of the person's team include, but are not limited to: the person's family, friends and other natural supports, circle of support, support/service broker, and service coordinator.*

Service planning topics for persons with intellectual and developmental disabilities can include, but are not limited to:

1. *health and safety issues;*
2. *degree of supervision needed;*
3. *independent living, social, and daily living skills;*
4. *dietary needs;*
5. *leisure and vocational interests and aptitudes and the need for greater social inclusion;*
6. *screening and treatment for co-occurring psychiatric disorders or substance use conditions;*
7. *the need for assistive technology, auxiliary aids, and other special accommodations;*
8. *positive behavior support planning;*
9. *medication needs;*
10. *issues related to adaptive, behavior, and cognitive functioning including concrete and abstract reasoning;*
11. *specialized supports such as physical, speech, and occupational therapy;*
12. *ancillary services;*
13. *end of life planning; and*
14. *the need for hospice or palliative care.*

PRG 5.02 (FP)
Interventions that limit physical movement, diminish sensory experience, restrict personal freedoms, or cause personal discomfort are implemented only when:

a. the organization can document its reasons for believing that the intervention will be beneficial to the person served;
b. the person has been fully informed about the risks and benefits of the intervention and has consented to it;
c. the intervention is prescribed by a qualified medical practitioner or recommended by an interdisciplinary team, and specific parameters for use of the intervention, such as time limits and clear criteria for when the intervention should be applied, have been established;
d. the organization periodically reviews the continued need for and effectiveness of the treatment or intervention; and
e. the intervention is not used as a substitute for appropriate staffing patterns, for the convenience of personnel, or as punishment.

NA: The organization does not use interventions that limit physical movement, diminish sensory experience, restrict personal freedoms, or cause personal discomfort.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Related Standards: BSM 1.02

Examples: *Examples of such treatments and interventions include, but are not limited to: splints or poseys to prevent self-injury; use of visual or auditory screens to reduce stimulation; and use of distasteful substances, textures, or activities as a consequence for behavior.*

PRG 5.03 (FP)
The organization provides assistive technology, or helps the person gain access to assistive resources, as needed, and the person is:

a. involved in the selection of specific technologies;
b. afforded the opportunity to try the device prior to purchase or assignment; and
c. trained on the use of specific assistive devices being provided.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

PRG 5.04
The organization supports persons with intellectual and developmental disabilities to establish meaningful social relationships, build and maintain natural support systems, exercise their rights and responsibilities, and participate in the life of their community by:

a. helping them identify and pursue the types of social roles and relationships they wish to pursue;
b. providing opportunities for social and physical interaction with people, other than service providers and other service recipients; and
c. helping them achieve an optimal level of community involvement and participation.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

PRG 5.05
Family support services and information are available to:

a. strengthen the family's ability to provide care;
b. prevent unwanted and inappropriate out-of-home placements;
c. help resolve conflicts between the person and his/her family, advocate, or others involved in establishing and implementing the person's plan; and
d. help maintain family unity.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Examples: *Informational topics that may assist caregivers include, but are not limited to: early childhood development, behavior, home economics, work-life balance, and nutrition.*

Examples of community support services include, but are not limited to: behavioral support, case management, counseling, early intervention services, financial assistance, in-home support, public entitlements, respite services, and support groups.

PRG 5.06 (FP)
Persons with intellectual and developmental disabilities receive support and education regarding sexuality and relationships that has been tailored to their assessed needs, capacity, and learning style including:

a. sexual health and development;
b. family planning;
c. prevention of STDs and HIV/AIDS; and
d. sexual abuse and exploitation including giving and receiving sexual consent.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Program Administration
PRG 6: Personnel Training for Intellectual and Developmental Disabilities Services

Personnel who provide direct services to people with intellectual and developmental disabilities are trained and able to provide services, supports, and other forms of direct assistance.
NA:

-
- The organization does not provide any programs or services to persons with intellectual and developmental disabilities. The organization is implementing the standards for Intellectual and Developmental Disabilities Services (IDDS).

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Self Study Evidence

• Table of contents of training curricula	

- Training curricula
- Documentation tracking staff completion of required training

On-Site Evidence

*

- Interviews may include: 1. Relevant personnel

On-Site Activities

*

PRG 6.01

Direct service personnel are trained on, or demonstrate competency in:

a. communication techniques;
b. de-escalation techniques for individuals with intellectual and developmental disabilities; and
c. implementing the principles of self-determination and inclusion.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

PRG 6.02

Direct service personnel are trained on, or demonstrate competency in, the following topics as appropriate to the service and needs of persons served:

a. assisted dining techniques and good nutrition;
b. lifting and transfer techniques;
c. safe transportation techniques;
d. health related supports;
e. use of assistive technology; and
f. teaching ADLs.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

PRG 6.03 (FP)

Direct service personnel are trained and evaluated on the restrictive interventions identified in the treatment plan prior to working with the individual and annually thereafter including:

a. the parameters under which interventions may be used;
b. the proper and safe use of chosen interventions; and
c. the potential for re-traumatization.

NA: The organization does not permit the use of restrictive interventions as part of behavior management.

NA Taken: *The organization does not provide any programs or services to persons with intellectual and developmental disabilities.*

Examples: *Restrictive interventions are those that limit physical movement, diminish sensory experience, restrict personal freedoms, or cause personal discomfort*

Administration and Management Standards

RPM: Risk Prevention and Management

Purpose
Comprehensive, systematic, and effective risk prevention and management practices sustain the ability to positively impact the communities and people it serves by reducing its risk, loss, and liability exposure.

Introduction

COA's Risk Prevention and Management standards require that organizations take a proactive approach to risk by continually improving systems and practices for identifying and mitigating potential risks, and learning from adverse events and challenges when they occur. Proactive, systemic risk prevention and management requires a holistic approach that involves staff throughout the organization and considers all areas of potential risk including, but not limited to: legal compliance, liability exposure, health and safety, human resources, contracting, technology, security of information, client rights and confidentiality, and finances. Such practices contribute to mission fulfillment by protecting the organization's long-term sustainability.

Note: *Please see the RPM Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see RPM Crosswalk.*

Table of Evidence

Self-Study Evidence *No Self-Study Evidence*

RPM 1: Legal and Regulatory Compliance

The organization annually reviews compliance with applicable federal, state, and local laws, codes, and regulations, including those related to:

a. licensure;
b. facilities
c. accessibility;
d. health and safety;
e. finances; and
f. human resources.

Related Standards: ASE 3.02, ASE 4.02, BSM 4, CR 2, FIN 3.02, FIN 6.04, GOV 5.01, GOV 5.05, HR 2.02, HR 2.03, HR 2.04, HR 5.01, PRG 1.05, PRG 1.07, PRG 2, PRG 3, TS 3.03

Interpretation: *In regards to element (b), organizations that rent facilities should obtain relevant documentation from their landlord. If the organization cannot obtain access to the required documentation from their landlord or from relevant public or private health and safety authorities, the organization may also solicit a recognized expert to verify compliance with applicable laws and safety codes.*

Examples: *In regards to element (b), examples of relevant regulations and codes can include:*

1. *certification of occupancy requirements;*
2. *zoning and building codes;*

3. *occupational safety and health administration codes;*
4. *health, sanitation, and fire codes; and*
5. *elevator inspections.*

In regards to element (c), relevant requirements can include for example, universal precautions for minimizing exposure to contagious and infectious disease; and storage, cleaning, and disposal of medical waste.

In regards to element (f), it is recommended practice to conduct an annual review of human resource practices to ensure compliance with applicable employment and labor laws. The Human Resource Management field refers to this annual review as an annual "audit".

Examples of human resource laws and regulations include:

1. *use of independent contractors;*
2. *use of contingent workers such as temporary employees, volunteers, and leased workers;*
3. *laws governing fair employment practices, including non-discrimination and harassment;*
4. *compensation and benefits;*
5. *maintenance of personnel records;*
6. *selection and retention practices, including retention of hiring records; and*
7. *background checks.*

Self-Study Evidence

*Provide a letter signed by the Governing Body Chair and CEO certifying the organization is presently in compliance with applicable laws, codes, and regulations	**File:** CEO letter
*Procedures for reviewing compliance with applicable laws, codes, and regulations related to management, operations, and services delivered	**File:** Risk Prevention and Management Procedure

Site Visit Evidence

- Results of most recent annual, internal compliance reviews
- Governing Body minutes for most recent discussion of legal compliance
- Relevant licenses as applicable to the organization's programs and operations
- Reports from licensing/regulatory review that include adverse findings or loss of licensure, as applicable

On-Site Activities

*Interviews may include:

1. Governing body
2. CEO
3. Relevant personnel

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement; e.g.,
   - One of the elements has not been reviewed in more than two years; or
   - The organization has been notified of compliance or licensure problems and is working with the relevant authority to remediate deficiencies.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - Two elements have not been reviewed in more than two years; or

- The organization is under sanction due to noncompliance with legal or regulatory requirements; or
- The letter certifying compliance with all applicable laws was not signed or was otherwise inadequate.

RPM 2: Risk Prevention and Management

The organization identifies and reduces potential loss and liability by:
a. conducting prevention and risk reduction activities; and
b. monitoring and evaluating risk prevention and management effectiveness.

Self-Study Evidence

*Procedures for quarterly review of immediate and ongoing risks	**File:** Risk Prevention and Management Procedure
*Procedures for investigation and review of critical incidents	**File:** Critical Incidents Procedure

Site Visit Evidence

- Quarterly risk management reports
- Results of independent investigations of critical incidents
- Governing body and management meeting minutes where risk prevention and management activities are reviewed

On-Site Activities

*Interviews may include:
1. Governing Body
2. CEO
3. Relevant personnel

Rating Indicators:
1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the RPM 2 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the RPM 2 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the RPM 2 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the RPM 2 Practices standards.

RPM 2.01 (FP)

The organization conducts a quarterly review of immediate and ongoing risks that includes a review of incidents, critical incidents, accidents, and grievances including the following, as appropriate to the program or service:

a. facility safety issues;
b. serious illness, injuries, and deaths;
c. situations where a person was determined to be a danger to himself/herself or others;
d. service modalities or other therapeutic interventions; and
e. the use of restrictive behavior management interventions, such as seclusion and restraint.

Related Standards: ASE 4, ASE 5, ASE 5.01, BSM 1.03, CR 1.05

Example: *The organization can examine critical incident data that disaggregates incidents by race and ethnicity to identify trends in service equity, such as disproportionate use of restrictive interventions*.

Note: *Results of the quarterly reviews may inform the annual insurance needs assessment in RPM 3.01.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Reviews are conducted quarterly but one of the elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
   - The organization conducts reviews less than quarterly; or
   - Two elements are not fully addressed; or
   - One element is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 2.02 (FP)

The organization conducts a review of each incident, serious occurrence, accident, and grievance that involves the threat of or actual harm, serious injury, or death; and review procedures:

a. require that the investigation be initiated within 24 hours of the incident and/or accident being reported and establish timeframes for completing the review;
b. require solicitation of statements from all involved individuals;
c. ensure an independent review;
d. require timely implementation and documentation of all actions taken;
e. address ongoing monitoring if actions are required and assessing their effectiveness; and
f. address applicable reporting requirements.

Related Standards: BSM 5.02

Examples: *Root cause analysis can be a useful approach to reviewing serious incidents and accidents. Root cause analysis is a term used to describe a variety of techniques used by organizations to identify the cause of a problem and determine how to prevent that problem from recurring.*

RPM 3: Insurance Protection

The organization is adequately insured.

Self-Study Evidence

Written notification to staff and governing body describing insurance coverage including the extent and limits of such coverage	**File:** Copy of INSURANCE COVERAGE_2024
Policy for legal assistance to personnel against whom claims are made	**File:** Legal Assistance Policy

Site Visit Evidence

- Current insurance policies with descriptions, amounts, and dates of coverage
- Results of most recent annual assessment of insurance needs

On-Site Activities

- Interviews may include:
  1. Governing Body

2. CEO/CFO
3. Relevant personnel

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the RPM 3 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the RPM 3 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the RPM 3 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the RPM 3 Practice standards.

RPM 3.01 (FP)

The organization annually assesses insurance needs in consultation with insurance professionals or experienced legal counsel, and obtains coverage that is commensurate with the scope and complexity of its services.

Related Standards: ASE 4.02, GOV 5.05

Examples: *Relevant types of insurance can include:*

1. *general liability;*
2. *worker's compensation;*
3. *disability;*
4. *fire and theft;*
5. *medical;*
6. *indemnification;*
7. *professional liability;*
8. *officer's or director's liability;*
9. *automobile liability;*
10. *property and casualty;*
11. *malpractice;*
12. *cybersecurity or cyber liability; and*
13. *bonding or other forms of employee theft insurance, for all staff and governing body members who sign checks, handle cash or contributions, or manage funds.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
   The organization obtains professional consultation about appropriate coverage.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Insurance needs are reviewed annually, however coverage may be insufficient in some areas.
3. Practice requires significant improvement; e.g.,
   - Insurance needs have not been reviewed for more than two years; or
   - Coverage is clearly inadequate in one key area.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 3.02

The organization:

a. provides written notification to the governing body and personnel of the amount and type of insurance coverage related to the scope of their activities performed on the organization's behalf;

b. advises the governing body and personnel of the extent and limits of liability coverage; and
c. provides and assumes the cost of legal assistance to personnel against whom claims are made related to lawful, authorized actions taken within the course and scope of their duties.

Interpretation: *All personnel and governing body members must receive this information at the initiation of their association with the organization and when any changes to the level and/or type of insurance coverage occur.*

Interpretation: *This standard does not require the organization to provide assistance to personnel who commit unlawful acts or acts that are not conducted in the course of, or in furtherance of, their employment. In addition, this standard does not require the organization to provide legal assistance to personnel if the organization's legal counsel determines that doing so would constitute a conflict of interest.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The organization generally provides a written description but on occasion the disclosure is verbal and informal.
3. Practice requires significant improvement; e.g.,
   - The organization provides information only upon request or provides partial disclosure.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 4: Technology and Information Management

The organization's technology and information systems have sufficient capability to support operations, service delivery, strategic planning, and quality improvement activities.

Interpretation: *The standards in this section address the management of all types of paper and electronic information maintained by the organization including:*

1. *case records and other information of persons served;*
2. *administrative, financial, and risk management records and reports;*
3. *personnel files and other human resources records; and*
4. *performance and quality improvement data and reports.*

Examples: *Implementing a controlled document system is one way an organization can organize, track, store and ensure the use of the most current version of documents. These systems address, for example, processes for:*

1. *updating, creating, and deleting documents;*
2. *notifying users of changes;*
3. *identifying documents; and*
4. *maintaining a master list of documents.*

Self-Study Evidence

*Information management procedures/guidelines	**File:** IT Policy
*Technology assessment	**File:** 20210315150234559.pdf

Site Visit Evidence

*Agreements with third parties (e.g., information technology vendors, business associates, etc.), when applicable

On-Site Activities

*Interviews may include:

1. Information systems manager
2. Relevant personnel

*Observe information systems

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the RPM 4 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the RPM 4 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the RPM 4 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the RPM 4 Practice standards.

RPM 4.01

The organization assesses its technology and information management needs including a review of:

a. current technology and information systems in use by the organization;
b. short- and long-term goals for utilizing technology; and
c. current technical skills of staff and need for staff training.

Related Standards: GOV 2.03, GOV 5.05, HR 1, TS 1.01, TS 2.02

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   One of the standard's elements was not fully addressed.
3. Practice requires significant improvement; e.g.,
   The assessment is very basic and provides minimal guidance to staff; or
   One of the elements was not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 4.02

The organization has an information management system that:

a. gives personnel consistent, timely, and appropriate access to all types of electronic and paper records; and
b. supports continuity and integration of care across programs and services by giving timely access to information about persons served to practitioners across the organization, as appropriate.

Interpretation: *Organizations moving to electronic systems may need to develop procedures for maintaining both electronic and paper records including procedures for maintaining consistency between the two file types and ensuring the electronic record is comprehensive and complete. If there are components of paper records that cannot be accommodated electronically, the organization should consider how it will retain and document the existence of supplemental, paper-based portions of records.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - A formal system is in place, but is not fully implemented so locating records may sometimes be time-consuming or difficult.
3. Practice requires significant improvement; e.g.,
   - The system is informal and unsystematic; or
   - Records are occasionally misplaced.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 4.03

The organization's electronic information systems are capable of:

a. capturing, tracking, and reporting financial, compliance, and other business information;
b. longitudinal reporting and comparison of performance and outcomes over time; and
c. the use of clear and consistent formats and methods for reporting and disseminating data.

Related Standards: FIN 4.02, FIN 4.03, FIN 6.01, PQI 5.02

Interpretation: *"Electronic information systems" are used for collecting, storing, analyzing, and disseminating information electronically. An electronic information system may consist of a single desktop or larger network of computers, laptops, and/or devices. Organizations are not required to implement robust electronic information systems; rather they must have systems that are appropriate for supporting their administrative operations and service delivery.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspects of the system need further development.
3. Practice requires significant improvement; e.g.,
   - The system is basic and minimally supports the organization's data needs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 5: Security of Information

Electronic and printed information is protected against intentional and unintentional destruction or modification and unauthorized disclosure or use.

Related Standards: CR 2, PRG 2.01, TS 2.02

Interpretation: *The standards in this section address security of all types of paper and electronic information maintained by the organization, unless otherwise noted, including:*

1. *case records and other information of persons served;*
2. *administrative, financial, and risk management records and reports;*
3. *personnel files and other human resources records; and*
4. *performance and quality improvement data and reports.*

Self-Study Evidence

Data security policies	**File:** Data Management Procedure **File:** IT Policy.pdf
Data security procedures, including HIPAA compliance as applicable	**File:** Data Management Procedure.pdf **File:** IT Policy.pdf
Policies on the use of social media, electronic communications, and mobile devices	**File:** IT Policy.pdf
Procedures on the use of social media, electronic communications, and mobile devices	**File:** IT Policy.pdf
Procedures for managing data interruptions/disaster recovery plan	**File:** Data Management Procedure.pdf **File:** IT Policy.pdf

Site Visit Evidence

- Agreements with third parties (e.g., information technology vendors, business associates, etc.), when applicable
- Results of HIPAA compliance review

On-Site Activities

- Interviews may include: relevant personnel
- Observe case record room/files and information system accessibility

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the RPM 5 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the RPM 5 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the RPM 5 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the RPM 5 Practice standards.

RPM 5.01

The organization protects confidential and other sensitive information from theft, unauthorized use or disclosure, damage, or destruction by:

a. limiting access to authorized personnel on a need-to-know basis;
b. using firewalls, anti-virus and related software, and other appropriate safeguards;
c. monitoring security measures on an ongoing basis;

d. having the ability to remotely wipe or disable mobile devices, if applicable, in the event that a device is lost, stolen, repurposed, or discarded; and
e. maintaining paper records in a secure location when not in use by authorized staff.

Related Standards: PRG 4.01

Examples: *In regards to element (a), the organization may limit access to authorized personnel by:*

1. *limiting access based on staff role within the organization;*
2. *ensuring the electronic system requires strong passwords/passcodes for access to confidential information, requires passwords/passcodes to be regularly changed, locks the user out of the system for incorrect login attempts, and automatically times out after a period of inactivity and prompts reauthentication;*
3. *disabling the equipment, passwords, and access of former employees; and*
4. *ensuring the system is capable of tracking who accesses confidential information in the system and recording when information is altered or deleted, also known as audit logs.*

In regards to element (e), secure storage of paper records can include:

1. *locked file cabinets;*
2. *a locked file room with limited access or a gatekeeper system whereby one person or a few people can unlock the file storage area or access the files themselves; or*
3. *a system using a keypad or keys where only authorized individuals are given the keypad code or copies of the keys.*

Other important considerations can include procedures related to information taken off-site by staff.

Note: *Please see the Facility Observation Checklist for additional guidance on this standard.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspect of the organization's data security procedures needs strengthening; or
   - With few exceptions, procedures are understood by staff and are being used.
3. Practice requires significant improvement; e.g.,
   - There is a major deficiency in at least one of the listed elements resulting in risk to the organization; or
   - There have been instances of unauthorized access to confidential or sensitive information; or
   - Procedures are not well-understood or used appropriately.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 5.02
Proper safeguards protect confidential information when transmitted electronically.

Related Standards: PRG 4.01

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 5.03
The organization has policies and procedures addressing the use and monitoring of:

a. social media;
b. electronic communications; and
c. mobile devices, including staff-owned devices, if applicable.

Related Standards: PRG 4.01

Examples: *"Social media and electronic communications" include a variety of applications and websites used to create and share content, for example:*

1. *the organization's own website;*
2. *external websites;*
3. *email;*
4. *texting;*
5. *blogs;*
6. *social networking and bookmarking sites such as Pinterest, Instagram, Twitter, and Facebook;*
7. *wikis; and*
8. *discussion forums.*

Risks associated with the use of social media and electronic communications may include:

1. *unauthorized or prohibited contact between staff and service recipients;*
2. *unauthorized or inappropriate use of organization logos or trademarks;*
3. *personal comments or opinions that can be misconstrued as representing the views of the organization, or that present the organization in a negative light;*
4. *inadvertent or deliberate disclosure of confidential or proprietary business information; and*
5. *inadvertent or deliberate disclosure of confidential or protected information about service recipients.*

Examples: *A social media policy typically addresses:*

1. *the organization's definition of "social media";*
2. *responsible parties (e.g., individuals responsible for setting up accounts, contributing content, monitoring content, etc.);*
3. *prohibited forms of communication;*
4. *the appropriate use of social media including confidentiality and privacy considerations; and/or*
5. *consequences for failure to follow the policy and/or related guidelines.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspect of the procedures need further development.
3. Practice requires significant improvement; e.g.,
   - Procedures are very basic and provide minimal guidance to staff; or
   - Procedures are not well-understood by staff or are frequently not being followed; or
   - Procedures are still under development and have only been partially implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 5.04

The organization is prepared for planned and unplanned interruptions of data and limits the disruption to its operations and service delivery by:

a. maintaining procedures for managing data interruptions and resuming operations;
b. backing up electronic data regularly, with copies maintained off premises;
c. regularly testing the organization's back-up plan including data restoration processes.

Related Standards: ASE 6.01, ASE 6.02

Interpretation: *This standard applies to any instance of prolonged data disruption, regardless of whether there is a corresponding emergency.*

Examples: *A disaster recovery plan is a set of procedures put in place to protect and recover an organization's IT infrastructure to ensure the continuation of business in the event of a disaster. The plan clearly defines what disaster means for the organization's administrative operations and service delivery. It also includes specific guidance on when primary systems are considered nonfunctional/shut down, at what point secondary systems should be activated, who has the authority to make that determination, and how to inform staff and stakeholders that a disaster has occurred.*

Factors that increase the effectiveness of a disaster recovery plan include:

1. *training staff on response procedures;*
2. *practicing procedures/conducting downtime drills;*
3. *testing disaster recovery systems on an ongoing basis; and*
4. *monitoring plan implementation.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Some aspects of the procedures need further development.
3. Practice requires significant improvement; e.g.,
   - Procedures are very basic and provide minimal guidance to staff; or
   - Procedures are still under development and have only been partially implemented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 5.05

The organization ensures its electronic system for managing health records or protected health information limits access to information in accordance with confidentiality rules and the person's privacy preferences to the greatest extent possible.

NA Taken in 2021: *The organization does not electronically manage health records or protected health information.*

Interpretation: *If the electronic health record system employed by the organization is not able to meet all client privacy preferences and/or all of the necessary confidentiality rules, the organization informs the service recipient of the system's limitations and obtains consent for the exchange of electronic health information based on those restrictions.*

Examples: *The HIPAA Security Rule and Meaningful Use criteria provide strong guidance to organizations regarding the capabilities of electronic health record (EHR) systems. Using a certified EHR is the best way to meet the Meaningful Use criteria. Organizations that are unable to acquire a certified EHR are encouraged to still strive to meet Meaningful Use recommendations in their selection and use of EHR systems.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures for monitoring and maintaining legal compliance require greater clarity or specificity.
3. Practice requires significant improvement; e.g.,
   - The organization is aware of compliance problems and is working to remediate deficiencies.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.,
   - The organization is aware of compliance problems and is not working to remediate deficiencies.

RPM 6: Contracts and Service Agreements

The pursuit of contracts and service agreements is:

a. consistent with the organization's mission;
b. aligned with, and supportive of, the organization's service array and resource development goals; and
c. responsive to the needs and desired outcomes of persons served.

Interpretation: *These standards apply to all contracts entered into by the organization in which it acts as a purchaser or vendor of social and human services as well as to contracts for the purchase of support services, such as maintenance or transportation services.*

Note: *These standards are not applicable to contracts with individual consultants and independent contractors, which are addressed in Human Resources Management (HR 7).*

Note: *See Applicability of COA Standards to Contracts and Non-contractual Service Agreements for additional guidance on this standard.*

Self-Study Evidence

Contracting procedures	**File:** Contracting Policy and Procedure.pdf
List of contracts/service agreements/memoranda of understanding (MOU)	**File:** boy scouts mou.pdf **File:** vgcc mous.pdf **File:** smart start mou.pdf **File:** united way mou.pdf 2024: All CSC MOUs

Site Visit Evidence

- Contracts/service agreements/MOUs
- Board meeting minutes of governing body review of significant contracts from the previous 12 months

On-Site Activities

- Interviews may include:
    1. Governing Body
    2. CEO/CFO
    3. Contract manager(s)
    4. Vendors

Rating Indicators:

1. The organization's practices fully meet the standard, as indicated by full implementation of the practices outlined in the RPM 6 Practice standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the RPM 6 Practice standards.
3. Practice requires significant improvement, as noted in the ratings for the RPM 6 Practice standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the RPM 6 Practice standards.

RPM 6.01

The organization:

a. establishes a system of standardized contracting practices;
b. pursues contracts that serve the organization's and service recipient's best interests, not private interests;
c. conducts due diligence in contracting activities including review of possible risks;
d. uses competitive bidding, when applicable; and
e. ensures governing body review of significant contracts.

Related Standards: GOV 5.05

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the elements needs strengthening.
3. Practice requires significant improvement; e.g.,
    - Two of the elements need strengthening; or
    - One element is not addressed at all; or
    - The governing body does not review significant contracts.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 6.02 (FP)

Written contracts:

a. are reviewed by legal counsel or another qualified individual prior to signing; and
b. contain all significant terms and conditions in accordance with applicable law.

Interpretation: *"Significant terms" should include, as appropriate to the type of contract:*

1. *roles and responsibilities of participating organizations;*

2. *services to be provided;*
3. *clearly defined performance goals;*
4. *measurable outcomes;*
5. *service authorization, including eligibility criteria;*
6. *provisions for training and technical support, as necessary;*
7. *duration of contract, including delineation of follow-up services;*
8. *policies and procedures for sharing information;*
9. *methods for resolving disputes;*
10. *a plan and procedure for timely payment, and consequences for failure to pay;*
11. *necessary documentation and means of reporting to, funding or oversight bodies; and*
12. *conditions for termination of the contract.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Though all contracts are reviewed, contracting procedures do not address the standard.
3. Practice requires significant improvement; e.g.,
   - Terms and conditions of contracts are often general, nonspecific, or unclear; or
   - There is evidence that some contracts have not been reviewed as required by the standard.
4. Implementation of the standard is minimal or there is no evidence of implementation at all; e.g.
   - Contracts are totally inadequate in specification of terms and conditions; or
   - Contracts are not routinely reviewed as required.

RPM 6.03

Non-contractual service agreements include, as appropriate:

a. services exchanged or provided, and/or the goals and objectives of such collaborations;
b. roles and responsibilities of each organization including reporting responsibilities;
c. procedures for sharing information;
d. confidentiality protections including signed written consent forms;
e. assignment of case coordination responsibilities;
f. service authorization procedures including accepting or rejecting cases; and
g. how to resolve communication difficulties.

NA Taken in 2021: *The organization does not enter into non-contractual service agreements.*

Interpretation: *This standard applies to non-contractual arrangements, also known as Memorandums of Understanding (MOUs), in which organizations collaborate with service providers to deliver specific services to a person or persons. This could include, for example, a service in which a service provider voluntarily comes into the host organization's facility to provide weekly smoking cessation classes.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - Procedures need strengthening; or
   - One element is not addressed at all.
3. Practice requires significant improvement; e.g.,
   - Terms and conditions of service agreements are often general, nonspecific, or unclear; or
   - At least two of the elements are not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

RPM 7: Quality Monitoring of Contracted Social and Human Services

The organization monitors and evaluates the quality and effectiveness of social and human services purchased from other provider organizations.

NA Taken in 2021: *The organization does not purchase social and human services from other organizations.*

Interpretation: *These standards only apply to contracts entered into by the organization in which it purchases social and human services from another organization, such as when a shelter program purchases vocational rehabilitation services for its clients. They do not apply to contracts where the organization acts as a vendor of social and human services or to contracts for the purchase of support services, such as maintenance or transportation services. These types of contracts are addressed in RPM6.*

The standards in this Core are also not applicable to contracts with individual consultants and independent contractors, which are addressed in Human Resources Management (HR 7).

Self Study Evidence

• Contract monitoring procedures	

On-Site Evidence

- Contracts
- Contractor progress reports

Documentation of contract remediation as appropriate

- **On-Site Activities**

Interviews may include:

1. Governing Body
2. CEO/CFO
3. Contract manager(s)

RPM 7.01 (FP)

Contractors who provide human or social services:

a. have sufficient human and financial resources to fulfill the terms of the contract; and
b. are licensed or otherwise legally authorized to provide the contracted services.

NA Taken: *The organization does not purchase social and human services from other organizations.*

RPM 7.02

The organization routinely monitors contractor progress toward fulfilling the terms of the contract.

NA Taken: *The organization does not purchase social and human services from other organizations.*

RPM 7.03

Contracts for social and human services include:

a. service quality, client satisfaction, and outcomes that accord with the organization's expectations;
b. criteria for evaluating vendor performance;
c. a process for remediating performance issues; and
d. protocols for routine communication of related data.

NA Taken: *The organization does not purchase social and human services from other organizations.*

COUNCIL ON ACCREDITATION

Service Delivery Administration Standards
Training and Supervision

Purpose
The organization supports personnel and promotes personnel competence, satisfaction, and retention by providing initial and ongoing training; a variety of personnel development opportunities; and regular, supportive supervision.

Introduction
COA's Training and Supervision (TS) standards focus on ensuring personnel have the competencies, support, and continuous learning opportunities they need to fulfill their roles at the organization and effectively meet the needs of the individuals and families they serve.

Personnel competence is the product of a dynamic combination of factors including experience, formal education, training, coaching, peer support, mentoring, and supportive supervision. As such, COA's TS standards reflect a multi-faceted approach to personnel development and supervision that enhances supervisors' abilities to respond to the individual needs of their workers while simultaneously promoting personnel competence, satisfaction, and retention across the organization.

Note: *COA's Training and Supervision (TS) standards do not apply to independent contractors.*

Table of Evidence

Self-Study Evidence *No Self Study Evidence*

TS 1: Personnel Development

The organization supports effective service delivery through a structured personnel development program that provides personnel with the knowledge, skills, and abilities needed to achieve positive outcomes for persons served.

Examples: *Professional development programs can include:*

1. *direct supervision;*
2. *formal, internal personnel training;*
3. *internal and external conferences and workshops;*
4. *encouraging personnel to join and participate in professional organizations;*
5. *helping personnel to identify training and educational experiences that are credit bearing; and*
6. *offering tuition reimbursement, financial assistance, or time off*

Self-Study Evidence

*Annual training and development plan	**File:** Master Training List
*Annual assessment of training needs	**File:** Staff-Qualifications-Workload-Report-
*Table of contents of orientation curriculum	**File:** Orientation checklist
*Procedures for evaluating training effectiveness	**File:** Professional Development

Site Visit Evidence

- Documentation tracking staff completion of orientation
- Training curricula
- Results of evaluation for training effectiveness

On-Site Activities

- Interviews may include:
    1. HR Director
    2. Relevant personnel

TS 1.01 (FP)

A personnel development plan:

a. is reviewed annually and revised in accord with an assessment of the organization's training needs;
b. incorporates a variety of educational methods;
c. is responsive to the history, cultural backgrounds, and related needs of personnel;
d. outlines specific competency expectations for each job category;
e. provides the opportunity for personnel to fulfill the continuing education requirements of their respective professions; and
f. provides opportunities to support advancement within the organization and profession; and
g. provides opportunities for personnel to practice cultural humility.

Related Standards: GOV 2.03, HR 1, HR 4.02, RPM 4.01

Examples: *Educational methods can include, but are not limited to:*

1. *interactive classroom trainings;*
2. *webinars, self-paced trainings, or other computer-assisted training models;*
3. *coaching; and*
4. *structured peer support opportunities.*

Examples: *Examples of opportunities for personnel to practice cultural humility can include:*

1. *lunch-and-learns, webinars, or lectures;*
2. *facilitated conversations;*
3. *employee resource groups; and*
4. *resource sharing.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - One of the standard's elements is not fully addressed.
3. Practice requires significant improvement; e.g.,
    - Two elements are not fully addressed; or
    - One of the elements is not addressed at all.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 1.02

New personnel are oriented within the first three months of hire to the organization's mission, philosophy, goals, and services.

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
    - Occasionally orientation extends beyond the three months.
3. Practice requires significant improvement; e.g.,
    - The curriculum is not well developed or lacks depth; or
    - A significant number of staff have not been oriented.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 1.03
The organization evaluates the effectiveness of its training activities and makes needed improvements.

Related Standards: PQI 3.03

Examples: *Examples of ways to demonstrate implementation of this standard include, but are not limited to:*

1. *surveying personnel to assess satisfaction with a training activity and perceived competence;*
2. *implementing pre- and post-testing to assess skill acquisition, including practitioner observation where appropriate;*
3. *tracking performance data over time to identify trends and make improvements to training activities; and*
4. *conducting more complex analysis to assess the impact of training on positive outcomes.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement.
3. Practice requires significant improvement.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 2: Training Content
Personnel are prepared to fulfill their job responsibilities.

Interpretation: *Standards in TS S 2 should be applied to independent contractors based on their role and the competencies stipulated in their contract. While organizations typically would not provide training to contractors directly, they should maintain documentation from contractors that demonstrates their competency in applicable areas. Competency can be demonstrated through education, training, experience, degree requirements, certifications, licenses, and pursuit of CEUs, as applicable.*

Self-Study Evidence

*Annual training calendar and/or training schedules	**File:** Master Training List 2021-on
*Table of contents of training curricula	**In 2021:** **File:** VGCC First Aid Randy **File:** Van driving curriculum **File:** Med Administration Training 2024 **File:** Crisis Response Part **File:** Food Safety and Preparation Review and Quiz **File:** Food Safety and Preparation Review and Quiz Answer Guide **File:** PhishingAwareness_Training **File:** Pool operator table of contents.pdf **File:** CCW Self Care 2020.pdf **File:** COVID19-Vaccine-101-Deck-Final.pdf **File:** communciation&relationships.pdf **File:** MHCO How Do I PQI and accreditation Training.ppt **File:** NCHumanTraffickingTaskForceManual.pdf **File:** DC Training - Interaction & Engagement --6 six months.pptx **File:** Ethical and Professional Standards of Conduct and Employee Rights 2020 with Answers.ppt **File:** attachment & belonging.pptx **File:** FMLA & Leave Requests for Employees

Site Visit Evidence

- Training curricula
- Documentation tracking staff completion of required trainings

On-Site Activities

- Interviews may include:
  1. Program directors
  2. Relevant personnel

TS 2.01 (FP)
All personnel who have regular contact with clients receive training on legal issues, including:

a. mandatory reporting, pursuant to relevant professional standards and as required by law, and the identification of clinical indicators of suspected abuse and neglect, as applicable;
b. federal and state laws requiring disclosure of confidential information for law enforcement purposes, including compliance with a court order, warrant, or subpoena;
c. duty to warn, pursuant to relevant professional standards and as required by law;
d. the agency's policies and procedures on confidentiality and disclosure of service recipient information, and penalties for violation of these policies and procedures; and
e. the legal rights of service recipients.

Related Standards: CR 2, PRG 2.01, PRG 4.04

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The curriculum related to one of the elements is not fully developed or lacks depth; or
   - A few personnel have not been trained, but are scheduled to be trained.
3. Practice requires significant improvement; e.g.,
   - The curriculum related to two of the elements is not fully developed or lacks depth; or
   - Training does not address one of the elements at all; or
   - A significant number of staff have not been trained.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 2.02
Personnel receive training on the following, as appropriate to their position and job responsibilities:

a. proper documentation techniques;
b. the maintenance and security of records; and
c. the use of technology and information systems including refresher trainings when changes or updates are made.

Related Standards: PRG 1, PRG 2.01, PRG 4.04, RPM 4.01, RPM 5

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The curriculum related to one of the elements is not fully developed or lacks depth; or
   - A few personnel have not been trained, but are scheduled to be trained.
3. Practice requires significant improvement; e.g.,
   - Training does not address one of the elements at all; or
   - A significant number of staff have not been trained.

4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 2.03

Direct service personnel receive training on:

a. communicating respectfully and effectively with service recipients;
b. engaging service recipients, including building trust, establishing rapport, and developing a professional relationship; c. the impact of trauma on individuals, families, and personnel; and
c. trauma-informed care, including screening, assessment, and service delivery practices.

Related Standards: PRG 4.04

Interpretation: *Training on trauma should be tailored to the type of service being provided. For example, it may not be appropriate or necessary for assessments in an Early Childhood Education (ECE) setting to be trauma informed. It is up to the organization to assess the applicability of this standard for each of its programs and service population and design the training accordingly.*

Rating Indicators:
1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   - The curriculum related to one of the elements is not fully developed or lacks depth; or
   - A few personnel have not been trained, but are scheduled to be trained.
3. Practice requires significant improvement; e.g.,
   - The curriculum related to two of the elements is not fully developed or lacks depth; or
   - Training does not address one of the elements at all; or
   - A significant number of staff have not been trained.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 2.04

Training for direct service personnel addresses differences within the organization’s service population, as appropriate to the type of service being provided, including:

a. interventions that address cultural and socioeconomic factors in service delivery;
b. the role cultural identity plays in motivating human behavior;
c. procedures for working with non-English speaking persons or individuals with communication impairments;
d. understanding bias or discrimination;
e. recognizing individuals and families with special needs;
f. the needs of individuals and families in crisis, including recognizing and responding to a mental health crisis;
g. the needs of victims of violence, abuse, or neglect and their family members; and
h. basic health and medical needs of the service population.

Related Standards: ASE 3.03, CR 1.03, PRG 4.04

Examples: *Depending on the type of service being provided relevant training topics may vary from specialized treatment approaches to procedures for referring individuals to other providers when those needs cannot be addressed by the organization. For example, personnel at a credit counseling agency may encounter individuals with substance use or mental health disorders or individuals who may be at risk for suicide. In such situations, personnel should be aware of the agency's procedures for referring those individuals to appropriate services. Mental Health First Aid (MHFA) is one way to prepare personnel to recognize, understand, and respond to service recipients and colleagues experiencing a mental health crisis. Similarly, "gatekeeper training" programs prepare personnel to recognize, interpret, and respond to signs of suicide risk.*

Rating Indicators:

1. The organization's practices reflect full implementation of the standard.
2. Practices are basically sound but there is room for improvement; e.g.,
   The curriculum related to one of the elements is not fully developed or lacks depth; or
   A few personnel have not been trained, but are scheduled to be trained.
3. Practice requires significant improvement; e.g.,
   The curriculum related to two of the elements is not fully developed or lacks depth; or
   Training does not address one of the elements at all; or
   A significant number of staff have not been trained.
4. Implementation of the standard is minimal or there is no evidence of implementation at all.

TS 2.05

Direct service personnel are trained on, or demonstrate competency in, providing inclusive care to individuals with intellectual and developmental disabilities including:

a. communication techniques;
b. de-escalation techniques for individuals with intellectual and developmental disabilities; and
c. implementing the principles of self-determination and inclusion.

TS 2.05

Direct service personnel demonstrate competence in, or receive training on how to:

a. identify and access needed community resources;
b. collaborate with other service providers;
c. access financial assistance, including public assistance and government subsidies; and
d. empower service recipients and their families to advocate on their own behalf.

Examples: *One example of community resources are personal advocates and the conditions under which a personal advocate may be needed.*

TS 2.06

Personnel receive training, as appropriate to the position or job category, that includes:

a. implementing practices that promote positive behavior;
b. recognizing psychosocial issues, medical conditions, and challenging behaviors that are a threat to self or others and knowing when to seek assistance;
c. understanding how the physical environment, and other factors, can lead to a crisis; and
d. understanding the impact of personnel behaviors and responses on the behavior of service recipients.

Related Standards: ASE 2.01

Examples: *Training on challenging behaviors that are a threat to self may include responding to age-appropriate but potentially dangerous behavior, for example, reacting to a child who runs into the street, so as not to harm him/her. Relevant psychosocial issues can include the role a service recipient's trauma history may play in their behavior.*

TS 2.07 (FP)

Direct service staff receive training on methods for de-escalating volatile situations, including:

a. listening and communication techniques, such as negotiation, centering strengths, and mediation;
b. involving the person in regaining control and encouraging self-calming behaviors;
c. separation of individuals involved in an altercation;
d. offering a voluntary escort to guide the person to a safe location;
e. voluntary withdrawal from the group or milieu to allow the person to calm down; and

f. other non-restrictive ways of de-escalating and reducing episodes of aggressive and out-of-control behavior.

Related Standards: ASE 2.01

TS 3: Supervision

Supervision supports personnel development, retention, and improved outcomes.

Self-Study Evidence

*Written supervision framework	**File:** Supervision Policy and Procedure.pdf

Site Visit Evidence

- HR policies and procedures regarding staff supervision
- Documentation of supervision or supervision logs
- Sample job descriptions of supervisors from each program or service (i.e. front line, managers, department director

On-Site Activities

- Interview:
    1. HR Director
    2. Supervisors
    3. Personnel at all levels

TS 3.01 (FP)

The organization has a supervision framework that:

a. identifies the job responsibilities, skill set, and other behaviors required of supervisors, including their administrative, educational, and supportive functions;
b. sets supervisor-supervisee ratios;
c. establishes expectations for the frequency and format of supervision;
d. establishes expectations for the frequency and format of ongoing performance review; and
e. establishes resources and supports for supervisors.

Related Standards: HR 4

Examples: *Examples of resources and supports for supervisors include, but are not limited to:*

1. *employment assistance programs;*
2. *mentoring and coaching;*
3. *offering lateral transfers to less stressful assignments; and*
4. *ensuring coverage so supervisors can take advantage of trainings or other professional development opportunities.*

TS 3.02

Supervisors have sufficient time to:

a. provide regularly scheduled supervision and conduct evaluation and training activities as outlined in the organization's supervision framework; and
b. offer flexible support in response to crisis situations or urgent needs.

Related Standards: HR 4.01

Interpretation: *Supervisors should maintain an administrative file with up-to-date documentation of each supervisory session, including the date and duration of each session as well as a brief outline or summary of what was discussed.*

TS 3.03

Supervisors' administrative, educational, and supportive functions include:

a. delegating and overseeing work assignments;
b. ensuring that service delivery is performed according to the organization's mission, policies and procedures, and applicable law and regulation;
c. promoting knowledge acquisition and skill development through various professional development opportunities;
d. assisting personnel in transferring the skills and knowledge obtained in the classroom to their work in the field; and
e. implementing policies and procedures designed to prevent, recognize, and respond to work-related stress.

Related Standards: RPM 1

Examples: *In regard to element (d), ways to support knowledge transference can include, but are not limited to:*

1. *working with personnel to identify the most appropriate trainings for their position;*
2. *clarifying the purpose and relevance of the training before it is delivered;*
3. *following up with personnel to establish a plan for incorporating acquired skills and knowledge into their work, including setting performance goals and methods for tracking progress when appropriate;*
4. *modeling appropriate practice and/or establishing mentorships with more experienced colleagues; and*
5. *observing practice in the field accompanied by constructive feedback.*

In regard to element (e), activities or practices that are designed to prevent, recognize and respond to work-related stress can include, but are not limited to:

1. *training supervisors and workers on the potential impacts of work-related stress and prevention strategies;* 2. *reflective supervision;*
3. *peer support;*
4. *encouraging flex time arrangements;*
5. *informal and formal assessment tools;*
6. *managing work assignments to avoid heavy caseloads of traumatized individuals; and*
7. *providing access to employee assistance programs.*

TS 3.04

Supervisors provide additional support to personnel when they are:

a. new;
b. developing competencies, including personnel who have not yet obtained professional licensure or certification;
c. experiencing challenging or traumatic circumstances with the individuals and families they work with; or
d. experiencing higher caseloads.

Interpretation: *The suicide attempt or death of a service recipient can be a traumatic experience for staff. To help staff process the loss of a service recipient to suicide, voluntary non-judgmental support services should be made available to help the affected staff and other personnel grieve and prepare for future contact with individuals at risk for suicide.*

Examples: *Examples of additional support that might be needed by personnel include, but are not limited to:*

1. *more frequent supervision;*
2. *additional training opportunities;*
3. *shadowing; and*
4. *voluntary crisis response services.*

Service Standards

Youth Independent Living Services

Purpose
Young adults who receive Youth Independent Living Services obtain safe and stable housing, develop life skills and competencies including work readiness, achieve educational and financial growth goals, and establish healthy, supportive adult and peer relationships.

Definition

Youth Independent Living Services are designed for older adolescents who have been separated from their homes, may have been disconnected from long-term family relationships, and may have assumed parenting responsibilities. These youth need skills and support to lead self-sufficient, healthy, productive, and stable adult lives.

Youth receiving these services may be in state custody, living in a foster care or kinship care home, or in a residential treatment or group home setting and typically face numerous challenges due to multiple, changing living arrangements.

These challenges include a lack of: connection to effective support for educational achievement and school continuity; access to employment preparation and jobs; personal financial education, competency and security; and sources of encouragement to save and start to accumulate assets.

Note: *Please see YIL Reference List for the research that informed the development of these standards.*

Note: *For information about changes made in the 2020 Edition, please see the YIL Crosswalk.*

Table of Evidence
Self-Study Evidence *No Self Study Evidence*

YIL 1: Person-Centered Logic Model

The organization implements a program logic model that describes how resources and program activities will support the achievement of positive outcomes.

Note: *Please see the Logic Model Template for additional guidance on this standard.*

Table of Evidence

Self-Study Evidence

*Program logic model that includes a list of outcomes being measured	**File:** Logic Model for Independent Living Program m.pdf
See program description completed during intake	

Site Visit Evidence *No Site Visit Evidence*

On-Site Activities

- Interviews may include:
  1. Program director
  2. Relevant personnel

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
   Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   Logic models need improvement or clarification; or
   Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
   At least one outcome has been identified for all of its programs.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   Logic models need significant improvement; or
   Logic models are still under development for a majority of programs; or
   A logic model has not been developed for one or more high-risk programs; or
   Outcomes have not been identified for one or more programs.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   Logic models have not been developed or implemented; or
   Outcomes have not been identified for any programs.

<u>YIL 1.01</u>

A program logic model, or equivalent framework, identifies:

a. needs the program will address;
b. available human, financial, organizational, and community resources (i.e. inputs);
c. program activities intended to bring about desired results;
d. program outputs (i.e. the size and scope of services delivered);
e. desired outcomes (i.e. the changes you expect to see in service recipients); and
f. expected long-term impact on the organization, community, and/or system.

Examples: *Please see the W.K. Kellogg Foundation Logic Model Development Guide and COA's PQI Tool Kit for more information on developing and using program logic models.*

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to:*

1. *needs assessments and periodic reassessments;*
2. *risks assessments conducted for specific interventions; and*
3. *the best available evidence of service effectiveness.*

Examples: *YIL services can addresses the attainment of foundational, short-term, achievable outcomes that lay groundwork for longer-term positive outcomes.*

Depending on age, time in program, and other factors, outcomes such as school graduation or training completion can either be immediate or can begin with improving on test scores or reading at or above grade level.

Steps toward achieving economic self-sufficiency can include achieving such financial growth goals as completing a financial education program, understanding and obtaining a good credit rating, or building a savings account.

YIL 1.02

The logic model identifies client outcomes in at least two of the following areas:

a. change in clinical status;
b. change in functional status;
c. health, welfare, and safety;
d. permanency of life situation;
e. quality of life;
f. achievement of individual service goals; and
g. other outcomes as appropriate to the program or service population.

YIL 2: Personnel

Personnel have the competency and support needed to provide services and meet the needs of youth.

Interpretation: *Competency can be demonstrated through education, training, or experience. Support can be provided through supervision or other learning activities to improve understanding or skill development in specific areas.*

Self-Study Evidence

*Table of contents of training curricula	**In 2021:** **File:** ILP Curriculum Solving Conflicts.pdf **File:** ILP curriculum Legal Awareness.pdf **File:** ILP Curriculum Money Management.pdf **File:** ILP curriculum Emergency Services.pdf **File:** ILP Curriculum Cleaning.pdf **File:** ILP curriculum Community Skills.pdf **File:** ILP Curriculum Transportation.pdf **File:** ILP Curriculum Housing.pdf **File:** ILP Curriculum Health.pdf **File:** ILP Curriculum Job Maintenance.pdf **File:** ILP Curriculum Job Skills.pdf **File:** ILP Curriculum Hygiene.pdf
* Procedures or other documentation relevant to continuity of care and case assignment	**File:** ILP Admissions Deferrals and Intake Procedure.pdf **File:** ILP Assessment and Service Planning Procedure.pdf
*List of program personnel that includes: • Title • Name • Employee, volunteer, or independent contractor • Degree or other qualifications • Time in current position See organizational chart and program staffing information	

Site Visit Evidence

- Sample job descriptions from across relevant job categories
- Documentation tracking staff completion of required trainings and/or competencies
- Training curricula
- Caseload size requirements set by policy, regulation, or contract, when applicable
- Documentation of current caseload size per worker

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
- Review personnel files

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, including education, experience, training, skills, temperament, etc., but the integrity of the service is not compromised; or
    - Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications;
    - Most staff who do not meet educational requirements are seeking to obtain them; or
    - With few exceptions, staff have received required training, including applicable specialized training; or
    - Training curricula are not fully developed or lack depth; or
    - Training documentation is consistently maintained and kept up-to-date with some exceptions; or
    - A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
    - With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
    - Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
    - Specialized services are obtained as required by the standards.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - A significant number of staff (direct service providers, supervisors, and program managers) do not possess the required qualifications, including education, experience, training, skills, temperament, etc.; and as a result, the integrity of the service may be compromised; or
    - Job descriptions typically do not reflect the requirements of the standards, and/or hiring practices do not document efforts to hire staff with required qualifications when vacancies occur; or
    - Supervisors do not typically provide additional support and oversight to staff without the listed qualifications;
    - A significant number of staff have not received required training, including applicable specialized training; or
    - Training documentation is poorly maintained; or
    - A significant number of supervisors do not meet the requirements of the standard, and the organization makes little effort to provide training and/or consultation to improve competencies; or
    - There are numerous instances where caseload sizes exceed the standards' requirements or the requirements of internal policy when a caseload size is not set by the standard; or
    - Workloads are excessive, and the integrity of the service may be compromised; or
    - Specialized staff are typically not retained as required and/or many do not possess the required qualifications;
    - Specialized services are infrequently obtained as required by the standards.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards.

YIL 2.01

Personnel providing counseling and case coordination services are qualified by:

a. a bachelor's degree in social work or another human services field; and
b. two years of relevant youth work experience, including experience in case work, group work, and case coordination.

YIL 2.02

Supervisors are qualified by:

a. an advanced degree in social work or related field, experience delivering youth services, and supervisory experience; or
b. a bachelor's degree in social work or related field, two years of direct service experience with a comparable population, and three years of supervisory experience.

YIL 2.03

All direct service personnel are trained on, or demonstrate competency in:

a. positive youth development;
b. normative youth development and the effects of early trauma, educational gaps and delays, and abuse and neglect on youth development;
c. public assistance programs, eligibility requirements, and benefits;
d. local housing resources; and
e. the community service delivery system.

YIL 2.04

When serving severely and persistently mentally ill, HIV diagnosed, or chemically dependent youth, or youth with other special health and mental health issues, staff-to-supervisor ratios are 1:6.

NA Taken: *The program is not designed to serve youth with special health or mental health needs.*

YIL 2.05

The organization minimizes the number of workers assigned to the youth over the course of their contact with the organization by:

a. assigning a worker at intake or early in the contact; and
b. avoiding the arbitrary or indiscriminate reassignment of direct service personnel.

YIL 2.06

Caseloads support the achievement of youth outcomes, are regularly reviewed, and generally range between 12 and 20 cases.

Interpretation: *The number of cases carried should be smaller when youth receive counseling or other intensive services, and the worker's travel time or geographic area is extensive, than when a worker is providing primarily follow-up contact and less intensive, more centralized services.*

Examples: *Factors that may be considered when determining employee workloads include, but are not limited to:*

1. *case complexity, special needs, and circumstances;*
2. *age and population characteristics, including ethnic and cultural factors;*
3. *the qualifications, competencies, and experience of the worker, including the level of supervision needed;*
4. *the work and time required to accomplish assigned tasks and job responsibilities;*
5. *case status, and progress toward achievement of desired outcomes; and*
6. *service volume.*

YIL 3: Intake and Assessment

The organization's intake and assessment practices ensure that youth receive prompt and responsive access to appropriate services.

Table of Evidence

Self-Study Evidence

*Screening and intake procedures	**File:** ILP Admissions Deferrals and Intake Procedure.pdf
*Assessment procedures	**File:** ILP Assessment and Service Planning Procedure.pdf
*Copy of assessment tool(s)	**File:** ILP Assessment and Service Planning Procedure.pdf **File:** CYW-ACE-Q-TEEN-1-copy.pdf **File:** Finding-Your-Ace-Score.pdf **File:** WCC CSE-IT 2.0_12.21.18.pdf **File:** CLS_assessments_LifeSkills.pdf **File:** Sample Resident assessment-choo.pdf

Site Visit Evidence

- Strategies for engaging youth
- Community resource and referral list

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - In a few rare instances, urgent needs were not prioritized; or
    - For the most part, established timeframes are met; or
    - Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or

- Active client participation occurs to a considerable extent.

3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
   - Procedures and/or case record documentation need significant strengthening; or
   - Procedures are not well-understood or used appropriately; or
   - Urgent needs are often not prioritized; or
   - Services are frequently not initiated in a timely manner; or
   - Applicants are not receiving referrals, as appropriate; or
   - Assessment and reassessment timeframes are often missed; or
   - Assessments are sometimes not sufficiently individualized;
   - Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
   - Several client records are missing important information; or
   - Client participation is inconsistent; or
   - Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   - There are no written procedures, or procedures are clearly inadequate or not being used; or
   - Documentation is routinely incomplete and/or missing.

YIL 3.01

The organization partners with community entities and providers to:

a. identify youth with potential need; and
b. increase youth interest and the likelihood that needed supports and services will be used.

Interpretation: *This standard promotes the "no wrong door" concept that youth will not be turned away when a narrow service does not meet comprehensive need. Instead, youth should be engaged at any point of entry and should be referred to or served by an appropriate constellation of providers.*

YIL 3.02
Youth are screened and informed about:

a. how well their request matches the organization's services; and
b. what services will be available and when.

YIL 3.03
The youth and worker meet within 7-14 days, or within a time period consistent with established program timeframes and state guidelines.

YIL 3.04 (FP)
Prompt, responsive, intake practices:

a. address applicable legal protections for youth;
b. clarify what youth need and want;
c. gather information necessary to identify critical service needs and/or to determine if a more intensive service is necessary;
d. provide the basis for further assessment;
e. give priority to urgent needs and emergency situations, including health and safety concerns;
f. support timely initiation of services;
g. determine if youth are eligible to receive services and funding; and

h. provide placement on a waiting list or referral to appropriate resources when individuals cannot be served or cannot be served promptly.

YIL 3.05
Prior to or at initiation of services each worker and youth:

a. confirm the youth's age and legal status and, as appropriate, obtain necessary, authorized, written approvals for service from a legal guardian;
b. contact prior placements for confirmation about services the youth may have received, as appropriate; and
c. arrange to meet where the youth lives so the worker can observe and document if the arrangement is safe, healthy, and provides suitable social, emotional, and physical care and support.

Interpretation: *"Legal status" refers to whether youth are in state custody or are legally emancipated.*

YIL 3.06
The organization plans for, establishes, and maintains stable, ongoing, goal directed caseworker-youth relationships with youth who can be unfamiliar with how to seek, accept, and use support.

YIL 3.07
Youth participate in an individualized, culturally and linguistically responsive assessment that is:

a. completed within established timeframes;
b. updated as needed based on the needs of the youth; and
c. focused on information pertinent for meeting service requests and objectives.

YIL 3.08

Standardized assessment tools are used in conjunction with youth input to identify:
a. strengths, needs, challenges, and protective factors;
b. emotional and social competence and current level of peer group and community involvement;
c. involvement in challenging, interesting activities;
d. family connections, and relationships with other responsible adults;
e. availability and use of informal supports;
f. life skills;
g. educational status and progress toward achieving an age-appropriate educational level or school completion;
h. housing; and
i. physical and mental health care needs.

Interpretation: *The Assessment Matrix - Private, Public, Canadian, Network determines which level of assessment is required for COA's Service Sections. The assessment elements of the Matrix can be tailored according to the needs of specific individuals or service design.*

YIL 4: Service Planning and Monitoring

Each youth participates in the development and ongoing review of a service plan that is the basis for delivery of appropriate services and support.

Table of Evidence

Self-Study Evidence

*Service planning and monitoring procedures	**File:** ILP Assessment and Service Planning Procedure

Site Visit Evidence *No Site Visit Evidence*

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - In a few instances, client or staff signatures are missing and/or not dated; or
    - With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - In several instances, client or staff signatures are missing and/or not dated; or
    - Quarterly reviews are not being done consistently; or
    - Level of care for some clients is clearly inappropriate; or
    - Service planning is often done without full client participation; or
    - Appropriate family involvement is not documented; or
    - Documentation is routinely incomplete and/or missing; or
    - Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

YIL 4.01

An assessment-based service plan is developed in a timely manner with the full participation of youth, and their family when appropriate, and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. possibilities for maintaining and strengthening family relationships and other informal social networks;
d. procedures for expedited service planning when crisis or urgent need is identified; and

e. the youth's signature.

YIL 4.02
The worker and a supervisor, or a clinical, service, or peer team, review the case quarterly, or more frequently depending on the needs of youth, to assess:

a. service plan implementation;
b. progress toward achieving service goals and desired outcomes; and
c. the continuing appropriateness of the agreed upon service goals.

Interpretation: *When experienced workers are conducting reviews of their own cases, the worker's supervisor must review a sample of the worker's evaluations as per the requirements of the standard.*

YIL 4.03
The worker and youth, and his or her family when appropriate, participate in a review of the plan according to established timeframes to:

a. review progress toward achievement of agreed upon service goals; and
b. sign revisions to service goals and plans.

YIL 5: Service Coordination for Youth with Special Needs

Youth with special needs receive additional services that are integrated into a coordinated, goal-oriented service plan designed to promote safe and stable living, and build independence.

NA Taken: *The organization does not serve youth with special needs.*

YIL 5.01

NA Taken: *The organization does not serve youth with special needs.*

YIL 5.02

NA Taken: *The organization does not serve youth with special needs.*

YIL 5.03

NA Taken: *The organization does not serve youth with special needs.*

YIL 6: Supportive Housing for Youth in Transition

The organization provides safe and accessible housing in community settings where youth can continue to receive needed supports and work towards independence.

Self-Study Evidence

*Acceptance procedures	**File:** ILP Admissions Deferrals and Intake Procedure
*House rules, including regarding overnight guests	**File:** ILP Daily Living.pdf
*Supervision and security procedures	**File:** ILP Daily Living.pdf
*Procedures for entering a youth's room or apartment	**File:** Non-Critical Incidents Procedure.pdf
*Eviction/discharge policy	**File:** ILP Discharge Procedure.pdf
*Eviction/discharge procedures	**File:** ILP Discharge Procedure.pdf

Site Visit Evidence

- Leasing and/or placement agreements, as applicable

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Observe facilities and settings

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

YIL 6.01 (FP)

Acceptance procedures include:

a. fair and objective selection criteria;
b. written notification regarding reasons for non-acceptance; and
c. connecting youth deemed ineligible to alternative housing options.

Interpretation: *Youth in transition oftentimes do not meet conventional housing criteria due to lack of sufficient income or rental histories. Organizations that provide housing to youth in transition should modify acceptance criteria – within legal and/or contractual boundaries – to accommodate this service population.*

YIL 6.02

Housing is provided in settings that are readily accessible to public transportation, shopping, and community-based services and resources.

YIL 6.03

House rules are developed with youths' participation, and youth are encouraged to organize, self-govern, and enforce the rules.

YIL 6.04

Youth are permitted to have guests, including overnight guests, as appropriate to the population and type of living situation, and are informed of their responsibility for the behavior of their guests.

YIL 6.05

The program ensures appropriate supervision and security for its youth resident population, as applicable.

YIL 6.06 (FP)

Youth are notified in writing about circumstances that permit maintenance personnel to enter a room or apartment without the occupant's permission, and receive at least 24-hours' notice when access is required in non-emergency situations.

YIL 6.08 (FP)

Written policies and procedures regarding eviction and discharge:

a. are provided and explained to youth at intake;
b. are clear and simple, avoiding overly rigid and bureaucratic language and rules;
c. define specific behaviors, conditions, or circumstances that may result in eviction and discharge;
d. include timely due process provisions; and
e. describe the conditions or process for re-admittance.

Interpretation: *Programs should be tolerant of youth behaviors and might expect some degree of non-compliance from youth in transition. Early discharge as a disciplinary strategy can have severely negative implications for service delivery goals, and outcomes and records of eviction impact creditworthiness and can hinder youth from obtaining secure housing arrangements in the future.*

YIL 7: Family, Community, and Workplace Connections

Services and supports effectively draw upon a full range of available family, school, workplace, neighborhood, and community resources that establish the youth as a primary resource for, and an active participant in, his or her development.

Table of Evidence

Self-Study Evidence

*Procedures for facilitating community and social connections	**File:** ILP Daily Living.pdf
*Procedures for referring youth to services	**File:** Resident Health Services, Wellness, and Medication Management Procedure.pdf **File:** Referrals for Family Support Services Procedure
*Table of contents of educational curricula	**In 2021:** **File:** ILP Curriculum Transportation.pdf **File:** ILP Curriculum Job Skills.pdf **File:** ILP Curriculum Job Maintenance.pdf **File:** ILP Curriculum Health.pdf **File:** ILP Curriculum Housing.pdf **File:** ILP Curriculum Hygiene.pdf **File:** ILP curriculum Emergency Services.pdf **File:** ILP Curriculum Money Management.pdf **File:** ILP curriculum Legal Awareness.pdf **File:** ILP curriculum Community Skills.pdf **File:** ILP Curriculum Solving Conflicts.pdf **File:** ILP Curriculum Cleaning.pdf

Site Visit Evidence

- Community resource and referral list
- Informational materials provided to youth
- Educational curricula

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
   Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
   Procedures need strengthening; or
   With few exceptions, procedures are understood by staff and are being used; or
   For the most part, established timeframes are met; or
   Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
   Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

Procedures and/or case record documentation need significant strengthening; or
Procedures are not well-understood or used appropriately; or
Timeframes are often missed; or
Several client records are missing important information; or
Client participation is inconsistent.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
   No written procedures, or procedures are clearly inadequate or not being used; or
   Documentation is routinely incomplete and/or missing.

YIL 7.01

To facilitate access to all available services and active membership in the community, the organization:

a. remains knowledgeable about local, regional, and state resources, including networking and leadership opportunities; and
b. finds and creates opportunities for individuals to develop positive ties to the community based on mutual interests and abilities.

YIL 7.02

The organization strives to engage youth directly as key partners, and to promote sufficient relevant resources, by encouraging youth participation in local or state leadership and advocacy activities, including community advisory and partnership groups.

YIL 7.03

Program activities facilitate:

a. youth-family connections;
b. development of social support networks and healthy, meaningful relationships with caring individuals;
c. participation in peer group activities where they can meet, lend support, and share positive experiences; and
d. a coordinated response to youth interests and needs.

Examples: *"Caring individuals" may include mentors, community members, friends, siblings, and other family members.*

YIL 7.04

Youth have the opportunity to develop a comprehensive set of daily living, social, and communication skills, including:

a. money management, including budgeting, saving, investing, and building credit;
b. use of community resources;
c. accessing public assistance;
d. nutrition and food preparation;
e. stress management and coping;
f. time management;
g. relationship building, effective communication, and conflict resolution;
h. problem solving and decision making;
i. hygiene, self-care, and personal safety; and

j. exercising legal rights and responsibilities, such as voting.

YIL 7.05

The organization provides housing support services, including:

a. information on obtaining housing and household management;
b. education regarding available community housing options;
c. education on tenant rights and responsibilities;
d. assistance obtaining a safe, growth-enhancing living environment; and
e. advocacy for safe, affordable, appropriate housing for youth with a goal of independent living.

YIL 7.06

Youth receive help locating and/or enrolling in educational or vocational programs appropriate to their needs, interests and abilities, including:

a. high school or GED programs;
b. colleges or universities;
c. vocational training programs; and
d. special education services.

YIL 7.07

Youth are helped to obtain and maintain employment, including assistance with:

a. development of good work habits, skills, and self-awareness essential to sustained employment;
b. development of self-confidence and presentation skills;
c. resume writing, completion of job applications, and preparation for interviews;
d. access to and use of employment information and data to understand job options, and clarify current and future work aspirations; and
e. use of local employment resources, job finding, and placement options, including on-the-job training.

YIL 7.08 (FP)

Youth are linked to necessary health services, including:

a. medical services, such as routine care and medication management or monitoring;
b. dental services;
c. counseling, mental health services, and chemical dependency services;
d. age-appropriate education regarding family planning, HIV/AIDS, and STD prevention, and general information about the prevention and treatment of disease; and
e. insurance coverage, when available.

YIL 7.09

Youth receive additional support services, as needed, including:

a. crisis intervention;
b. transportation;
c. legal assistance, including assistance with citizenship and naturalization;

d. parent education and family support;
e. child care and development; and
f. activities that support social, cultural, and recreational interests, and religious observance.

Examples: *Opportunities to participate in culturally appropriate social, cultural, recreational, and religious activities can help to expand the range of life experiences, and meet the needs of indigenous groups or individuals with special needs.*

YIL 8: Transition from the Service System

Youth participate in planning for transition to the community and are prepared for adulthood with positive experiences and skills to move successfully to living and managing on their own.

Table of Evidence

Self-Study Evidence

* Transition planning procedures	**File:** ILP Assessment and Service Planning Procedure.pdf **File:** ILP Discharge Procedure.pdf

Site Visit Evidence

- Information provided to youth

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - For the most part, established timeframes are met; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - Active client participation occurs to a considerable extent.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Timeframes are often missed; or
    - Several client records are missing important information; or
    - Client participation is inconsistent.
4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

YIL 8.01
The organization prepares youth for a successful transition by providing youth and collaborating providers:

a. transfer or termination of custody information, as applicable;
b. information about rights and services to which the person may have access as a result of a disability;
c. information needed to access specialized services and navigate adult-serving systems;
d. information on availability of affordable community-based healthcare and counseling;
e. court and public assistance systems information;
f. child care services information; and
g. support through community volunteers or individuals who have made a successful transition, as appropriate.

YIL 8.02
During the transition process, and prior to case closing, the organization explores the full range of living situations, from supported living to fully independent living environments, with youth and engages them in an evaluation of the risks and benefits of various housing options.

Interpretation: *Personnel providing housing support services to LGBTQ youth should consider the sexual orientation, gender identification, and personal preferences of youth when matching them with available housing options. LGBTQ youth are disproportionately subjected to sexual and physical violence which may make certain living accommodations, such as open bathing facilities or single-sex communal facilities, less desirable for this demographic.*

YIL 8.03
The organization ensures that an adequate living arrangement is in place for every person transitioning to independence and provides:

a. supervised household management practice, when possible;
b. tenancy and landlord supports, as appropriate; and
c. support when needed to address potential landlord-tenant issues impacting youth residents.

YIL 8.04
For every person transitioning to independence, the organization ensures that basic resources are in place, including:

a. a source of income;
b. affordable health care;
c. access to at least one committed, caring adult; and
d. access to positive peer support.

YIL 8.05

The organization provides youth transitioning to independence with six months minimum advance notice of the cessation of any health, financial, educational or other benefits that will occur at transition or case closing.

YIL 8.06
The organization assists youth in obtaining or compiling documents necessary to function as an independent adult, including:

a. an identification card;
b. a social security or social insurance number;
c. a resume, when work experience can be described;

d. a driver's license, when the ability to drive is a goal;
e. medical records and documentation, including a Medicaid card or other health eligibility documentation;
f. an original copy of the youth's birth certificate;
g. religious documents and information, when appropriate;
h. documentation of immigration, citizenship, or naturalization, when applicable;
i. death certificates when parents are deceased;
j. a life book or a compilation of personal history and photographs, as appropriate;
k. a list of known relatives, with relationships, addresses, telephone numbers, and permissions for contacting involved parties;
l. previous placement information; and
m. educational records, such as high school diploma or general equivalency diploma, and a list of schools attended, when age-appropriate.

YIL 9: Case Closing and Aftercare

The organization works with youth to plan for case closing and, when possible, to provide aftercare.

Table of Evidence

Self-Study Evidence

*Case closing procedures	**File:** ILP Discharge Procedure.pdf
*Aftercare and follow-up procedures	**File:** ILP Discharge Procedure.pdf

Site Visit Evidence

- Relevant portions of contract with public authority, as applicable

On-Site Activities

- Interviews may include:
    1. Program director
    2. Relevant personnel
    3. Youth
- Review case records

Rating Indicators:

1. All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.
2. Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,
    - Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
    - Procedures need strengthening; or
    - With few exceptions, procedures are understood by staff and are being used; or
    - Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
    - In a few instances, the organization terminated services inappropriately; or
    - Active client participation occurs to a considerable extent; or
    - A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.
3. Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,
    - Procedures and/or case record documentation need significant strengthening; or
    - Procedures are not well-understood or used appropriately; or
    - Services are frequently terminated inappropriately; or

- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several client records are missing important information; or
- Client participation is inconsistent.

4. Implementation of the standard is minimal or there is no evidence of implementation at all, as noted in the ratings for the Practice Standards; e.g.,
    - No written procedures, or procedures are clearly inadequate or not being used; or
    - Documentation is routinely incomplete and/or missing.

YIL 9.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, the youth, and others, as appropriate to the needs and wishes of the youth.

YIL 9.02

Upon case closing, the organization notifies any collaborating service providers, as appropriate.

YIL 9.03

If an individual has to leave the program unexpectedly, the organization makes every effort to identify other service options and link the youth with appropriate services.

Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.*

YIL 9.04

As a continuing resource for information, crisis management, referral, and support, the organization provides each person with:

a. a transition plan summary, including the individual's options;
b. a list of emergency contacts, and
c. the organization's contact information.

YIL 9.05

The organization follows up on the transition or aftercare plan, as appropriate, when possible, and with the permission of the youth.

Examples: *Reasons why follow-up may not be appropriate include, but are not limited to, cases where the person's participation is involuntary, or where there may be a risk to the individual such as in cases of domestic violence.*