2018

July 1, 2018–June 30, 2019

Medical Rehabilitation

Standards Manual

CARF INTERNATIONAL

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

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Introduction

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

The CARF International group of companies includes:

- CARF
- CARF Canada
- CARF Europe

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

Mission

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

Vision

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

Moral Ownership

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

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

Values

CARF believes in the following core values:

- All people have the right to be treated with dignity and respect.
- All people should have access to needed services that achieve optimal outcomes.
- All people should be empowered to exercise informed choice.

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

In addition, CARF is committed to:

- The continuous improvement of both organizational management and service delivery.
- Diversity and cultural competence in all CARF activities and associations.
- Enhancing the involvement of persons served in all of CARF's activities.
- Persons served being active participants in the development and application of standards of accreditation.
- Enhancing the meaning, value, and relevance of accreditation to persons served.

Purposes

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

- To develop and maintain current, field-driven standards that improve the value and responsiveness of the programs and services delivered to people in need of life enhancement services.
- To recognize organizations that achieve accreditation through a consultative peer-review process and demonstrate their commitment to the continuous improvement of their programs and services with a focus on the needs and outcomes of the persons served.
- To conduct accreditation research emphasizing outcomes measurement and management and to provide information on common program strengths as well as areas needing improvement.
- To provide consultation, education, training, and publications that support organizations in achieving and maintaining accreditation of their programs and services.
- To provide information and education to persons served and other stakeholders on the value of accreditation.
- To seek input and to be responsive to persons served and other stakeholders.
- To provide continuous improvement services to improve the outcomes for organizations and the persons served and their community of influence.

Development of the Standards

The CARF standards have evolved and been refined over 50 years with the active support and involvement of providers, consumers, and purchasers of services. The standards are maintained as international consensus standards. The standards define the expected input, processes, and outcomes of programs for persons served. CARF recognizes and accepts its responsibility to assess and review the continuing applicability and relevance of its standards. CARF convenes its International Advisory Council; advisory committees; and regional, national, and international focus groups to systematically review and revise CARF's standards and develop standards for new accreditation opportunities. Composed of individuals with acknowledged expertise and experience, these committees and groups, including persons served, make recommendations to CARF concerning the adequacy and appropriateness of the standards.

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

Applying the Standards

The organization is expected to demonstrate conformance to the **applicable standards** during the site survey so that the survey team can determine the organization's overall level of conformance and, ultimately, allow CARF to determine the accreditation decision. On subsequent surveys, the organization is expected to demonstrate continuous conformance from any previous period of CARF accreditation.

Some sections of the standards, such as the ASPIRE to Excellence® section which relates to the overall business practices of the organization, are applicable regardless of the programs or services for which the organization is seeking accreditation. The standards in other sections are applicable in accordance with instructions in those sections.

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

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

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

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

Blended Surveys

Some organizations may want to become accredited for programs or services included in different standards manuals. This is possible using what CARF terms a "blended" survey. Blending allows an organization to seek accreditation through one survey for programs or services with applicable standards in more than one manual. For example, services found in the *Employment and Community Services Standards Manual* can be blended into a survey using the *Medical Rehabilitation Standards Manual*. The primary manual (i.e., the one into which other standards are blended) is determined by the predominant focus of the programs or services for which the organization is seeking accreditation. Factors that CARF considers when blending programs include the integrity of the programs and services and whether to incorporate standards from a related program or service section, such as the rehabilitation process or quality services for the persons served.

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

CARF Publications

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

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

Customer Service Unit	Standards Manuals and Related Publications
Aging Services	■ Aging Services Standards Manual ■ Aging Services Survey Preparation Workbook* ■ Continuing Care Retirement Community Standards Manual ■ Continuing Care Retirement Community Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Behavioral Health	■ Behavioral Health Standards Manual ■ Behavioral Health Survey Preparation Workbook* ■ Opioid Treatment Program Standards Manual ■ Opioid Treatment Program Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Child and Youth Services	■ Child and Youth Services Standards Manual ■ Child and Youth Services Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Employment and Community Services	■ Employment and Community Services Standards Manual ■ Employment and Community Services Survey Preparation Workbook* ■ Standards Manual Supplement Employment Service Centres in Canada** ■ Standards Manual Supplement for Networks** ■ Standards Manual Supplement for One-Stop Career Centers**
Medical Rehabilitation	■ Medical Rehabilitation Standards Manual ■ Medical Rehabilitation Survey Preparation Workbook* ■ Standards Manual Supplement for Networks**
Vision Rehabilitation Services	■ Vision Rehabilitation Services Standards Manual with Survey Preparation Questions ■ Standards Manual Supplement for Networks**
*CARF recommends using the companion survey preparation workbook for your standards manual. The workbook assists in conducting a self-evaluation in preparation for the accreditation survey. **Supplements for the standards manuals are available for download at: **www.carf.org/Accreditation/QualityStandards/OnlineStandards**.	

Note: *Standards manuals become effective on July 1, 2018, to allow organizations sufficient time to incorporate changes into their operations.*

Accreditation Policies and Procedures

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

Note: *Customer Connect is CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Customer Connect is the primary means of transmitting certain documents, such as the survey fee invoice and quality improvement plan. These documents are posted to Customer Connect and an email is sent to the individual identified as the organization's Survey Key Contact. Organizations should use Customer Connect regularly to view accreditation- and survey-related documents and to keep CARF informed of any changes in the name or email address of the key contact person.*

The submission of a survey application constitutes the organization's agreement to adhere to the CARF policies and procedures that are in effect on the date on which the survey application is submitted to CARF and to all subsequent changes as they become effective. The review and appeal process set forth in these policies and procedures, as amended from time to time, shall be the organization's sole remedy with respect to the survey, accreditation decision, and continuation or termination of accreditation. By submitting the survey application, the organization expressly waives and releases CARF from any and all claims, demands, actions, lawsuits, and damages that may arise from or relate to, directly or indirectly, the survey, accreditation decision, and continuation or termination of accreditation.

Accreditation Conditions

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

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

Intent Statements

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

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

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

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

Intent Statements

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

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

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

Intent Statements

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

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

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

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

Intent Statements

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

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

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

Accreditation Decisions

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

CARF uses the following guidelines to determine each accreditation decision:

Three-Year Accreditation

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

One-Year Accreditation

The organization satisfies each of the CARF Accreditation Conditions and demonstrates conformance to many of the standards. Although there are significant areas for improvement in relation to the standards, there is evidence of

the organization's capability to improve and commitment to progress toward their improvement. On balance, the services benefit those served, and the organization appears to protect their health, welfare, and safety.

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

Provisional Accreditation

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

Nonaccreditation

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

Preliminary Accreditation

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

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

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

Overview of the Steps to Accreditation

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

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

STEP 3 **Submit the survey application.**	The organization submits the survey application via Customer Connect, **customerconnect.carf.org**. ■ The survey application requests detailed information about leadership, program(s)/service(s) that the organization is seeking to accredit, and the service delivery location(s). ■ The organization submits the completed survey application, required supporting documents, and a nonrefundable application fee at least three full calendar months before the two-month timeframe in which it is requesting a survey. Organizations undergoing resurvey submit their survey application on the date that corresponds with their accreditation expiration month (see page 12). ■ The submission of the completed survey application indicates the organization's desire for the survey and its agreement to all terms and conditions contained therein. ■ If any information in the survey application changes after submission, the organization should notify CARF immediately.
STEP 4 **CARF invoices for the survey fee.**	After reviewing all information in the survey application, CARF invoices the organization for the survey fee. The survey fee invoice is posted to the Customer Connect website and an email notification is sent to the organization's key contact person. Scheduling of the survey begins immediately upon invoicing. Any changes in problem dates must be communicated in writing to CARF by this time. The fee is based on the number of surveyors and days needed to complete the survey.
STEP 5 **CARF selects the survey team.**	CARF selects a survey team with the appropriate expertise. ■ Surveyors are selected by matching their program or administrative expertise and relevant field experience with the organization's unique requirements. ■ CARF notifies the organization of the names of team members and the dates of the survey at least 30 days before the survey.
STEP 6 **The survey team conducts the survey.**	The survey team determines the organization's conformance to all applicable standards on site through the observation of services, interviews with persons served and other stakeholders, and review of documentation. ■ Surveyors also provide consultation to organization personnel. ■ The organization is informed of the survey team's findings related to the standards at an exit conference before the team leaves the site. The survey team submits its findings to CARF, but the team does not determine the accreditation decision.

STEP 7 **CARF issues the accreditation decision.**	CARF reviews the survey findings and issues one of the following accreditation decisions: ■ Three-Year Accreditation ■ One-Year Accreditation ■ Provisional Accreditation ■ Nonaccreditation Approximately six to eight weeks after the survey, the organization is notified of the accreditation decision and receives a written report. The organization is also provided with a certificate of accreditation that lists the program(s)/service(s) included in the accreditation.
STEP 8 **Submit a Quality Improvement Plan.**	Within 90 days after notification of accreditation, the organization fulfills an accreditation condition by submitting to CARF a Quality Improvement Plan (QIP) outlining the actions that have been or will be taken in response to all recommendations identified in the report.
STEP 9 **Submit the Annual Conformance to Quality Reports.**	An organization that achieves a Three-Year Accreditation submits a signed Annual Conformance to Quality Report (ACQR) to CARF on the accreditation anniversary date each year during the term of accreditation. This is a condition of accreditation. ■ CARF sends the organization the form for this report approximately ten weeks before it is due. ■ The ACQR reaffirms the organization's ongoing conformance to the CARF standards.
STEP 10 **CARF maintains contact with the organization.**	CARF maintains contact with the organization during the term of accreditation. Organizations should also contact CARF as needed to help maintain conformance to the standards and keep CARF informed of administrative or other items. ■ CARF offers publications to help organizations provide quality program(s)/service(s). ■ CARF's public website, **www.carf.org**, and its secure customer website, Customer Connect (**customerconnect.carf.org**), provide news, information, and resources. ■ CARF seminars and conferences are excellent ways to receive updates and other information about the accreditation process and the standards.

CARF Events

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

Steps to Accreditation

Step 1. Consult with a designated CARF Resource Specialist

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

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

Step 2. Conduct a self-evaluation

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

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

Step 3. Submit the survey application

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

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

Survey Timeframe At a Glance

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

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

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

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

Note: *Actual survey timeframes are assigned by CARF based upon surveyor availability.*

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

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

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

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

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

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

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

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

An organization may submit more than one survey application if it wants to have separate surveys for different program(s)/service(s) or sites that it operates. In separate surveys, each accreditation decision is independent and based solely on the individual survey and the level of conformance demonstrated by the organization

and the program(s)/service(s) that are part of that survey. In this case, different decisions may be issued as appropriate.

Step 4. CARF invoices for the survey fee

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

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

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

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

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

Please contact CARF for current fees.

Outstanding Debt

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

Step 5. CARF selects the survey team

Surveyors are assigned to surveys based on a number of factors, the most important of which is the surveyors' experience with the types of program(s)/service(s) being surveyed. Other considerations include the availability of surveyors, language, and the need to avoid conflicts of interest.

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

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

Scheduling the Survey Dates

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

Cancellation and Rescheduling

The organization is notified of the specific survey dates at least 30 calendar days prior to the survey. An organization is considered scheduled for a site visit on the date the notification is sent. The dates established by CARF are final. A cancellation/rescheduling fee, plus all related nonrefundable travel cancellation expenses, will be assessed if

an organization requests any change affecting the scheduled dates or configuration of its survey, whether cancellation, postponement, or other date change, or if the survey is cancelled by CARF due to survey fees not paid sufficiently in advance of the survey.

It should be noted that CARF does not wait for receipt of the survey fee to schedule the survey. Therefore, to avoid a cancellation/rescheduling fee, the organization must notify CARF in writing of any changes in available survey dates prior to CARF's notice of established dates.

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

Step 6. The survey team conducts the survey

Involvement of the Persons Served

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

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

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

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

Before the Survey

Preparation

In conjunction with the appropriate standards manual, the organization should use CARF's other publications to adequately prepare for the site survey. Many of these publications have been written to help an organization prepare for a survey. CARF may be contacted by telephone or email to answer questions that the organization may have regarding the survey process or interpretation of the standards. Inquiries about the standards or survey process can be made as frequently as needed by an organization seeking accreditation, and there is no charge for this support.

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

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

The survey poster

At least 30 days prior to the survey, the organization must display a poster announcing the pending survey and the survey dates. This poster can be downloaded in various languages from the Resources section of Customer Connect (**customerconnect.carf.org**) in an editable format so that organizations may make adjustments (such as font, color, and size) to ensure the poster is accessible for all persons served. This poster must remain conspicuously posted at all locations until the survey concludes. Information on the poster includes a description of CARF as a review organization and instructions for

interested persons to contact CARF to submit comments about the organization's performance and their satisfaction with services. These comments can be submitted through a toll-free phone number or via email, fax, or letter. Information received by CARF may be sent to the surveyors. The survey team may interview persons who have submitted comments or contacted CARF prior to the survey when on site. All interviews are confidential.

Pre-survey contact

Approximately three weeks before the visit, the survey team coordinator will contact the organization to discuss logistics and answer questions the organization may have regarding scheduling interviews and other items. The survey team may request that additional information that is not confidential be made available at the hotel the night before the survey or otherwise in advance. While provision of such information in advance of the survey is at the discretion of the organization, it can help facilitate an efficient and consultative on-site survey.

Assemble or arrange access to records

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

Third-party representatives

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

The Survey

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

First Day

Opening of business

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

After the orientation conference

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

Mid-morning to late afternoon

The survey team meets to coordinate efforts and proceed with survey activities. The organization is asked to schedule interviews with any persons identified, based on their availability. Every effort is made to minimize disruption to ongoing operations. If the organization has any question about the scheduling of interviews, these should be addressed with the survey team coordinator.

With a short lunch break, the team spends the rest of the day observing the program(s)/service(s) being surveyed; interviewing various personnel, persons served, leadership, funding source representatives, community members, and others; and reviewing documents such as records of the persons served, fiscal reports,

administrative records, and other materials. Records for review shall be selected by the survey team. A responsible person from the organization should be on the premises at all times to facilitate the process and answer questions for the team; however, this person should not attend individual interviews or survey team meetings.

Evening

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

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

Second or Last Day

If the survey involves more than two days, the following schedule applies to the last survey day. The other day(s) will be used for further observation, interviews, and documentation review. It should be noted that the last day of the survey typically ends not later than 3:00 pm.

Opening of business

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

Late Morning

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

Early Afternoon

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

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

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

After the Survey

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

Step 7. CARF issues the accreditation decision

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

The report contains the accreditation decision and identifies recommendations for standards that were not fully met. When the organization is resurveyed, it is held accountable for follow up on the recommendations in the previous report and for evidence of conformance to standards throughout the term of accreditation, and for all

applicable standards in the current standards manual.

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

Step 8. Submit a Quality Improvement Plan

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

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

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

Step 9. Submit the Annual Conformance to Quality Reports

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

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

Step 10. CARF maintains contact with the organization

Ongoing Communication of Administrative Items and Significant Events

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

- Change in leadership.
- Change in ownership, acquisition, consolidation, joint venture, or merger.
- Change in organization name.
- Change in mail and/or email address(es).
- Relocation, expansion, or elimination of an accredited program or location.
- Financial distress.
- Investigation.
- Material litigation.
- Catastrophe.
- Sentinel event.
- Governmental sanctions, bans on admission, fines, penalties, loss of programs, or *CMS survey deficiency (*CCRCs and US PCLTCCs only).

Changes in ownership and/or leadership, the addition of a site to an existing accreditation, mergers, consolidations, joint ventures, and acquisitions involving accredited program(s)/service(s) may require the payment of an administrative fee or a supplemental survey.

Forms for reporting administrative items and significant events

Forms for reporting administrative items and significant events are available on the CARF website at **www.carf.org/Accreditation/AccreditationProcess/OngoingCommunication** and in the Resources section of Customer Connect (**customerconnect.carf.org**). Please contact CARF for more details.

Falsification of Documents

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

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

In the event that an organization loses accreditation or is not accredited because of CARF's reasonable belief of falsification of documents or information, CARF will not accept a survey application from the organization for a period of at least twelve months. CARF may also notify the appropriate governmental agencies.

Public Information

Identification of Accreditation by the Organization

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

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

Certificate of Accreditation

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

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

An accreditation applies only to the organization's specific program(s)/service(s) surveyed

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

Upon dissolution of the organization or loss of accreditation for any reason, each unexpired certificate must be returned to CARF and the organization must refrain from representing itself or its program(s)/service(s) as accredited and must cease to use or display the certificate or the CARF logo in any manner. Similarly, if accreditation is suspended, the organization must not represent itself or its program(s)/service(s) as accredited or use or display the certificate or the CARF logo until and unless accreditation is restored.

Release of Information by CARF

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

1. Whether CARF has received a survey application from a specific organization.
2. Scheduled survey dates for a specific organization.
3. Whether a survey has been completed.
4. The date of expiration of accreditation of a particular organization.
5. An organization's accredited program(s)/service(s).
6. An organization's accreditation decision and status.
7. Whether an organization has requested review of a One-Year Accreditation, Provisional Accreditation, or Non-accreditation decision.
8. Whether an organization is involved in appealing or may still appeal a Nonaccreditation decision.
9. As required by law or contract.

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

Subsequent Surveys

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

Resurveys

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

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

If new program(s)/service(s) are being added or the mission and focus of the organization or its program(s)/service(s) or locations have changed since the previous survey, it is suggested that the organization contact its CARF resource specialist.

Supplemental Surveys

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

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

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

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

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

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

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

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

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

Monitoring Visits

CARF may conduct announced or unannounced monitoring visits of organizations with accredited programs/services. A monitoring visit may be conducted any time CARF receives information that an organization may no longer be conforming to the standards. The organization's accreditation may be modified as a result of a monitoring visit, and submission of a new Quality Improvement Plan may be required. A monitoring visit may consist of a partial or full survey team depending on the nature of the information received. The cost of a monitoring visit is covered by CARF.

Extension of Accreditation

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

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

If an organization with a Three-Year Accreditation intends to request an extension greater than three months, additional information must be submitted for consideration. The organization must submit written information with the completed survey application and application fee that details demographic and program/service changes since the last survey and an update on the performance of each accredited program/

service. The organization should also send the following items and/or information to CARF at least five months prior to the expiration month:

- A letter from the organization's leadership explaining the reasons that the extension is being requested.
- A copy of the most recent performance analysis, as specified in Standard 1.N.1. in this manual.
- An update of the Quality Improvement Plan.
- If the organization is required to be accredited by any funding or referral entity, then a letter of support for consideration of the extension from that entity.

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

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

If an extension is granted, only those program(s)/service(s) that are currently accredited and that the organization intends to have resurveyed will be included in the extension.

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

Allegations, Suspensions, and Stipulations

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

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

If an allegation is received after a survey but before the accreditation report and accreditation decision are released, CARF may withhold the release of the report and decision until such time as CARF may determine.

Disputed Accreditation Decisions

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

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

Review of One-Year or Provisional Accreditation Decisions

1. Request for Review. CARF must receive a written request for a Review from the organization ("Request") within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey. The Request must clearly identify each specific recommendation disputed by the organization ("Disputed Recommendation")

and a detailed explanation of the rationale for the dispute with respect to each Disputed Recommendation.

2. Review Fee. CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review fee, which is equal to CARF's current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.
3. Scheduling. Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.
4. On-Site Review. The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review ("Findings"); however, it is the responsibility of the organization to provide information to the survey team that demonstrates conformance to the applicable standards. While the Disputed Recommendations are the focus of the Review, any standard applied on the Survey may be applied on the Review.
5. Accreditation Decision. CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings and any recommendations from the Survey not identified in the Request.
6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization's knowing and intentional waiver of this review process. All CARF Accreditation Policies and Procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation decision, and all other matters related to the Review are final. All decisions and determinations related to and interpretations of this review process shall be determined at CARF's sole and binding discretion.

Review and Appeal of Nonaccreditation Decisions

Review

1. Request for Review. CARF must receive a written request for a Review from the organization ("Request") within 30 calendar days of the date of the letter that communicates the accreditation decision from the Survey.
2. Review Fee. CARF shall determine the number of surveyors and days for the Review and issue an invoice for the nonrefundable Review fee, which is equal to CARF's current survey fee. The fee is due and payable by the organization within ten calendar days of the invoice date.
3. Scheduling. Following payment of the Review fee, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the Review within 60 calendar days of receipt of payment. Once scheduled, CARF shall notify the organization of the date(s) of the Review and the assigned survey team.
4. On-Site Review. The Review shall be conducted using the standards applied on the Survey. The Review survey team shall conduct interviews, review documents, and otherwise gather information to determine findings as of the date(s) of the Review ("Findings"); however, it is the responsibility of the organization to provide information to the survey team that demonstrates conformance to the applicable standards. A Review is intended to be a full survey; accordingly, all standards applied on the Survey may be applied on the Review.
5. Accreditation Decision. CARF shall issue an accreditation decision, with or without stipulations, based on its on-balance consideration of the Findings.
6. Miscellaneous. If CARF does not timely receive a Request or full payment of the Review fee, such shall constitute the organization's knowing and intentional waiver of this review process. All CARF Accreditation

Policies and Procedures are applicable to this review process to the extent not inconsistent herewith. The Findings, accreditation decision, and all other matters related to the Review, are final; provided, however, that if the result of the Review is Nonaccreditation, the organization may be entitled to appeal pursuant to the process set forth below. All decisions and determinations related to and interpretations of this review process shall be determined at CARF's sole and binding discretion.

Appeal

1. Notice of Appeal. An organization issued a Nonaccreditation from a Nonaccreditation Review is entitled to a hearing before an appeal panel ("Panel") if CARF receives written notice of appeal from the organization ("Notice") within ten calendar days of the date of the letter that communicates the accreditation decision from the Review. The sole issue on appeal shall be whether the Review was conducted in a manner consistent with CARF's published review process; that is, whether the Review survey team conducted interviews, reviewed documents, and otherwise gathered information to determine Findings ("Issue").
2. Materials and Election. CARF must receive from the organization within ten calendar days of the Notice date: (a) all written materials it shall present at the hearing ("Materials") or a written statement that no materials shall be presented ("Statement"); and (b) a written election to conduct the hearing either by telephone or in person at CARF headquarters in Tucson, Arizona, U.S.A. ("Election").
3. Scheduling. Following receipt of the Materials or Statement and the Election, CARF shall contact the organization to obtain days to avoid in scheduling. CARF shall make reasonable efforts to schedule the hearing within 60 calendar days of receipt of the Materials or Statement and the Election. Once scheduled, CARF shall notify the organization of the date of the hearing and the designated Panel.
4. Appeal Hearing. During the hearing, the organization shall have up to one hour to present the previously submitted Materials, if any, and any unwritten information it believes support a determination that the Review survey team did not conduct interviews, review documents, and otherwise gather information to determine Findings. Thereafter, the Panel may pose questions to the organization and to the Review survey team. Finally, the organization shall have up to 20 minutes to provide any concluding remarks. The organization and survey team shall not question each other.
5. Irrelevant Information. Any information deemed irrelevant to the Issue may be excluded from the hearing and/or not considered by the Panel. The Panel shall under no circumstances consider the Findings.
6. Accreditation Decision. CARF shall affirm the Nonaccreditation or issue another accreditation decision, with or without stipulations, based on consideration of the relevant information received by the Panel at the hearing.
7. Miscellaneous. If CARF does not timely receive Notice, the Materials or Statement, or the Election, or if the organization fails to present relevant information at the scheduled hearing, such shall constitute the organization's knowing and intentional waiver of this appeal process. The accreditation decision and all other matters related to the appeal are final and not subject to review or appeal. All decisions and determinations related to and interpretations of this appeal process shall be determined at CARF's sole and binding discretion.

Changes in the 2018 Manual

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

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

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

Section 1. ASPIRE to Excellence®

1.A. Leadership

- In Standard 1.A.6., element a.(9), *Organizational fundraising* is new, and element c. has been revised and restructured to add *Personnel*.
- Standard 1.A.9. is new and addresses requirements related to organizational fundraising.

1.C. Strategic Planning

- In Standard 1.C.2., element b.(3) has been revised and restructured to add *Workforce*.

1.D. Input from Persons Served and Other Stakeholders

- In Standard 1.D.2., element b.(7), *Workforce planning,* is new.

1.E. Legal Requirements

- In Standard 1.E.1., previous element m. has been deleted.

1.G. Risk Management

- Standard 1.G.4., addressing reviews of contracted services, is new.

1.H. Health and Safety

- In Standard 1.H.4., element b.(9), *Workplace violence,* is new.

1.I. Workforce Development and Management

- This section was previously *Human Resources.* The standards in this section have been revised and updated in their entirety based on input from the field.

1.J. Technology

- In Standard 1.J.2., previous element a.(4) has been deleted.

1.K. Rights of Persons Served

- Standard 1.K.4. has been revised for clarity, and element b.(1) is new; subsequent elements were renumbered accordingly.

Section 2. The Rehabilitation and Service Process for the Persons Served

2.A. Program/Service Structure for all Medical Rehabilitation Programs

- In Standard 2.A.1., element a.(9) has been modified slightly to add contract services.
- In Standard 2.A.10., previous elements a. and b. have been deleted as these concepts are now addressed in Standards 1.I.5.a.(1)–(2); subsequent elements were renumbered accordingly.

2.B. The Rehabilitation and Service Process for the Persons Served

- Standard 2.B.8. has been revised for clarity and expanded to specify that persons served are provided with current information throughout their stay.
- Standard 2.B.46. has been modified to specify that the analysis of records of persons served must be in writing.

2.C. The Service Process for the Persons Served in Home and Community Services

- Standard 2.C.11. has been modified to specify that the analysis of records of persons served must be in writing.

Section 3. Program Standards

The optional specialty program designation standards that were previously in this section as subsections 3.F.–3.K. have been moved to Section 4; subsection lettering and standards have been renumbered accordingly.

Section 4. Specialty Program Designation Standards

This section is new in the 2018 manual and contains optional specialty program designation standards that were previously included in Section 3; subsection lettering and standards have been renumbered accordingly.

4.B. Amputation Specialty Program

This section was previously Section 3.G.

- Standard 4.B.17. (was 3.G.17.) has been revised and expanded. Elements a.(2) and a.(3) were modified for clarity; element b. addressing the collection of follow-up information is new; previous element a.(4) is now b.(1), and previous element b. is now c.

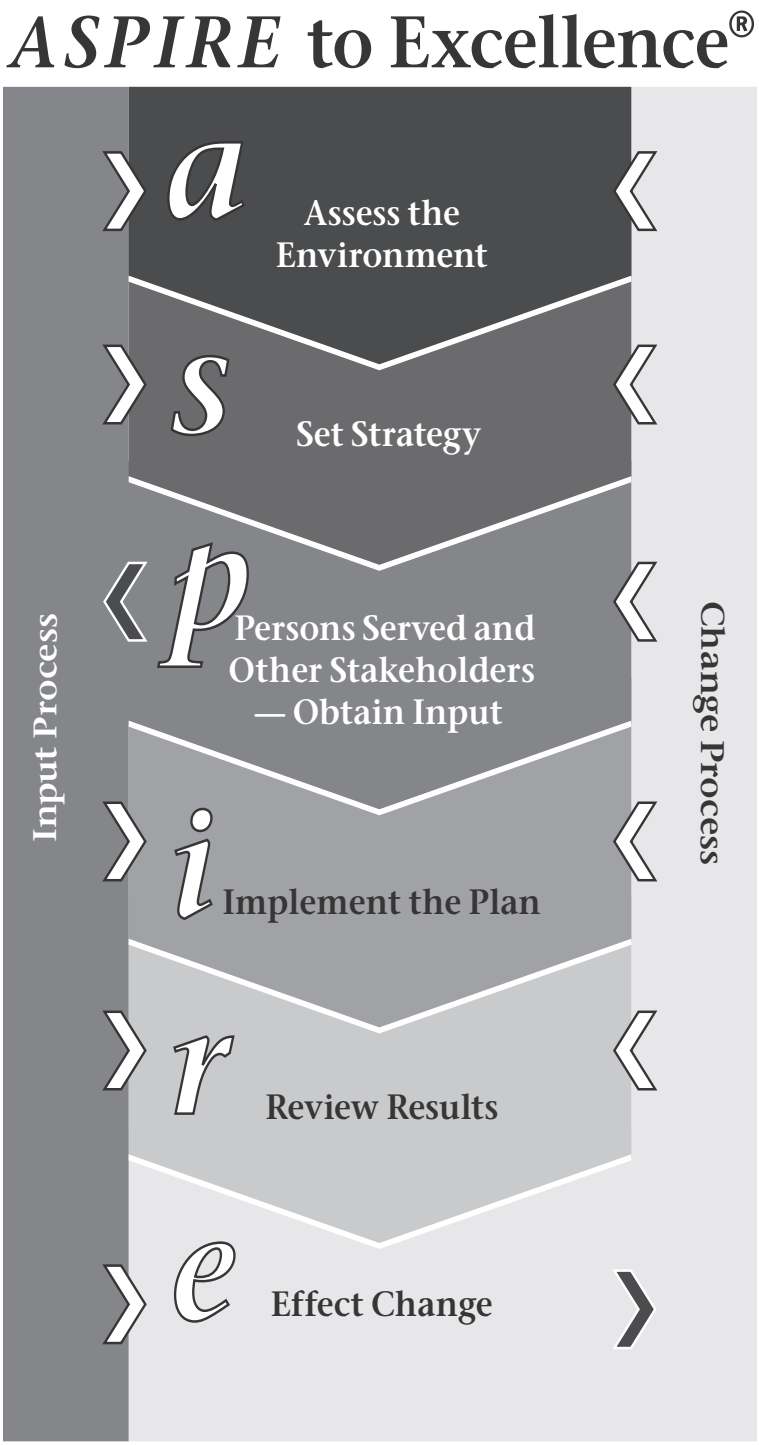
Glossary

The following term has been added:

- Contract

Section 1

ASPIRE to Excellence®



Assess the Environment

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

A. Leadership

Description

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

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

Examples

The leadership structure can be documented in the form of an organizational chart, table of organization, or narrative description of the positions and lines of authority within the organization. Responsibilities of leadership might be described in job descriptions, bylaws, policies or narrative descriptions. For small organizations it is common to see a short narrative description of positions, responsibilities, and lines of authority as there are typically so few staff members covering all areas of responsibility. For very small organizations, the job descriptions may be sufficient to identify this information. The survey team verifies that whoever is identified fulfills the responsibilities of leadership.

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

Intent Statements

The organization's person-centered philosophy should be evident in the development and delivery of services, systems, approaches, and interventions. Implementation of this philosophy from the unique perspectives of the leadership, personnel, and persons served is addressed during the survey process.

See the Glossary for the definition of *stakeholders*.

Examples

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

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

2.c. The person-centered philosophy could be communicated a number of ways, including:

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

1.A. **3. The identified leadership guides the following:**

- **a. Establishment of the:**
  - **(1) Mission of the organization.**
  - **(2) Direction of the organization.**
- **b. Promotion of value in the programs and services offered.**
- **c. Achievement of outcomes in the programs and services offered.**
- **d. Balancing the expectations of the persons served and other stakeholders.**
- **e. Financial solvency.**
- **f. Risk management.**
- **g. Ongoing performance improvement.**
- **h. Development of corporate responsibilities.**
- **i. Implementation of corporate responsibilities.**
- **j. Compliance with:**
  - **(1) All legal requirements.**
  - **(2) All regulatory requirements.**
- **k. Review of the organization's policies at least annually.**
- **l. Health and safety.**
- **m. Succession planning.**
- **n. Strategic planning.**

Intent Statements

3.k. Review of the organization's policies at least annually addresses all policies specific to the program(s) seeking accreditation and policies that directly relate to or impact the program(s). Through a systematic review of its policies an organization can address the relevance, pertinence, and necessity of existing policies as well as the need for updates or new policies to guide its operations and practices.

3.m. Succession planning identifies actions to be taken by the organization should key personnel be unavailable to perform their duties due to retirement, resignation, serious illness, death, or other reasons. Succession planning may be formal or informal depending on the needs of the organization. See Standards 1.I.3.g. and 1.I.11. in Section 1.I. Workforce Development and Management.

Examples

The leadership ensures that specific activities are conducted to enhance its ability to guide the organization ethically, effectively, and efficiently. The delegation of activities, the feedback and collaboration of various levels of the leadership, and the checks and balances that the leadership has created are evident.

3.k. Leadership delegates review of the rehabilitation program's policies to the rehabilitation

managers. Systemwide policies that directly impact rehabilitation program operations are identified and reviewed by the leadership of the rehabilitation program. Suggestions for revisions of systemwide policies are forwarded for consideration to the departments responsible for the specific policies.

In some organizations, such as those operated by governmental or public agencies, personnel and other policies may be established by the agency and not by the organization. Human resource policies may also include union contracts or may be identified in statute, administrative rule, or other governmental document. The expectation is that the organization reviews the policies at least annually and brings forward suggested changes to provide input for consideration in policy revisions.

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

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

- **a. The persons served.**
- **b. Personnel.**
- **c. Other stakeholders.**

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

- **a. Addresses:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **b. Is based on the consideration of the following areas:**
  - **(1) Culture.**
  - **(2) Age.**
  - **(3) Gender.**
  - **(4) Sexual orientation.**
  - **(5) Spiritual beliefs.**
  - **(6) Socioeconomic status.**
  - **(7) Language.**
- **c. Is reviewed at least annually for relevance.**
- **d. Is updated as needed.**

Intent Statements

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

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

Examples

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

In developing a cultural competency and diversity plan, an organization looks at the diversity of its community, internal and external stakeholders and potential changes in demographics to be proactive in education, training and service delivery. To facilitate the culturally competent organization, the plan might include areas such as recruitment efforts for personnel, modification of educational materials for persons served and family/support systems, support for training and education of personnel, or incorporation of spiritual beliefs into service delivery options.

Training and education to promote cultural competence may be offered directly by the organization, by community resources, or

through web-based resources. Training might focus on the cultures and spiritual beliefs including views of disability and its causes, and the influence of culture on service delivery and predicted outcomes.

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

Resources

Please refer to Appendix D for resources related to cultural competency and diversity.

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

- **a. Written ethical codes of conduct in at least the following areas:**
  - **(1) Business.**
  - **(2) Marketing.**
  - **(3) Contractual relationships.**
  - **(4) Conflicts of interest.**
  - **(5) Use of social media.**
  - **(6) Service delivery, including:**
    - **(a) Exchange of:**
      - **(i) Gifts.**
      - **(ii) Money.**
      - **(iii) Gratuities.**
    - **(b) Personal fundraising.**
    - **(c) Personal property.**
    - **(d) Setting boundaries.**
    - **(e) Witnessing of legal documents.**
  - **(7) Professional responsibilities.**
  - **(8) Human resources.**
  - **(9) Organizational fundraising.**
  - **(10) Prohibition of:**
    - **(a) Waste.**
    - **(b) Fraud.**
    - **(c) Abuse.**
    - **(d) Other wrongdoing.**
- **b. Written procedures to deal with allegations of violations of ethical codes, including:**
  - **(1) A no-reprisal approach for personnel reporting.**
  - **(2) Timeframes that:**
    - **(a) Are adequate for prompt consideration.**
    - **(b) Result in timely decisions.**
- **c. Education on ethical codes of conduct for:**
  - **(1) Personnel.**
  - **(2) Other stakeholders.**
- **d. Advocacy efforts for the persons served.**
- **e. Corporate citizenship.**

Intent Statements

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

Corporate responsibility assists in:

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

Examples

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

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

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

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

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

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

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

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

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

6.d.–e. Examples of advocacy and corporate citizenship efforts could be:

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

areas of water and energy, or reduction of greenhouse gas emissions.

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

- **a. Implementation of a policy on corporate compliance that has been adopted by the organization's leadership.**
- **b. Implementation of written procedures that address exclusion of individuals and entities from federally funded healthcare programs.**
- **c. Designation of a staff member to serve as the organization's compliance officer:**
  - **(1) That is documented.**
  - **(2) Who:**
    - **(a) Monitors matters pertaining to corporate compliance.**
    - **(b) Conducts corporate compliance risk assessments.**
    - **(c) Reports on matters pertaining to corporate compliance.**
- **d. Training of personnel on corporate compliance, including:**
  - **(1) Role of the compliance officer.**
  - **(2) The organization's procedures for allegations of fraud, waste, abuse and other wrongdoing.**
- **e. Internal auditing activities.**

Intent Statements

The acceptance of federal funding requires acceptance of the responsibility and accountability for tracking the funds and determining and overseeing how funds are being used and reported. Receiving federal funding includes direct and indirect federal funding. The receipt of federal funding may occur in a variety of ways, including the direct receipt of Medicaid or Medicare funding, funding through another entity (such as a block grant or funds received through a vocational rehabilitation or other state agency contract), or funding through being a federally funded network.

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

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

Examples

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

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

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

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

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

becomes too serious and/or before it is detected through a regulatory or governmental audit or survey. Additional benefits of an effective corporate compliance program are:

- Reducing the likelihood of a violation occurring.
- Reducing the likelihood of civil liability, which comes chiefly in the form of demands for return of overpayments, civil money penalties, and whistle-blower lawsuits.
- Providing management with a different and generally more accurate view of the organization.
- Establishing a structure of information relevant to the compliance program.
- Establishing a structure to maximize the right of confidentiality under the attorney-client privilege.

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

7.c.(2)(a) The compliance officer may perform compliance related activities or monitor activities delegated to other personnel.

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

7.c.(2)(c) The compliance officer reports to top-level leadership regarding compliance related activities, results of internal auditing activities, and results of investigations from reports of suspected fraud, waste, and abuse from organizational personnel.

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

Resources

Please refer to Appendix D for resources related to corporate compliance.

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

Intent Statements

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

Examples

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

Resources

Please refer to Appendix D for resources related to evidence-based practice and research.

Applicable Standards

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

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

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

Intent Statements

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

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

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

Examples

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

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

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

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

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

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

9.a.(4) Written procedures might address how funds or other donations will be applied in accordance with donor intent; e.g., a capital campaign

to fund a new building or renovations; a golf tournament, casino night, or auction to fund the purchase of a vehicle to transport persons served or new equipment that will be used by persons served; or ongoing efforts to raise funds to support services for persons who would otherwise be unable to participate in the organization's programs/services.

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

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

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

Resources

- Charity Watch: **www.charitywatch.org/home**
- Charity Review Council: **www.smartgivers.org**
- Charity Navigator: **www.charitynavigator.org**
- CFRE International: **www.cfre.org**
- Association of Fundraising Professionals: **www.afpnet.org**
- IRS Exempt Organizations Select Check: **www.irs.gov/charities-non-profits/exempt-organizations-select-check**
- IRS Charitable Solicitation—State Requirements: **www.irs.gov/charities-non-profits/charitable-organizations/charitable-solicitation-state-requirements**
- Charities Institute Ireland: **www.charitiesinstituteireland.ie/principles-for-fundraising**

9.a.(3) Resources related to valuing of donations include:

- Goodwill: **www.amazinggoodwill.com/donating/IRS-guidelines**
- Salvation Army Donation Value Guide: **satruck.org/Home/DonationValueGuide**
- Internal Revenue Service: **www.irs.gov/uac/about-publication-561**
- Canadian Revenue Agency: **www.cra-arc.gc.ca/chrts-gvng/chrts/prtng/rcpts/dtrmnfmv-eng.html**

9.a.(5) IRS information on documentation and record keeping can be found at: **www.irs.gov/charities-non-profits/contributors/written-record-of-charitable-contribution**

B. Governance (Optional)

Description

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

Applicable Standards

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

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

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

For more information, please contact your customer service unit.

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

- **a. Facilitate ethical governance practices.**
- **b. Assure stakeholders that governance is:**
  - **(1) Active in the organization.**
  - **(2) Accountable in the organization.**
- **c. Meet the legal requirements of governance.**

Intent Statements

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

Examples

Examples could include:

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

- Annual reports to stakeholders.
- Input meetings with stakeholders.
- How board members understand the organization's fundraising goals and strategies, identify prospective donors, and engage with donors.

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

- **a. The selection of the board, including:**
  - **(1) Board membership criteria.**
  - **(2) Selection process.**
  - **(3) Exit process.**
- **b. Board member orientation.**
- **c. Board development.**
- **d. Board education.**
- **e. Board leadership, including selection of:**
  - **(1) Board chair.**
  - **(2) Committee chairs.**
- **f. Board structure, including:**
  - **(1) Board size.**
  - **(2) Board composition.**
  - **(3) Definition of independent, unrelated board representation.**
  - **(4) Duration of board membership.**
- **g. Board performance, including:**
  - **(1) Financial matters, if any, between the organization and individual board members, including:**
    - **(a) Compensation.**
    - **(b) Loans.**
    - **(c) Expense reimbursement.**
    - **(d) Stock ownership.**
    - **(e) Other matters of financial interest.**
  - **(2) Use of external resources, including, as applicable:**
    - **(a) External auditors.**
    - **(b) Executive compensation advisors.**
    - **(c) Other advisors, as needed.**
  - **(3) Self-assessment of the entire board at least annually.**
  - **(4) Periodic self-assessment of individual members.**
  - **(5) Written conflict-of-interest declaration that is signed at least annually.**
  - **(6) Written ethical code of conduct declaration that is signed at least annually.**
  - **(7) External interactions.**

Intent Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

Examples

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

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

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

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

- Completing meeting questionnaires (e.g., questions rated *strongly agree, agree, neutral, disagree,* or *strongly disagree*).
  - *We (the board) spent our time on the most important governance topics.*
  - *We used our time effectively.*
  - *The meeting was chaired effectively.*
- Discussing the board's effectiveness at the conclusion of each board meeting, rolled into a year-end review documented in board minutes.
- Completing a year-end questionnaire tallied for board discussion. The following are sample questions, which can be rated by board members as *Excellent, Good, Fair, Poor,* or *N/A*:
  - Legal Frameworks:
    - *Statements in the governing documents (e.g., bylaws, policies) setting forth the board's function and duties are:*
  - Board Structure:
    - *The board's size in relation to the organization's needs is:*
    - *The board's spread and balance in regard to expertise, age, diversity, interest, and points of view are:*
  - Board Comprehension:
    - *The board's comprehension of the interests of various constituencies (funders, persons served, and advocates) with which the organization deals is:*
  - Board Practices:
    - *The board's orientation to the organization is:*
    - *The frequency of board meetings in relation to organizational needs is:*
    - *The board's practices with regard to amendments of bylaws are:*
    - *The board's practices with regard to election of officers are:*
    - *The board's practices with regard to establishing committees and their mandates are:*
  - Board Performance:
    - *The board's performance in formulating the organization's long-term goals is:*
    - *The board's ability to monitor its own accomplishments and progress is:*
    - *Performance standards expected by the board for attending all regularly scheduled meetings are:*
    - *Performance standards expected by the board for committee participation are:*
    - *Performance standards expected by the board for referral of prospective board members are:*
  - Relations with Executive Leadership:
    - *The board's working relationship with the chief executive officer is:*
    - *The definitions of the roles of the chief executive officer and board are:*

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

- A yearly self-assessment questionnaire and resulting discussion with the board chair. The following are sample questions, which can be rated by board members as *Excellent, Good, Fair, Poor,* or *N/A*:
  - *My understanding of the organization's mission, vision, and core values is:*
  - *My understanding of the legal requirements and stipulations under which the board acts is:*
  - *When outside auditors present the financial statements, my understanding of those documents is:*
  - *My attendance at board meetings is:*
  - *My preparedness for board and committee meetings is:*
  - *My working relationship with other board members is:*

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

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

Intent Statements

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

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

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

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

Examples

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

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

- **a. Agenda planning.**
- **b. Developing meeting materials.**
- **c. Distributing meeting materials.**
- **d. Overseeing the following committee work, as applicable:**
  - **(1) Governance development.**
  - **(2) Governance management.**
  - **(3) Financial audit.**
  - **(4) Executive compensation.**
  - **(5) Other pertinent activities, as defined by the board.**

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

- **a. At least annually, a formal written review of executive leadership performance in relation to:**
  - **(1) Overall corporate performance versus target.**
  - **(2) Individual performance versus target, if applicable.**
  - **(3) Professional development.**
  - **(4) Professional accomplishments.**
  - **(5) Professional opportunities.**
- **b. An executive leadership succession plan that is reviewed at least annually.**

Intent Statements

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

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

Examples

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

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

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

- **a. A written statement of total executive compensation philosophy.**
- **b. Review by an authorized board committee composed of independent, unrelated board members.**
- **c. Defined total compensation mix, up to and including, as warranted:**
  - **(1) Base pay.**
  - **(2) Incentive plans.**
  - **(3) Benefit plans.**
  - **(4) Perquisites.**
- **d. Total compensation references to:**
  - **(1) Market comparator data.**
  - **(2) Functionally comparable positions.**
- **e. A documented process that outlines:**
  - **(1) Terms of compensation arrangements.**
  - **(2) Approval date.**
  - **(3) Names of board members on the committee who approved the compensation decision.**
  - **(4) Data used in the compensation decision.**
  - **(5) Disclosures of conflict of interest, if any.**
  - **(6) Review of executive compensation records at least annually.**
  - **(7) Authority of board members to exercise executive compensation actions.**

Intent Statements

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

Examples

As a general guide, publicly traded for-profit companies have models of executive compensation programs/approaches or protocols that

detail the principles and philosophies of various compensation models. These, with modification, could be used by not-for-profit organizations.

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

Resources

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

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

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

Examples

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

Set Strategy

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

C. Strategic Planning

Description

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

1.C. **1. The ongoing strategic planning of the organization considers:**

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

Intent Statements

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

support operations, effective service delivery, and performance improvement.

This standard relates to Standard 1.J.1.

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

Examples

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

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

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

1.i. External stakeholders may include educational institutions.

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

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

1.C. **2. A strategic plan:**

- **a. Is developed with input from:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **b. Reflects the organization's financial position:**
  - **(1) At the time the plan is written.**
  - **(2) At projected point(s) in the future.**
  - **(3) With respect to allocating resources necessary to support accomplishment of the plan in the following areas:**
    - **(a) Financial.**
    - **(b) Workforce.**
- **c. Sets:**
  - **(1) Goals.**
  - **(2) Priorities.**
- **d. Is implemented.**
- **e. Is reviewed at least annually for relevance.**
- **f. Is updated as needed.**

Intent Statements

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

Examples

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

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

2.b.(2) An organization is better able to define success with proactive long-term financial planning measures. As the future financial position of an organization is impacted by ever changing marketplace factors such as coding, payment, reimbursement, and costs, the strategic plan might include information reflecting long-term financial planning to support the goals and priorities identified. Points in the future might be one

year, two years or other points in time depending on regulatory and business factors impacting the organization.

2.e.–f. An organization determines the method of review and update. Significant changes in factors impacting the strategic plan could prompt leadership to consider reviewing or updating more often than annually to maintain a dynamic and relevant plan.

1.C. **3. The strategic plan is shared, as relevant to the needs of the specific group, with:**

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

Examples

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

Persons Served and Other Stakeholders—Obtain Input

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

D. Input from Persons Served and Other Stakeholders

Description

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

1.D. **1. The organization demonstrates that it obtains input:**

- **a. On an ongoing basis.**
- **b. From:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **c. Using a variety of mechanisms.**

Intent Statements

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

Examples

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

1.a. It is important to not only use a variety of mechanisms to collect information but also

to collect information throughout the year. For example, simply having an annual public forum would not meet the intent of this standard because the standard requires ongoing collection of information.

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

Mechanisms may include:

- Input forums such as advisory groups, consumer forums, or focus groups.
- Consumer boards/councils.
- Conferences.
- Presentations to stakeholders.
- Individual meetings or telephone conversations.
- Social media and online forums.
- Communication logs.
- Telephone, written, or online surveys.
- Suggestion boxes.
- Complaint or incident summaries.
- Performance improvement activities.
- Strategic, financial, and human resource planning
- Environmental scans
- Program/service development.

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

1.D. **2. The leadership:**

a. Analyzes the input obtained.

b. Uses the input in:

(1) Program planning.

(2) Performance improvement.

(3) Strategic planning.

(4) Organizational advocacy.

(5) Financial planning.

(6) Resource planning.

(7) Workforce planning.

Intent Statements

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

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

Examples

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

For example, the organization might open a new pediatric program after collecting input from persons served and key referral sources in the community, implement a plan to expand the parking lot for a community-based program because of customer complaints of no parking spaces, or expand employment site job analysis due to increased requests from businesses and large employer groups for effective return-to-work or injury prevention strategies. Other examples of the use of input might be in changing service delivery models; developing, improving, or eliminating services; developing short- and long-range planning; and identifying personnel training needs.

Implement the Plan

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

E. Legal Requirements

Description

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

1.E. **1. The organization demonstrates a process to comply with the following obligations:**

- **a. Legal.**
- **b. Regulatory.**
- **c. Confidentiality.**
- **d. Reporting.**
- **e. Licensing.**
- **f. Contractual.**
- **g. Debt covenants.**
- **h. Corporate status.**
- **i. Rights of the persons served.**
- **j. Privacy of the persons served.**
- **k. Employment practices.**
- **l. Mandatory employee testing.**

Intent Statements

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

Examples

Systems are in place for ongoing review and monitoring of legal and regulatory requirements to ensure compliance. Policies, procedures, and

practices are revised to reflect changes in requirements. Information on legal/regulatory topics is provided to personnel through trainings, meetings, alerts, or other communications to ensure accurate knowledge and compliance.

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

Resources

Please refer to Appendix D for resources related to corporate compliance.

1.E. **2. The organization implements written procedures to guide personnel in responding to:**

- **a. Subpoenas.**
- **b. Search warrants.**
- **c. Investigations.**
- **d. Other legal action.**

Examples

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

1.E. **3. Policies and written procedures address:**

- **a. Confidential administrative records.**
- **b. The records of the persons served.**
- **c. Security of all records.**
- **d. Confidentiality of records.**
- **e. Compliance with applicable laws concerning records.**
- **f. Timeframes for documentation in the records of the persons served.**

Intent Statements

In order to protect the privacy of all stakeholders and any confidential information that its records may contain, an organization ensures that it addresses the applicable legal and regulatory requirements concerning privacy of health information and confidential records. Security includes such things as storage, protection, retention, and destruction of records. Safeguards such as reasonable protection against fire, water damage, and other hazards do not need to be described in writing.

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

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

Examples

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

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

Protection of records from permanent loss or damage includes protection from fire and water damage as well as records recovery in the event of a fire or water damage.

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

An example of a critical interaction that warrants documentation is a discussion between the therapist and family during a daily therapy session in which the parents determine that they are no longer able to take their son home with them as outlined in the original discharge plan. Another example is a spouse who informs the rehabilitation program that she has filed for divorce from her husband who is receiving rehabilitation services for a recent stroke.

F. Financial Planning and Management

Description

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

1.F. **1. The organization's financial planning and management activities are designed to meet:**

- **a. Established outcomes for the persons served.**
- **b. Organizational performance objectives.**

Examples

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

For example, an organization plans to add a vocational service to its spinal cord system of care. The financial planning for this includes special design needs for accessibility; equipment that reflects opportunities in the community; support for fabrication, modifications and adaptation of equipment; and specialized staff recruitment and training.

1.F. **2. Budgets are prepared:**

- **a. Prior to the start of the fiscal year.**
- **b. That:**
  - **(1) Include:**
    - **(a) Reasonable projections of:**
      - **(i) Revenues.**
      - **(ii) Expenses.**
      - **(iii) Capital expenditures.**
    - **(b) Input from various stakeholders, as required.**

(c) Comparison to historical performance.
(d) Consideration of necessary cash flow.
(e) Consideration of external environment information.
(2) Are disseminated, as appropriate, to:
(a) Personnel.
(b) Other stakeholders.
(3) Are:
(a) Written.
(b) Approved by the identified authority.

Examples

2.b.(1) The annual budget reflects projected revenues and expenses. Input from professional and administrative personnel in budget development demonstrates the organization's intent to anticipate its fiscal needs.

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

1.F. **3. Actual financial results are:**
a. Compared to budget.
b. Reported, as appropriate, to:
(1) Personnel.
(2) Persons served.
(3) Other stakeholders.
c. Reviewed at least monthly.

Examples

3.b.(2) Persons served may be interested in the financial status, stability, or viability of an organization for a variety of reasons; e.g., they are personally responsible for the payment of fees; they anticipate being engaged with the organization for an extended period of time; they are seeking new or enhanced equipment, technology, facilities, or programs/services and want to know whether the organization's budget will support these; they are considering donating to or investing in the organization; etc.

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

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

1.F. **4. The organization identifies and reviews, at a minimum:**
a. Revenues.
b. Expenses.
c. Internal:
(1) Financial trends.
(2) Financial challenges.
(3) Financial opportunities.
(4) Management information.
d. External:
(1) Financial trends.
(2) Financial challenges.
(3) Financial opportunities.
(4) Industry trends.
e. Financial solvency, with the development of remediation plans if appropriate.

Examples

Management information includes items such as:

- Average daily census.
- Percentage of private pay versus Medicare/Medicaid or pay from other public funds.
- Staff turnover trends that may impact revenue.

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

- Changes in reimbursement rates.
- Competition in the marketplace.

- Changes in consumer preferences.
- Interest rates and the availability of financing.
- Regulatory and legislative changes.

Industry trends may include items such as:

- Information at a national, state or provincial, regional, or local level.
- Comparison to providers of similar services throughout the region or comparison to similar business activities that are operated.
- Practices in service delivery or business management that are becoming more widespread and could impact the program.

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

Once collected, this information is incorporated into the organization's strategic and financial planning processes.

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

Remediation plans address potential threats to financial solvency if any are identified through financial review and analysis. For example, a decline in census and resultant revenue could be further assessed through an analysis of referral patterns and satisfaction of stakeholders or conducting a competitive analysis to determine if the census decline is widespread or only at the organization. A remediation plan could identify strategies to increase the number of persons served through advertising and/or senior management meetings with referring hospitals, physicians, or other referral sources to ensure that they are informed about the services offered by the organization. A cash flow concern could be addressed through a remediation plan to improve accounts receivable collection cycles.

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

- **a. The types of relationships.**
- **b. Financial reliance on related entities.**
- **c. Responsibilities between related entities and the organization, including:**
  - **(1) Legal.**
  - **(2) Contractual.**
  - **(3) Other.**
- **d. Any material transactions.**

Intent Statements

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

Examples

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

Examples of relationships include:

- Parent-subsidiary structures.
- Affiliations.
- Alliances.
- Guarantees.
- Limited partnerships.
- Other third-party operating support.
- Material contracts such as food services, pharmacy, and therapy.
- Financial support from related foundations.

Disclosure of these relationships can be accomplished through:

- Audited financial statements.
- Annual reports distributed to residents and persons served.
- Marketing materials.
- Tax report filings.

5.d. Material, when used in accounting, is defined as the magnitude of an omission or misstatement of accounting information that

makes it probable that the judgment of a reasonable person relying on that information would have been changed or influenced by the omission or misstatement. When used in finance, it refers to the magnitude of the financial impact on an organization. If the magnitude of the items relative to the whole organization is significant, then it is material. For example, a company with $2,000 of total assets has $1,000 worth of investments, the investment is material. A $1,000 impact on a $500 million total asset corporation is immaterial.

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

- **a. Implements fiscal policies and written procedures, including internal control practices.**
- **b. Provides training related to fiscal policies and written procedures to appropriate personnel including:**
  - **(1) Initial training.**
  - **(2) Ongoing training.**

Intent Statements

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

Examples

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

The organization may want to seek guidance from a source with the expertise to confirm that it is in accord with legal requirements and following generally accepted accounting principles.

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

- **a. At least quarterly.**
- **b. To:**
  - **(1) Determine that the bills are accurate.**
  - **(2) Identify necessary corrective action.**

Intent Statements

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

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

Examples

This review focuses specifically on the appropriateness of billing practices.

The review is conducted by persons trained to compare the dates and service codes on the organization's billing system to the dates, units, and types of services provided to the persons served. The scope of the review may vary depending on the services and programs provided. For inpatient settings, the billing audit could include medications, supplies, therapies, diagnostic testing, etc. A residential setting may include solely the daily charges, whereas an outpatient clinic might include therapies and supplies that were provided during that visit.

This type of review may be required by some funding or regulatory sources, but it is also a good practice to incorporate into a fiscal management program to ensure that services are being billed appropriately. In some countries there may be a comparison to ensure that for billing the coding has been done correctly, looking at the elements that would ensure the correct code was assigned.

Although only a quarterly review is required, as part of risk management an organization may choose to conduct this review more frequently,

such as when billing or coding procedures are revised, new personnel are hired or new information systems are implemented, or to determine accuracy of billing following corrective training.

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

- **a. Identifies the basis of the fee structures.**
- **b. Demonstrates:**
  - **(1) Review of fee schedules.**
  - **(2) Comparison of fee schedules.**
  - **(3) Modifications when necessary.**
- **c. Discloses to the persons served all fees for which they will be responsible.**

Intent Statements

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

Examples

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

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

Comparison of fee schedules could be with what was charged before and what new analysis might show is needed; it could be comparing to fee schedules from the funding source, but it does not require that it be external to the organization.

Persons served and personnel are kept apprised of changes and modifications to fee schedules.

8.c. Upon entry to the program, persons served are provided with an explanation of the fees for which they are responsible and when changes in fees are necessary, the organization shares this information also.

1.F. **9. If the organization takes responsibility for the funds of persons served, it implements written procedures that define:**

- **a. How the persons served will give informed consent for the expenditure of funds.**
- **b. How the persons served will access the records of their funds.**
- **c. How funds will be segregated for accounting purposes.**
- **d. Safeguards in place to ensure that funds are used for the designated and appropriate purposes.**
- **e. When interest-bearing accounts are used, how interest will be credited to the accounts of the persons served.**
- **f. How account reconciliation is provided to the persons served at least monthly.**

Examples

If the organization serves as a representative payee for the persons served, is involved in managing the funds of the persons served, receives benefits on behalf of the persons served, or temporarily safeguards funds or personal property for the persons served, it demonstrates that it has a system in place to protect the fiscal interests of the persons served. Personnel and the persons served and/or their guardians are informed of the practices in place. Persons served have access to records of their funds.

9.c.–d. A system to identify the purposes for which funds are expended may include accounting codes or line items to identify the reasons for expenditures of funds of the persons served. The organization is not required to establish separate bank accounts or other physically separate accounts for the funds of the persons served.

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

Intent Statements

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

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

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

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

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

Examples

The scope of this independent examination may vary based on the accounting requirements to which the organization is subject. It may be a full audit or a review. For a governmental entity, this standard may be met by review within its own system of oversight.

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

- **a. Provides the letter during the survey for review.**
- **b. Provides management's response, including corrective actions taken or reasons why corrective actions will not be taken.**

G. Risk Management

Description

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

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

- **a. Includes:**
  - **(1) Identification of loss exposures.**
  - **(2) Analysis of loss exposures.**
  - **(3) Identification of how to rectify identified exposures.**
  - **(4) Implementation of actions to reduce risk.**
  - **(5) Monitoring of actions to reduce risk.**
  - **(6) Reporting results of actions taken to reduce risks.**
  - **(7) Inclusion of risk reduction in performance improvement activities.**
- **b. Is:**
  - **(1) Reviewed at least annually for relevance.**
  - **(2) Updated as needed.**

Intent Statements

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

Examples

1.a.(1) There will be a range of risks in any organization. Some may result in minor annoyances or a waste of resources, while others could expose the organization to litigation, government sanction, property loss, or business interruption. Identifying loss exposures could consider risks related to governance, financial practices, human resources, services provided, populations served, information technology, emergency preparedness, environmental safety, and the physical plant.

1.a.(2) The analysis of loss exposure should include an estimate of the likelihood of the occurrence, potential frequency and severity, the potential loss, the risk to the persons served, the level of public outcry, the disruption of services, the reputation of the organization, and/or the effect on personnel morale.

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

- Risk control through avoiding the exposure altogether (if possible), reducing the probability of loss, reducing the severity of the consequences if a loss were to occur, and/or transferring the loss to another organization through a contractual transfer.
- Risk financing done by either assuming the financial responsibility for the loss (through self-insurance) or by transferring it to an outside organization (through insurance).

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

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

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

- **a. Is reviewed:**
  - **(1) For adequacy.**
  - **(2) At least annually.**
- **b. Protects assets.**
- **c. Includes:**
  - **(1) Property coverage.**
  - **(2) Liability coverage.**
  - **(3) Other coverage, as appropriate.**

Intent Statements

When effectively managed, insurance, whether third-party or self-insurance, can cover many tangible risks an organization faces. The organization's insurance package includes appropriate coverage for any services it may provide in more than one state/province or other jurisdiction.

Examples

Insurance is an important component of an organization's risk management strategy. Insurance policies provide adequate amounts and types of coverage for all aspects of the organization's operations and protect and defend persons, such as personnel and board members, volunteers, and persons served, against reasonable claims due to adverse events for which the organization is liable.

Types of coverage could include vehicles, workers' compensation, directors' and officers' liability, errors and omissions, professional liability, business interruption, cybersecurity, property, and casualty.

The organization conducts a regular review of its insurance coverage with the assistance of someone who is knowledgeable about insurance needs and types of coverage. This may be an insurance broker or anyone else with experience who also knows and is aware of the needs, risks, and assets of the organization.

1.G. **3. The organization implements written procedures regarding communications that address:**

- **a. Media relations.**
- **b. Social media.**

Examples

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

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

Resources

Please refer to Appendix D for resources related to social media.

1.G. **4. If any of the services delivered by the program seeking accreditation are provided under contract with another organization or individual, reviews of the contract services:**

- **a. Assess performance in relation to the scope and requirements of their contracts.**
- **b. Ensure that they follow all applicable policies and procedures of the organization.**
- **c. Ensure that they conform to CARF standards applicable to the services they provide.**
- **d. Are performed at least annually.**

Intent Statements

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

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

Examples

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

H. Health and Safety

Description

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

Applicable Standards

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

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

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

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

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

Identified exceptions:

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

- *Private homes* of persons served.
- *Community settings* that are not owned/leased or *controlled/operated* by the organization.
- Used solely by an *employee-owner* for administration and no other persons or personnel are located, meet, or are served at the location.
- Used by the organization for service delivery one hour or less in any week.
- Used by the organization for administration by less than the equivalent of one full-time employee in any week.

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

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

Examples

The physical environment of the organization shows evidence of ongoing attention to safe practices, reduction of health and safety risks, and an overall concern for the health and safety of the persons served and personnel. Documentation of daily maintenance tasks is not required.

1.H. 2. The organization implements written procedures to promote the safety of:

a. Persons served.

b. Personnel.

Intent Statements

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

Examples

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

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

Examples

Education may include how to identify possible physical risks and ways to reduce risks. Examples of risks include throw rugs on uneven surfaces that raise fall risk, burners on stoves in the person's house, or overloaded electrical outlets.

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

- **a. Both:**
  - **(1) Upon hire.**
  - **(2) At least annually.**
- **b. In the following areas:**
  - **(1) Health and safety practices.**
  - **(2) Identification of unsafe environmental factors.**
  - **(3) Emergency procedures.**
  - **(4) Evacuation procedures, if appropriate.**
  - **(5) Identification of critical incidents.**
  - **(6) Reporting of critical incidents.**
  - **(7) Medication management, if appropriate.**
  - **(8) Reducing physical risks.**
  - **(9) Workplace violence.**

Intent Statements

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

Examples

Competency-based training is designed to address the identified knowledge, skills and behaviors for successful performance of an activity or function. Training methods consider the individual learning style, preferences and needs of the personnel to facilitate effective learning. Ways to structure training so that they are competency-based may include demonstration and return demonstration in which the trainer demonstrates a skill (such as using a fire extinguisher or other equipment) and the trainee performs the same skill in return to ensure competency. Another technique might be to have a written quiz or assessment following a training presentation to ensure that key concepts are understood. Verbal quizzes in which the trainee describes to the trainer how he/she would respond in an emergency may also be useful in assessing competencies.

Content of the education and training may vary with the required competencies, job duties and responsibilities of the personnel. In addition to training on health and safety in an organization setting, training is provided regarding identification of risks, ways to prevent or minimize risks, and emergency procedures involved in working in community settings or a person's home when applicable to the programs or services provided.

Many organizations have a safety fair for personnel on these important safety activities. Other organizations find it helpful to develop a training plan that considers the training and information needs of personnel, contractors, visitors, managers, and those with responsibilities in the event of an emergency.

The plan identifies for a specified period:

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

Some activities organizations may consider using are:

- Orientation and Education Sessions—These are regularly scheduled to allow discussion, provide information, answer questions, and identify needs.
- Demonstration, exercise, or role-playing—A situation is simulated as closely as possible to allow for practice of skills and applied knowledge.
- Employee Training—General training for all employees that addresses:
  - Individual roles and responsibilities.
  - Individualized needs of persons served.
  - Information about threats, hazards, and protective actions.
  - Crisis intervention training.
  - Notification, warning, and communication procedures.
  - Continuation/contingency for essential services.
  - Means for locating family members in an emergency.
  - Emergency response procedures.

- Evacuation, shelter, and accountability procedures.
- Emergency shutdown procedures.

The organization determines which employees will be mandated to receive specific training applicable to their position as detailed in their job description.

Evidence of training may be documented in education attendance forms, personnel files, or meeting minutes.

4.b.(9) Training might include what types of behaviors, actions, or communication constitute workplace violence; e.g., bullying, intimidation, sexual harassment, or disruptive behavior, and actions to take under such circumstances; e.g., communication with the offending party, the mechanism to seek assistance within the organization, and reporting requirements.

1.H. **5. There are written emergency procedures:**

- **a. For:**
  - **(1) Fires.**
  - **(2) Bomb threats.**
  - **(3) Natural disasters.**
  - **(4) Utility failures.**
  - **(5) Medical emergencies.**
  - **(6) Violent or other threatening situations.**
- **b. That satisfy:**
  - **(1) The requirements of applicable authorities.**
  - **(2) Practices appropriate for the locale.**
- **c. That address, as follows:**
  - **(1) When evacuation is appropriate.**
  - **(2) Complete evacuation from the physical facility.**
  - **(3) When sheltering in place is appropriate.**
  - **(4) The safety of all persons involved.**
  - **(5) Accounting for all persons involved.**
  - **(6) Temporary shelter, when applicable.**
  - **(7) Identification of essential services.**
  - **(8) Continuation of essential services.**
  - **(9) Emergency phone numbers.**
  - **(10) Notification of the appropriate emergency authorities.**

Intent Statements

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

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

Examples

The procedures should include actions to be taken by personnel in the event of an emergency, consider any unique needs of the persons served, and be appropriate and specific to the service delivery site or location.

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

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

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

earthquakes, blizzards, ice storms, and snowstorms.

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

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

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

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

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

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

5.c.(7)–(8) Essential services may include services, products and operations necessary to maintain the health and safety of the persons served such as availability of medications and medical devices, communication systems, and systems for operation of essential business operations such as information support and payroll systems. Procedures identify internal and external resources and responsibilities for ensuring the continuation of essential services.

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

Resources

Please refer to Appendix D for resources related to emergency preparedness, planning, and procedures.

1.H. **6. The organization has evacuation routes that are:**

- **a. Accessible.**
- **b. Understandable to:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders, including visitors.**

Examples

6.a. Evacuation routes refer to the clearly visible and known routes of egress. Signage such as a posted map or diagram is not required. If an organization chooses to use signage, this may be simple Exit signs over doors, Braille representation, diagrams, or directional signs showing corridors and line of travel to exit doors, and accessibility of the signage would consider location, height, and other needs relative to the persons served and other stakeholders. Additionally, the exit ways should be clear of obstructions such as equipment, furniture or locked doors. Evacuation routes should not result in individuals getting to an unsafe location such as ungraded land, a rooftop with no opportunity for egress, or where emergency personnel cannot reach the individuals.

1.H. **7. Unannounced tests of all emergency procedures:**

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

Intent Statements

Practicing emergency procedures helps the persons served and personnel to better respond in actual emergency situations. Simulated evacuations should be limited to situations where actual evacuations are not possible. Emergency procedure testing is part of an organization's performance improvement activities. Analysis of results of the tests may indicate ways to improve performance.

Examples

Emergency tests may be done in a variety of ways. Actual physical tests or drills that move personnel through the procedure allow for practice and provide an indication of how personnel might respond in an actual emergency. With the exception of evacuation drills, tests of the emergency procedures could also be accomplished with unannounced written tests that detail what should be done in the event of an actual emergency. All personnel who would be expected to participate in an emergency procedure should be included in the testing. The emergency procedure testing is used to improve the knowledge and readiness of personnel in the event of actual emergency situations.

While local authorities may direct an organization to shelter in place or evacuate to another part of the building under certain circumstances, tests of the evacuation procedures include complete evacuation from the physical facility. Persons served may be involved in tests of the evacuation procedures. If persons served are not involved in the test, personnel should simulate the types of restrictions that persons served may have during an evacuation when actually moving through the process of evacuation. Volunteers or personnel who are not associated with the program seeking accreditation may also assist by simulating persons served in testing of an emergency evacuation. Although the need for complete evacuation from the physical facility may be rare or counter to the guidance of applicable authorities, practice drills help prepare personnel for the worst case scenario.

Implementation of an emergency procedure in the event of an actual emergency may be used in place of an emergency drill or unannounced written test.

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

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

1.H. **8. There is immediate access to:**

- **a. First aid expertise.**
- **b. First aid equipment.**
- **c. First aid supplies.**
- **d. Relevant emergency information on the:**
  - **(1) Persons served.**
  - **(2) Personnel.**

Intent Statements

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

8.d. The organization has a mechanism in place to ensure that emergency information is kept current on persons served and personnel.

Examples

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

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

8.b.–c. The organization may implement guidelines defined by local health and safety authorities regarding the availability of first aid equipment and supplies. The organization makes first aid supplies easily accessible to personnel at all sites it owns/leases/controls where services or administration are located and in all vehicles in which persons served are transported.

8.d. It is critical to have emergency information on the persons served and personnel readily available in the event that, during an emergency, the building could not be reentered or an emergency situation occurs in which information is needed immediately. This is information that might also be needed if personnel or a person served has an emergency and may include information on medical conditions, emergency contact persons, a primary care doctor, allergies, or the use of medications or assistive devices.

If the persons served are transported for group activities or services, a summary of this information is available to the personnel overseeing the outing. Emergency information about persons served is readily available to personnel on a need-to-know basis.

Many organizations have a portable file with critical information. An organization may also be able to use existing personnel files and records of the persons served if these would be readily accessible in an emergency.

1.H. **9. The organization has written procedures regarding critical incidents that include:**

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

Intent Statements

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

Examples

The organization ensures that it follows legal requirements regarding the reporting of incidents to the proper authorities. The terminology

used in Canada may be serious occurrences. Reporting requirements can be obtained from regulatory and licensing agencies, protection and advocacy services, and funding sources.

Written procedures include an algorithm for determining what constitutes a critical incident/serious occurrence and procedures for how investigations are to be conducted, how documentation is to be completed, who is responsible for completing documentation, who is to be notified, and where written documentation of incidents is to be kept. The reporting of critical incidents/serious occurrences is essential. Reporting ensures that information is communicated and significant events that could jeopardize the health and safety of participants and personnel are documented.

An incident reporting form is developed so that all necessary information about the incident is included. Information to include on the incident form includes the date, time, and location of the incident; who was involved; what led to the incident; a description of what happened; the consequences of the incident; witnesses; who was notified; and follow-up recommendations. Personnel completing the form are to provide descriptive and factual information. Software programs may be used by some organizations for reporting critical incidents to ensure more consistency in documentation, timely review, remediation, and sharing of information with involved personnel, and to facilitate analysis.

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

1.H. **10. A written analysis of all critical incidents is provided to or conducted by the leadership:**

- **a. At least annually.**
- **b. That addresses:**
  - **(1) Causes.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of personnel.**
  - **(6) Prevention of recurrence.**
  - **(7) Internal reporting requirements.**
  - **(8) External reporting requirements.**

Intent Statements

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

Examples

If critical incidents are analyzed at the level of the larger entity or organization, there is still a process to review, analyze, and address the data associated with critical incidents specific to the programs/services seeking accreditation. Analyzing critical incidents at the level of the program/service could identify program/service specific causes, trends, actions, prevention of recurrence, and education needs that may differ from the rest of the organization. The written analysis might be a separate report or contained within the organizationwide report.

This analysis is a critical piece of information in both risk management and performance improvement activities. A critical component is the concept of prevention. Changing the environment, attitudes, and service delivery techniques are all part of the process, but if the organization is not committed to the prevention of incidents, the improvement will not last. The results of the actions taken for improvement are reviewed and evaluated to ensure that the actions taken are effective.

10.b.(7)–(8) Some incidents may involve issues that are internal to the operation of the organization and that are reported only to the appropriate supervisors. However, incidents of neglect, abuse, or death must be reported to the appropriate external authorities, as required by law.

1.H. **11. The organization implements procedures:**

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

Intent Statements

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

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

Examples

The organization could provide staff education on universal precautions, handwashing technique, the use of alternative cleansing solutions, or the use of aseptic techniques. Posted signs, items in the newsletter, or other means could be used to educate family members, volunteers, and other visitors about preventing the spread of infection. The organization could have surveillance activities for monitoring and trending acquired infections.

A written infection control plan and other policies could be developed to include surveillance, isolation and precautions, health of persons served, employee health, education, antibiotic usage and resistance, and HIV-related issues.

The infection control plan addresses both community-acquired and facility-acquired infections. The activities may address a variety of prevention techniques, such as isolation precautions, guidelines for visitors, and sterilization or cleaning of equipment.

Resources

Please refer to Appendix D for resources related to infection control.

Applicable Standards

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

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

1.H. **12. When transportation is provided for persons served there is evidence of:**

- **a. Appropriate licensing of all drivers.**
- **b. Regular review of driving records of all drivers.**
- **c. Insurance covering:**
  - **(1) Vehicles.**
  - **(2) Passengers.**
- **d. Safety features in vehicles.**
- **e. Safety equipment.**
- **f. Accessibility.**
- **g. Training of drivers regarding:**
  - **(1) The organization's transportation procedures.**
  - **(2) The unique needs of the persons served.**
- **h. Written emergency procedures available in the vehicle(s).**
- **i. Communication devices available in the vehicle(s).**
- **j. First aid supplies available in the vehicle(s).**
- **k. Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations.**
- **l. If services are contracted, a review of the contract at least annually against elements a. through k. of this standard.**

Intent Statements

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

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

Examples

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

This standard is not applied when the organization occasionally arranges transportation with an external provider but does not have a contract in place with the external transportation provider. The transportation might be utilized for the persons served for activities such as community outings, special events, or appointments.

If personal vehicles are used to transport persons served, the organization and the personnel who are providing transportation should review this activity with their insurance carriers to identify and address risks and responsibilities.

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

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

12.d.–e. If an organization transports infants and children, this includes the use of age-appropriate restraining devices to be secured in the vehicles. Height, weight, cognition, etc., should be taken into consideration.

12.e. Safety equipment might include road warning/hazard equipment, fire extinguishers, or road signs that can be placed outside of the vehicle

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

Training in unique needs of the persons served may also include how to provide assistance to persons with orthopedic or neurological conditions, sensory impairments, or challenging behaviors if such information is needed for the safety of persons served.

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

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

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

12.l. If an organization contracts for transportation services, the agreement contains clauses that ensure that all service and performance standards are being met.

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

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

Intent Statements

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

13.a.(1) This inspection may be conducted in a single, uninterrupted process that moves methodically and comprehensively through an entire program area or physical location, or the organization may have several external inspections conducted that together constitute a comprehensive inspection of all areas relevant to the operation of its programs or services.

Examples

If the programs and services are part of a larger entity, inspectors may already be inspecting the facility. The organization's safety personnel should be advised of what needs to be inspected so that it can be part of all the safety inspections that the overall organization completes. Areas covered in these inspections relate to the types of programs and services that the organization provides.

Examples of the areas that might be included in the inspections as appropriate to the services provided include:

- Heating and cooling systems.
- Electrical systems.
- Emergency warning devices.
- Walking and working surfaces.
- Ingress and egress.
- Health and sanitation related to:
  - Food preparation.
  - Eating areas.
  - Restrooms.
- Structural integrity of facility.
- Operations involving hazardous materials and processes, including the safe and effective management of biohazardous materials.
- Air contaminants and ventilation.
- Fire protection systems and equipment.
- Recreation/visitation areas.
- Operation of machinery, power tools, and handheld equipment.
- Machinery guarding.
- Personal protective equipment and clothing.
- The working environment, including:
  - Illumination.
  - Noise.
- Special processes, including:
  - Welding.
  - Use of chemical treatments.
  - Spray painting.
- Use of x-ray equipment.
- Swimming pools.
- Other areas appropriate to the services provided.

13.a.(2) When the program is provided by a unit of a larger entity, such as a hospital, the larger entity's safety engineers or other personnel are not considered external authorities. External means external to the entire system, not just to a unit of the organization. Exceptions include settings such as Veterans Health Administration sites, other federal or tribal programs, and government-owned organizations. In these instances, the organization should contact the CARF office.

An external authority used by the organization (e.g., a representative of a licensure body) should be recognized and credentialed as such (e.g., a licensed or registered safety engineer or risk management authority).

External authorities may include, but are not limited to:

- A licensed or registered safety engineer.
- A representative of an agency that provides workplace safety, health, or physical plant inspection on a consultative or licensing basis.
- An engineer involved in industrial operations or a plant engineer familiar with the types of programs being provided.
- A safety specialist familiar with the types of programs being provided.
- An architect familiar with the types of programs being provided.

- A representative of the organization's insurance, fire insurance, or workers' compensation insurance carrier.
- A safety consultant who is in private practice.
- An industrial health specialist.
- A representative of the state/provincial or other jurisdictional fire marshal's office.
- A local fire control authority.
- A technical assistance consultant in health.
- A risk management specialist.

13.b. A report identifies health and/or safety areas inspected, location of each inspection, issues that were discovered during the inspection, and an action plan that supports improvement.

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

- **a. Are conducted at least semiannually on each shift.**
- **b. Result in a written report that identifies:**
  - **(1) The areas inspected.**
  - **(2) Recommendations for areas needing improvement.**
  - **(3) Actions taken to respond to the recommendations.**

Intent Statements

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

Examples

A self-inspection is an inspection that is conducted by individuals or groups within the organizational structure. Many organizations have an ongoing review of their environment for safety. The inspection includes all physical structures, maintenance systems, equipment, machinery, vehicles, and emergency systems. Areas covered could mirror or supplement those included in external inspections. Regular inspections help determine if safety practices are being consistently followed.

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

1.H. **15. If applicable, there are written procedures concerning hazardous materials that provide for safe:**

- **a. Handling.**
- **b. Storage.**
- **c. Disposal.**

Examples

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

I. Workforce Development and Management

Description

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

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

Intent Statements

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

1.I. **2. Workforce development and management practices reflect the organization's:**

a. Mission.

b. Culture.

c. Person-centered philosophy.

d. Performance measurement and management system.

e. Risk management plan.

f. Strategic plan.

Intent Statements

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

This standard relates to a number of others in Section 1 including, but not limited to, Standard 1.A.3.a. on establishment of the organization's mission and direction; 1.A.5. on cultural competency and diversity; 1.A.2. on person-centered philosophy; 1.M.1.–7. and 1.N.1.–3. on performance measurement, management, and improvement; 1.G.1.–4. on risk management; and 1.C.1.–3. on strategic planning.

2.b. Culture relates to the diversity of the workforce as well as the culture of the organization as a whole.

Examples

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

- Recruitment, selection, orientation, and ongoing training and development activities.
- Written and verbal communications.
- Efforts to seek input and feedback from persons served, the workforce, and other stakeholders for planning and improvement purposes.
- Each individual's knowledge of how he or she contributes to decreasing risks, increasing the value of the services delivered, and advancing the organization's strategic direction.

1.I. **3. Ongoing workforce planning includes:**

- **a. Workforce analysis.**
- **b. Written job descriptions.**
- **c. Review and update of written job descriptions in accordance with organizational needs and/or the requirements of external entities.**
- **d. Recruitment.**
- **e. Selection.**
- **f. Retention.**
- **g. Succession planning.**

Intent Statements

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

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

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

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

3.d. Recruitment is the activity of identifying and soliciting individuals, either from within or outside of the organization, to fill current vacancies or areas of anticipated growth. Individuals with knowledge of the position(s) being recruited for have input into recruitment plans and activities.

Often considered part of recruitment, sourcing is proactive searching for qualified job candidates for current or planned open positions at an organization. Sourcing may identify and collect relevant information on candidates who are actively searching for jobs (active job seekers) as well as candidates who are not actively looking for job opportunities (passive job seekers).

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

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

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

Examples

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

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

1.I. **4. The organization implements written procedures that address:**

- **a. Verification of:**
  - **(1) Backgrounds of the workforce in the following areas, if required:**
    - **(a) Criminal checks.**
    - **(b) Immunizations.**
    - **(c) Fingerprinting.**
    - **(d) Drug testing.**
    - **(e) Vulnerable population checks.**
    - **(f) Driving records.**

(2) **The credentials of all applicable workforce (including licensure, certification, registration, and education):**
   (a) **With primary sources.**
   (b) **When applicable, in all states/provinces or other jurisdictions where the workforce will deliver services.**
(3) **Fitness for duty, if required.**

b. Actions to be taken in response to the information received concerning:
(1) **Background checks.**
(2) **Credentials verification.**
(3) **Fitness for duty.**

c. Timeframes for verification of backgrounds, credentials, and fitness for duty, including:
(1) **Prior to the delivery of services to the persons served or to the organization.**
(2) **Throughout employment.**

Intent Statements

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

4.a.(1) The organization is aware of and adheres to any external requirements (e.g., of funders, regulatory entities, contractual agreements, etc.) for background checks of its workforce as well as any requirements it may have established internally.

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

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

High school diplomas do not need primary source verification, but college degrees, when required for the position, would need to be verified with primary sources. When a licensing authority requires and verifies the education required for the license, evidence of licensing from the licensing authority as the primary source will also serve as evidence that the education has been verified.

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

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

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

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

Examples

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

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

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

- Whether there are violations on the driving record.
- Proof of insurance.

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

- An original letter or copy of a letter from the appropriate credentialing, licensing, or certification board.
- A copy of the license or certification provided by the credentialing organization.
- A phone log or other notation made by an individual responsible for conducting primary source verification.
- A copy of a web page listing (for those situations where verification is completed online or through the internet by checking a listing of licensed/certified personnel).

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

Resources

A resource for information on medical license portability in the United States is **www.licenseportability.org**.

1.I. **5. Onboarding and engagement activities include:**

a. Orientation that addresses the organization's:

(1) Mission.

(2) Culture.

(3) Person-centered philosophy.

(4) Performance measurement and management system.

(5) Risk management plan.

(6) Strategic plan.

(7) Workforce policies and procedures.

b. On-the-job training.

c. Position roles and responsibilities.

d. Position performance expectations.

e. Communication systems and expectations.

Intent Statements

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

Examples

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

- The terminology of performance measurement and management.
- Roles and responsibilities in implementing the performance measurement and management system, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.
- How performance information is used by the organization, including to review implementation of its mission and core values, improve the quality of its programs and services, facilitate organizational decision making, review and update its strategic plan, and communicate business and service results to stakeholders.

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

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

5.e. Communication systems and expectations might address:

- Mechanisms used throughout an organization, such as an intranet system used to communicate policies, procedures, and job aids; personal use of organizational email; appropriate use of the organization's social media channels; and use of personal devices to access organizational information and resources.
- Mechanisms used to communicate about the persons served. Refer to Standard 2.A.7.
- Expectations for maintaining confidentiality and privacy.
- Expectations for maintaining current personal and emergency contact information.

1.I. **6. The organization promotes engagement through respect for all individuals in the workforce, including:**

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

Intent Statements

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

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

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

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

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

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

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

Examples

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

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

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

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

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

1.I. **7. Workforce development activities include:**

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

Intent Statements

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

Examples

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

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

1.I. **8. The organization implements written procedures for performance appraisal that address:**

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

Intent Statements

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

Examples

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

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

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

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

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

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

1.I. **9. There is an adequate workforce to:**

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

Intent Statements

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

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

Examples

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

1.I. **10. As applicable, the organization demonstrates a process to address the provision of services by the workforce consistent with relevant:**

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

Intent Statements

The organization is knowledgeable about and ensures that services are provided in accordance

with external and internal requirements and education relevant to its workforce.

Examples

10.a. Regulatory requirements may specify a certain credential for a position, a number of hours of service delivery, a number of hours of inservice training, etc.

1.I. **11. The organization's succession planning addresses, at a minimum:**

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

Intent Statements

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

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

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

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

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

Additional Resources

- Society for Human Resources Management: **www.shrm.org**
- HR Business and Legal Resources: **https://hr.blr.com**
- Association for Talent Development: **www.td.org**
- O*Net Online: **www.onetonline.org**
- Office of Personnel Management: **www.opm.gov**
- Jobbank Employer Resources (Government of Canada): **www.jobbank.gc.ca/content_pieces-eng.do?cid=3264#HR_needs**
- Labour standards in Canada: **www.cic.gc.ca/english/work/labour-standards.asp**

J. Technology

Description

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

1.J. **1. The organization implements a technology and system plan that:**

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

Intent Statements

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

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

Examples

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

1.a.(6) Assistive technology may include screen reading software for computers, adaptive telephones, adaptive mouse devices for using computers, and voice recognition software.

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

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

The organization is considering incorporation of applications such as recording cueing strategies into community integration and vocational programming, but not all persons served have access to tablets or internet access to incorporate this new technology. The organization explores options for access.

Resources

Please refer to Appendix D for resources related to technology plans.

Standards for Service Delivery Using Information and Communication Technologies

Applicable Standards

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

Description

Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, telemental health, telerehabilitation, telespeech, etc. Based on the individualized plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served,

family/support system members, and other providers in remote settings. The use of technology for strictly informational purposes, such as having a website that provides information about the programs and services available, is not considered providing services via the use of information and communication technologies.

The provision of services via information and communication technologies may:

- Include services such as assessment, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.
- Involve a variety of professionals such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.
- Encompass settings such as:
  - Hospitals, clinics, professional offices, and other organization-based settings.
  - Schools, work sites, libraries, community centers, and other community settings.
  - Congregate living, individual homes, and other residential settings.

1.J. **2. The organization implements written procedures:**

a. That address:

(1) Consent of the person served.

(2) Audio recording, video recording, and photographing the person served.

(3) Decision making about when to use information and communication technologies versus face-to-face services.

b. To confirm prior to the start of each session that all necessary technology and/or equipment:

(1) Is available at:

(a) Originating site.

(b) Remote site.

(2) Functions properly at:

(a) Originating site.

(b) Remote site.

Intent Statements

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

Examples

2.a.(3) Information and communication technologies may be used for remote monitoring of a person served. For example, the individual plan might include:

- Biometric monitoring of persons with chronic conditions, such as monitoring of weight, blood pressure, or heart rate to allow assessment of stable health or the need for medical attention.
- Motion sensors in someone's home that indicate how much/when a person is up and about, may be in need of help, or may have left the home without the supervision necessary to be safe.
- Case management visits via computer or other electronic device for routine communications.
- Interactive voice response, such as someone with diabetes or a heart condition who reports symptoms telephonically by responding to prerecorded questions. Certain answers prompt an alert to be sent to a service provider who can follow up with the person as needed.
- Personal emergency response systems, such as a pendant or bracelet worn by a person served. When the button is pushed, or when the device senses a fall, an emergency alert is transmitted to a predetermined contact to respond.

Resources

- **2.a.(1)** Telemedicine & Informed Consent: How Informed Are You? **http://southwesttrc.org/blog/2017/telemedicine-informed-consent-how-informed-are-you**
- Ontario Telemedicine Network (OTN): **https://support.otn.ca/sites/default/files/consent_guideline.pdf**

1.J. **3. As appropriate, personnel who deliver services via information and communication technologies receive competency-based training on equipment:**

- **a. Features.**
- **b. Set up.**
- **c. Use.**
- **d. Maintenance.**
- **e. Safety considerations.**
- **f. Infection control.**
- **g. Troubleshooting.**

Intent Statements

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

Examples

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

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

1.J. **4. As appropriate, instruction and training are provided:**

- **a. To:**
  - **(1) Persons served.**
  - **(2) Members of the family/support system.**
  - **(3) Others.**
- **b. On equipment:**
  - **(1) Features.**
  - **(2) Set up.**
  - **(3) Use.**
  - **(4) Maintenance.**
  - **(5) Safety considerations.**
  - **(6) Infection control.**
  - **(7) Troubleshooting.**

1.J. **5. Service delivery includes:**

- **a. Online information 24 hours a day, 7 days a week.**
- **b. Personnel to provide assistance with accessing services provided by the organization.**
- **c. Based on identified need:**
  - **(1) An appropriate facilitator at the site where the person served is located.**
  - **(2) Modification to:**
    - **(a) Treatment techniques/interventions.**
    - **(b) Equipment.**
    - **(c) Materials.**
    - **(d) Environment of the remote site, including:**
      - **(i) Accessibility.**
      - **(ii) Privacy.**
      - **(iii) Usability of equipment.**

Examples

5.a. Online information may include:

- A description of the services offered via information and communication technologies, providers, referral process, etc.
- Technology requirements such as high-speed internet access, computer headset with microphone, webcam, etc.
- Contact information for scheduling or technical support; e.g., the person or department to contact, phone number, and/or email address.
- Information to support or supplement the services provided; e.g., home exercise programs, forms to use for tracking information, when to seek emergency care or assistance between scheduled sessions, a calendar of group sessions, etc.

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

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

- **a. All participants in the session are identified, including those at:**
  - **(1) Originating site.**
  - **(2) Remote site.**
- **b. The organization provides information that is relevant to the session.**

Examples

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

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

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

- **a. The provider becoming familiar with the emergency procedures of the remote site, if the procedures exist.**
- **b. Identification of local emergency resources, including phone numbers.**

Examples

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

Additional Resources

Please refer to Appendix D for resources related to information and communication technologies.

K. Rights of Persons Served

Description

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

1.K. **1. The organization implements policies promoting the following rights of the persons served:**

- **a. Confidentiality of information.**
- **b. Privacy.**
- **c. Freedom from:**
  - **(1) Abuse.**
  - **(2) Financial or other exploitation.**
  - **(3) Retaliation.**
  - **(4) Humiliation.**
  - **(5) Neglect.**
- **d. Access to:**
  - **(1) Information pertinent to the person served in sufficient time to facilitate his or her decision making.**
  - **(2) Their own records.**
- **e. Informed consent or refusal or expression of choice regarding:**
  - **(1) Service delivery.**
  - **(2) Release of information.**
  - **(3) Concurrent services.**
  - **(4) Composition of the service delivery team.**
  - **(5) Involvement in research projects, if applicable.**
- **f. Access or referral to:**
  - **(1) Legal entities for appropriate representation.**
  - **(2) Self-help support services.**
  - **(3) Advocacy support services.**
- **g. Adherence to research guidelines and ethics when persons served are involved, if applicable.**
- **h. Investigation and resolution of alleged infringement of rights.**
- **i. Other legal rights.**

Intent Statements

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

Examples

1.a. The policies address the sharing of confidential billing, utilization, clinical, and other administrative and service-related information and the operation of any internet-based services that may exist.

Information that is used for reporting or billing is shared according to confidentiality guidelines that recognize applicable regulatory requirements, such as the Health Insurance Portability and Accountability Act (HIPAA) in the United States.

In Canada, the regulatory requirements may be found in:

- The federal Personal Information Protection and Electronic Documents Act (PIPEDA). In some provinces and territories, for example British Columbia, Alberta, and Quebec, the federal government has exempted organizations from PIPEDA because substantially equivalent provincial legislation is in place.
- Provincial legislation dealing with freedom of information and protection of personal information in the public sector.
- Legislation that deals specifically with health information in those provinces and territories that have such legislation.

1.c. The organization ensures that the person served is protected from physical, sexual, psychological, and fiduciary abuse; harassment and physical punishment; and humiliating, threatening, or exploiting actions. Sexual abuse or harassment may include any gestures, verbal or physical, that reference sexual acts or sexuality or objectify the individual sexually. Fiduciary abuse refers to any exploitation of the persons served

for financial gain. This abuse could include misuse of the funds of the persons served. Humiliation may include treatment in a manner that is demeaning or demoralizing, making fun of a person, or making an example of a person in a disrespectful manner.

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

1.K. **2. The rights of the persons served are:**

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

Intent Statements

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

Examples

Information about rights could be communicated to the persons served in a variety of ways. The method of communication may vary based on the needs of the persons served. Information might be provided in a handbook for the persons served, posted on the walls, in large print, and/or translated into different languages. It might also be provided by audio or video recordings, in-house television, through one-on-one conversation, or using an interpreter.

2.a.(3) It is important that programs providing services in a continuing duration of longer than one year establish a process to ensure that rights are reviewed with the person served at least annually. Some programs choose to set a date to review rights at times when service plans are reviewed, alternate living arrangements are discussed, or other forms are due to be reauthorized and documented.

1.K. **3. The organization:**

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

Intent Statements

The organization identifies clear protocols related to formal complaints, as defined by the organization.

Examples

These procedures are explained to personnel and persons served in a way that meets their needs.

This explanation may include a video or audio recording, a handbook, or interpreters.

1.K. **4. An analysis of all formal complaints:**
- **a. Is conducted at least annually.**
- **b. Is documented, including:**
  - **(1) Whether formal complaints were received.**
  - **(2) Trends.**
  - **(3) Areas needing performance improvement.**
  - **(4) Actions to be taken to address the improvements needed.**
  - **(5) Actions taken or changes made to improve performance.**

Intent Statements

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

Examples

Since complaints may, in some organizations, be part of risk management, this information may be evidenced in a variety of reports and used for a variety of different purposes. This analysis can be helpful to an organization in identifying changes to make in service delivery and business operations, in determining the effectiveness of changes it has made, and in risk analysis and management.

L. Accessibility

Description

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

1.L. **1. The organization's leadership:**
- **a. Assesses the accessibility needs of the:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **b. Implements an ongoing process for identification of barriers in the following areas:**
  - **(1) Architecture.**
  - **(2) Environment.**
  - **(3) Attitudes.**
  - **(4) Finances.**
  - **(5) Employment.**
  - **(6) Communication.**
  - **(7) Technology.**
  - **(8) Transportation.**
  - **(9) Community integration, when appropriate.**
  - **(10) Any other barrier identified by the:**
    - **(a) Persons served.**
    - **(b) Personnel.**
    - **(c) Other stakeholders.**

Intent Statements

The leadership has a working knowledge of what should be done to promote accessibility and remove barriers. Organizations address accessibility issues in order to:

- Enhance the quality of life for those served in their programs and services.
- Implement nondiscriminatory employment practices.
- Meet legal and regulatory requirements.
- Meet the expectations of stakeholders in the area of accessibility.

The leadership should address how input was solicited from the persons served, personnel, and other stakeholders to assist in the identification of barriers, and take into consideration any accessibility needs—physical, cognitive, sensory, emotional, or developmental—that may hinder full and effective participation on an equal basis with others.

Examples

Evidence of accessibility planning may be found in minutes of meetings where analysis, action planning, and goals are established; in conversations with stakeholders; in minutes of focus groups and council meetings; in community events in which the organization participates; in surveys; in affirmative action plans; in building or remodeling plans; in grant applications; in Americans with Disabilities Act (ADA) plans; etc.

Assessing accessibility needs and identifying barriers is the basis for development of an accessibility plan and actions to be taken.

The key to an accessibility plan is to identify the barrier(s).

1.b.(1) Architectural or structural barriers are generally easy to identify and may include steps without ramps that prevent access to a building for an individual who uses a wheelchair, multilevel buildings without elevators, narrow doorways that need to be widened, bathrooms that need to be made accessible, and historic buildings.

1.b.(2) Environmental barriers can be interpreted as any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained. An organization that is located in an area where the persons served and/or personnel do not feel safe is an example of an external environmental barrier. Internal environmental barriers may include low lighting for persons with visual impairments, a noisy environment for persons with difficulty hearing, an open office or therapy space that compromises confidentiality or poses distractions to concentration, type or lack of furnishing and décor that impact the comfort level of the persons served and personnel; or fragrances in the workplace that trigger physical reactions impacting health or ability to optimally perform job functions.

1.b.(3) Attitudinal barriers are assumptions or biases that an organization's personnel and other stakeholders have of persons served or their families and support systems that may impact access to services or benefits to be gained. These might include assumptions regarding capabilities and function based on age, ethnic background, or socioeconomic status. Other barriers may be evidenced in the terminology and language that the organization uses in its literature (e.g., does the organization use "person-first" language or refer to groups of persons by their impairments?); how persons served are viewed by the organization, their families, and the community (e.g., dependent versus independent or interdependent, incompetent versus competent, inferior versus equal), whether or not consumer input is solicited and used, and whether or not the admission criteria of the organization screen out individuals for characteristics not related to its defined scope or resources to provide services.

1.b.(4) Financial barriers include limited payment for needed services, insufficient funding for services, and lack of additional resources in a community to offset additional needs.

1.b.(5) Employment barriers may include limited involvement of employers in work placements, lack of understanding of on-site treatment for return-to-work success, and unwillingness or inability of employers to modify work requirements and expectations.

1.b.(6) Communication barriers may include lack of translation of materials into a language or formats that are appropriate for stakeholders to understand, lack of assistive technology to augment communication, lack of hearing amplification equipment in community settings that the persons served use, or website accessibility issues. If an organization has a website, it could request assistance from technical centers to evaluate its website to ensure the clarity of the site and ease of accessing information. Literacy and health literacy may also be barriers to communication.

1.b.(8) Transportation barriers may include persons being unable to get to service locations,

limited accessible or affordable public transportation, increasing number of persons served with no transportation available to them, or limited transportation services for persons with activity limitations.

1.b.(9) Barriers to community integration include any barrier that would keep the persons served from returning to full participation in their community of choice. For example, participation in sports may be limited by the lack of a lift at the public swimming pool for access by persons served with limited mobility or the lack of scheduling availability of the local gym for an adaptive sports program; accommodations may be needed for the persons served to return to previous volunteer activities with the community food bank.

1.b.(10) Although the major areas where barriers are usually found have been identified in the standard, the uniqueness of the organization and the persons served may present additional barriers. These barriers should be explored in assessing accessibility needs as well for possible inclusion in accessibility plans.

In addition to barriers resulting from facility design and attitudinal and competency barriers, many people experience barriers of inaccessible diagnostic, therapeutic, procedural, rehabilitation, and exercise equipment such as examination and treatment tables and chairs, weight scales, x-ray equipment, glucometers, blood pressure cuffs, and treadmills and other exercise machines.

Resources

Please refer to Appendix D for resources related to accessibility and to health literacy.

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

- **a. Includes, for all identified barriers:**
  - **(1) Actions to be taken.**
  - **(2) Timelines.**
- **b. Is reviewed at least annually for relevance, including:**
  - **(1) Progress made in the removal of identified barriers.**
  - **(2) Areas needing improvement.**
- **c. Is updated as needed.**

Intent Statements

There may be barriers identified that the organization does not have the authority or resources to remove; effective accommodations may be the appropriate action to be taken in those circumstances.

Examples

The accessibility plan may be found in a variety of documents. At a minimum, the accessibility plan(s) addresses:

- The barriers that limit access to programs and services.
- A detailed outline of the methods to be used in removing barriers.
- A schedule for taking necessary steps to decrease or remove the identified barriers. If the time period for achieving removal of a barrier will be lengthy, the plan could identify interim steps to be taken to address the barrier and progress toward removal.

Identification of the persons responsible for correcting identified barriers to services is not required by the standard; however, many organizations find it helpful to include this in the plan.

Implementation of the accessibility plan is monitored regularly to facilitate updates to the plan. In its plan, an organization may identify short- and long-range actions to be taken. Barrier removal that is not readily achievable at first might be achievable later when the organization has more resources available.

The organization's plan may also have options for the use of and referral to other services, affiliates, and networks that may be more accessible.

1.L. **3. Requests for reasonable accommodations are:**

- **a. Identified.**
- **b. Reviewed.**
- **c. Decided upon.**
- **d. Documented.**

Intent Statements

The organization evaluates and carefully considers the merits of all requests for accommodation to determine whether any remedial actions are appropriate.

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

Examples

A request for a reasonable accommodation does not automatically require that the organization meet the request. There should be an investigation of the request. How is the organization alerted to the need for the reasonable accommodation? What is the review process? Who is responsible for approving or denying the accommodation request? What are the decision-making criteria?

When an accommodation cannot be made, the organization demonstrates a referral system that assists the persons served to use other resources that are accessible.

Requests for reasonable accommodation by staff members might be addressed through a human resources department or a designated accessibility coordinator.

Review Results

To stay on target at both strategic and tactical levels, the organization must constantly monitor and assess its performance against a series of performance indicators and targets. Only by setting specific, measurable goals and tracking performance can the organization determine the degree to which it is achieving the desired service and business outcomes. Appropriate organizational and stakeholder representatives must review and analyze results to determine areas for improvement. This review and analysis positions the organization to develop and initiate performance improvement changes.

M. Performance Measurement and Management

Description

CARF-accredited organizations are committed to continually improving their organizations and service delivery to the persons served. Data are collected and analyzed, and information is used to manage and improve service delivery.

1.M. **1. The organization has a written description of its performance measurement and management system that includes, at a minimum:**

- **a. Mission.**
- **b. Programs/services seeking accreditation.**
- **c. Objectives of the programs/services seeking accreditation.**
- **d. Personnel responsibilities related to performance measurement and management.**

Intent Statements

A critical component of quality, the implementation of performance measurement and management systems for both business and service delivery allows an organization to look objectively at how well it is accomplishing its mission. There is a direct connection between a number of day-to-day processes addressed throughout the CARF standards, e.g., those related to financial management, complaint management, professional development for personnel, individualized service delivery, etc., and performance management in that those processes become sources of information used to analyze performance. This written description provides the context for the organization's efforts

and could be used to educate personnel and other relevant stakeholders about its approach to performance measurement and management, included in marketing or performance information that is shared with stakeholders, and/or incorporated into ongoing strategic planning activities.

Examples

1.c. The objectives of the programs/services offered include both business and service delivery objectives, e.g., minimize personnel turnover; completion of safety drills at least annually at all locations and on all shifts; maximize persons served who return to work; maximize discharge of persons served to home without the need for assistance.

1.d. Personnel may have a variety of roles and responsibilities in implementing performance measurement and management systems, such as completing assessment tools from which data are gathered, collecting data, analyzing data, participating on performance improvement teams, or working in a quality department that has overall responsibility for performance management and quality.

1.M. **2. The organization demonstrates how its data collection system addresses the following:**

- **a. Reliability.**
- **b. Validity.**
- **c. Completeness.**
- **d. Accuracy.**

Intent Statements

Accurate and consistent data will be the deciding factor in the success of an organization moving to or maintaining a fact-based, decision-making model.

Examples

There are a variety of ways an organization can demonstrate that it addresses the integrity of the data it uses for outcomes assessment, performance improvement, and management decision making. These approaches can range from the simple to sophisticated. It is not required that the organization subscribe to a proprietary data vendor in order to achieve data integrity.

2.a. Reliability. The organization takes steps to ensure that data are collected consistently in a way that could be reproduced at another time or by other data gatherers. For example:

- New and existing personnel are trained on recording each data element they are responsible for collecting; measures or codes are explained and periodically reviewed.
- Inter-rater reliability assessments can be conducted in which different staff members record measures for the same persons served and data are compared statistically to assess whether different staff members arrive at the same ratings for a given individual.
- The organization wants to measure severity at intake to the program. It searches the literature and selects a measure that has been widely tested and demonstrated to be reliable with this population.
- The organization serves a large number of persons each year. Rather than send satisfaction questionnaires to all of them, the organization selects a random sample of 50 percent from each of its program areas' clientele. Before the questionnaires are sent, the data manager reviews the characteristics of the sample to ensure that the sample is representative of the total group served in terms of diagnosis/reason for seeking services, age, gender, and ethnicity.

2.b. Validity. The organization chooses indicators, measures, and data elements that measure what it intends to measure. For example:

- Stakeholders express interest in return to work and in minimizing days lost due to incapacity for persons referred to the program. The organization chooses to collect employment status at follow-up and asks about the number of days of work lost due to activity limitations instead of just the diagnostic data it has always summarized.
- A program's stakeholders are interested in reducing the level of impairment in persons served. The program does a literature review and selects a standardized tool or measure known to be valid and reliable.

2.c. Completeness. The organization takes steps to ensure that the data used for decision making are as complete as possible; no accredited programs are omitted from the information and performance improvement effort; no groups of persons served are omitted from the data gathering or analysis; no data elements or indicators are systematically missing; and any database is checked for completeness of records before final analyses are run and decisions made. For example:

- The quality council and data manager collaborate on designing an information system regarding the persons served that includes necessary data elements for all programs of the organization. They decide to design an organizationwide system but identify each record with the particular program in which the person participates so analysis can be done separately for all the programs to be surveyed.
- Staff training for the data recording activities includes attention to the importance of recording each data field for every person served.
- The data manager routinely cross checks the number of records of the persons served in the database with the operations officer's report of the number of persons served during a reporting period to ensure that data are available on all persons served before analysis is conducted and reports are generated. Missing records are located and entered into the database before analysis is conducted.

2.d. Accuracy. The organization takes steps to ensure that data are recorded properly and that errors are caught and corrected. For example:

- Spot checks of the records of the persons served are made to ensure that data abstracted from the record are correctly placed into the database.
- The data manager routinely reviews the distribution of values in test data runs and asks the direct care staff members to double check the accuracy of cases that seem to be outside of expectations in terms of maximum or minimum values. (For example, did someone really stay in the program 205 days or was it 20 days?)

1.M. **3. The data collected by the organization:**

- **a. Include:**
  - **(1) Financial information.**
  - **(2) Accessibility information.**
  - **(3) Resource allocation.**
  - **(4) Surveys, if applicable.**
  - **(5) Risk management.**
  - **(6) Governance reports, if applicable.**
  - **(7) Human resource activities.**
  - **(8) Technology.**
  - **(9) Health and safety reports.**
  - **(10) Strategic planning information.**
  - **(11) Field trends, including research findings, if applicable.**
  - **(12) Service delivery.**
- **b. Address:**
  - **(1) The needs of persons served.**
  - **(2) The needs of other stakeholders.**
  - **(3) The business needs of the organization.**
- **c. Allow for comparative analysis.**
- **d. Are used to set:**
  - **(1) Written business function:**
    - **(a) Objectives.**
    - **(b) Performance indicators.**
    - **(c) Performance targets.**
  - **(2) For each program seeking accreditation, written service delivery:**
    - **(a) Objectives.**
    - **(b) Performance indicators.**
    - **(c) Performance targets.**

Intent Statements

Organizations continually collect data from a variety of internal and external sources. These data are analyzed and the results are used to make informed decisions about the needs of the persons served and other stakeholders as well as the business needs of the organization.

Business function and service delivery objectives, performance indicators, and performance targets are set as appropriate to the specific needs of the organization. There does not necessarily

need to be a performance indicator and target for each area of data collected.

3.d.(2)(b) At a minimum, service delivery performance indicators for each program seeking accreditation include indicators for effectiveness of services, efficiency of services, service access, and satisfaction and other feedback from a variety of perspectives including the persons who received the services and other stakeholders. These indicators are the basis for the measurement of service delivery indicators addressed in Standard 1.M.6.b.

See the Glossary for definitions of *performance indicator* and *performance target*.

Examples

3.a. A variety of information and data collected relative to standards in other sections of this manual also relate to this standard. For example:

- Related to the standards in Section 1.F., financial information includes, but is not limited to, information about the budget (1.F.2.), financial results (1.F.3.), revenues and expenses (1.F.4.), financial reliance on related entities (1.F.5.), and accuracy of billing (1.F.7.).
- Accessibility information is addressed in 1.L.2.
- Data on resource allocation might encompass data on any of the resources needed to support the overall scope of each program/service including, but not limited to, human resources; finances; physical space; personnel training; materials, equipment, and supplies; etc.
- Surveys may refer to satisfaction questionnaires or state/provincial or other jurisdictional surveys used to obtain input from stakeholders (1.D.1.), identify the expectations and needs of stakeholders (1.C.1.) or collect satisfaction and other feedback from stakeholders (1.M.6.b.(4), 4.A.22., 4.C.33., 4.D.31.); national surveys; regulatory surveys; OIG reviews; CARF surveys; other accreditation surveys; etc.
- Risk management information could be found in the risk management plan (1.G.1.).
- Governance reports related to board committee work (1.B.4.) or executive compensation (1.B.6.).
- Human resource resources activity related to completion of performance appraisals (1.I.8.); trends in recruitment, retention or turnover (1.I.3.); and the effectiveness of learning opportunities provided to personnel (2.A.13.).
- Data on technology might relate to the technology and system plan (1.J.1.). It might also relate to the use of technology in service delivery or the need for technology expertise (3.C.9., 4.E.6., and 4.F.11.).
- Health and safety reports might include reports on tests of emergency and evacuation procedures (1.H.7.), critical incidents (1.H.10.), health and safety inspections (1.H.13.–14.), etc.
- Information on field trends might be incorporated into governance oversight of executive compensation (1.B.6.), strategic planning consideration of service area needs and demographics (1.C.1.); industry trends that have a financial impact on the organization (1.F.4.); and the service delivery models and strategies utilized by the program (2.A.6.).

Data and information for use in performance assessment and improvement may be gathered in a variety of ways:

- Periodically, a report could be completed that encompasses the critical issues surrounding business performance.
- With advance planning and a consistent outline to follow in order to comment on relevant data, a report could be pulled together at the end of the fiscal or calendar year, whichever timeframe is more meaningful to the organization.
- The data could be gathered by different personnel or board members and summarized by one individual.

3.b. To be in conformance to this standard, the organization should be prepared to demonstrate knowledge of the needs and goals of the persons served and other key stakeholders.

Consistent with the World Health Organization's *International Classification of Functioning,*

Disability and Health, the needs of the persons served include the reasons they are seeking services, goals they want to achieve, activities in which they want to engage, and roles and participation in their communities of choice.

Needs of the persons served may be identified in assessments, treatment planning, and development of predicted outcomes. Needs of other stakeholders might be identified through payer requirements, government mandates, or surveys of key stakeholders.

3.d.(1) It is not expected that there be a business function objective or performance indicator for each of the data sources or information analysis systems listed in 1.M.3.a.(1)–(12). However, the organization should be prepared to present evidence and discuss the process for using data from these sources and systems in setting objectives and determining and measuring the indicators selected. For example:

- In the area of financial planning and management the organization might identify indicators related to expenses, revenues, or other budgetary information; financial reliance on related entities; or its review of billing against records of the persons served.
- In the area of accessibility status reports the organization might identify an indicator related to implementation of its accessibility plan and progress made in the removal of barriers.
- In the area of risk management an indicator might be identified related to the organization's actions to reduce risks.
- Human resource indicators might be identified for recruitment, retention, or personnel turnover or the provision of training to personnel.
- Health and safety indicators might relate to the analysis of unannounced tests of emergency procedures, critical incidents, or infection control.

3.d.(1)(c) and **3.d.(2)(c)** To identify performance targets, some organizations may use standardized tools that have an established benchmark, review relevant literature for industry performance standards, or develop their own performance targets from review of their historical performance.

1.M. 4. The organization collects data about the characteristics of the persons served.

Intent Statements

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

Examples

Characteristics may include a wide variety of data that reflect relevant information about the persons served. Typical characteristics include age, gender, ethnicity, diagnosis, impairment, activity limitation, education levels, living arrangements, and primary language. Demographic record keeping may already be occurring through other sources and may be accessed to avoid duplication of effort.

1.M. 5. The organization collects data about the persons served at:

a. The beginning of services.
b. Appropriate intervals during services.
c. The end of services.
d. Point(s) in time following services.

Examples

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

5.d. The program collects postdischarge data that include:

- Obtaining evaluation of the program(s) by the persons served.
- Collecting clinical information that compares the current status of the persons served to their status at discharge.

If the organization uses sampling to collect follow-up data, the sample is representative of the population served in the program.

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

1.M. **6. The organization measures:**

- **a. Business function performance indicators.**
- **b. Service delivery performance indicators for each program/service seeking accreditation in each of the following areas:**
  - **(1) The effectiveness of services.**
  - **(2) The efficiency of services.**
  - **(3) Service access.**
  - **(4) Satisfaction and other feedback from:**
    - **(a) The persons served.**
    - **(b) Other stakeholders.**

Intent Statements

Refer to the Glossary for definitions of *effectiveness*, *efficiency*, and *service access*.

Examples

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

The indicators an organization chooses to measure relate to the information that the persons served and other stakeholders want to know about its programs and services. The organization should establish measurable objectives in each area and then collect the data to measure results. The organization may choose the same indicator for each program seeking accreditation; however, the measurement should allow for analysis of performance at the level of the program. Performance information at the level of the program is important in identifying areas for service delivery improvement.

6.b.(1) Effectiveness measures address the results of care through measuring change over time. Measures of effectiveness for a pediatric specialty program might address return to school by placement, adolescents returned to work, and children/adolescents who were involved in play/leisure activities in the last week.

Effectiveness measures for an amputation specialty program might address whether the person served is able to achieve or maintain independence with use of prosthesis, level of independence with ADL, ambulation, quality of residual limb and skin care, range of motion, strength, or participation in leisure and recreational activities.

6.b.(2) Efficiency measures address the relationship between resources used and the results or outcomes achieved. Resources may include time, money, staff, space, or equipment.

6.b.(3) Service access might include the number of days from referral to admission to the program, number of days from referral to authorization for admission, ability to admit persons to an inpatient program over the weekend, impact of funding or resources available, and the convenience of service hours and locations.

1.M. **7. For each service delivery performance indicator, the organization determines:**

- **a. To whom the indicator will be applied.**
- **b. The person(s) responsible for collecting the data.**
- **c. The source from which data will be collected.**
- **d. A performance target based on an industry benchmark, the organization's performance history, or established by the organization or other stakeholder.**

Examples

7.a. It is important to include the persons the organization served or intended to serve to ensure that individuals who drop out prematurely or who do not return are included in the performance improvement system. Valuable information for program improvement can be gathered from persons who leave the program prior to successful completion. An organization

that follows up only on successful discharges would not be in conformance to this standard.

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

7.d. The establishment of performance target of a level to be achieved is critical. Some organizations use standardized tools that already have an established benchmark while other organizations develop their own indicators targets by reviewing their historical performance in an identified indicator. A review of the literature and published evidence-based practices is helpful in this process.

The development of a performance target ensures that there will be action for improvement if the target is not met.

Effect Change

Following the review and analysis of results, the organization must carefully evaluate the information learned so that it may be translated into focused actions to improve performance against targets. The evaluation drives the organization to engage in a dynamic, proactive process to review, renew, or revise its strategy and tactics, while ensuring alignment of organizational purpose, service and business practices, and organizational resources. Achieving excellence requires a disciplined continuous improvement process.

N. Performance Improvement

Description

The dynamic nature of continuous improvement in a CARF-accredited organization sets it apart from other organizations providing similar services. CARF-accredited organizations share and provide the persons served and other interested stakeholders with ongoing information about their actual performance as a business entity and their ability to achieve optimal outcomes for the persons served through their programs and services.

1.N. **1. A written analysis is completed:**

- **a. At least annually.**
- **b. That analyzes performance indicators in relation to performance targets, including:**
  - **(1) Business functions.**
  - **(2) Service delivery of each program seeking accreditation, including:**
    - **(a) The effectiveness of services.**
    - **(b) The efficiency of services.**
    - **(c) Service access.**
    - **(d) Satisfaction and other feedback from:**
      - **(i) The persons served.**
      - **(ii) Other stakeholders.**
  - **(3) Extenuating or influencing factors.**
- **c. That:**
  - **(1) Identifies areas needing performance improvement.**

(2) Results in an action plan to address the improvements needed to reach established or revised performance targets.

(3) Outlines actions taken or changes made to improve performance.

Intent Statements

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

Examples

The performance analysis reviews data aggregated at a program/service level for each program/service seeking accreditation, including specialty programs, in order that the action plan can target improvements at the individual program/service level.

An analysis of performance provides information to aid in the strategic positioning of the organization and in achieving its mission and targets. The analysis results in a written report that is designed to support the actions and activities for improving the organization through reviews by the leadership/governance, communicating information with stakeholders, and supporting the plans for improving service delivery. A summary analysis gives needed information for making decisions and improvements in services. Data and information in the report may be presented in narrative form, in charts, or in graphs.

CARF does not prescribe the style or structure of the report; typically reports contain at least the following:

- Demographic data.
- A report on the data collected (business performance indicators, effectiveness, efficiency, service access, and satisfaction measurements) and discussion of analysis of the data.
- Follow-up data collected from those who have exited services.
- An update on action items from the previous report (e.g., what has been accomplished or has resulted from changes suggested by analysis of the previous year's outcomes).
- A conclusion, including recommendations and a to-do list with action items.

1.a. An organization might choose to conduct an analysis more frequently because of the value the information provides it in managing its programs and services.

1.b. The organization compares the results achieved to the performance targets identified for effectiveness, efficiency, service access, feedback from persons served, and feedback from other stakeholders. A comparison of all areas is required.

1.b.(3) Examples of extenuating or influencing factors that could impact performance include a change in leadership, relocation, reductions in budget, personnel shortages, and new regulations.

1.N. **2. The analysis of performance indicators is used to:**

a. Review the implementation of:

(1) The mission of the organization.

(2) The core values of the organization.

b. Improve the quality of programs and services.

c. Facilitate organizational decision making.

d. Review or update the organization's strategic plan.

Intent Statements

Mission-driven measurement underpins the performance improvement framework that is created through the standards. Analyzing performance indicators provides a basis for decision making that aligns with and validates that the organization's mission and core values are in place and practiced. Although not every performance indicator that is measured and analyzed may be acted on, the information gleaned from the analysis allows for a fact-based approach to decision making, planning, and performance improvement.

Examples

The organization uses a fact-based, decision-making process to identify and respond to organizational needs. To be in conformance to this standard, the organization should be prepared to demonstrate:

- Knowledge of the operational status of the organization, the business strategies it employs to be successful, and how performance improvement is utilized at all levels of the organization.
- How it makes decisions to expand, remodel, open new sites, develop new services, modify a treatment approach, or change staffing patterns.
- Methods for reaching these decisions, which may include reviews of information, outcomes management reports, budgets, strategic plans, and satisfaction surveys.

1.N. **3. The organization communicates performance information:**

- **a. To:**
  - **(1) Persons served.**
  - **(2) Personnel.**
  - **(3) Other stakeholders.**
- **b. According to the needs of the specific group, including:**
  - **(1) The format of the information communicated.**
  - **(2) The content of the information communicated.**
  - **(3) The timeliness of the information communicated.**
- **c. That is accurate.**

Intent Statements

In a consumer-driven market, CARF-accredited organizations realize the importance of sharing their performance information with the persons served and other stakeholders. The information is tailored to meet the needs of a variety of stakeholders both internal and external to the organization.

Examples

Performance information could be communicated a number of ways, including a bulleted short summary or fact sheet, pie charts, bar graphs, a narrative report, a balanced scorecard, press releases, annual reports, posting summaries or graphics on the organization's website, and newsletters. The content of the information shared is tailored to the needs of the audience and what the specific stakeholder group would like to know about the program or services. The information is presented in a language and format that is understandable to those with whom it is shared. Format may vary for different stakeholder groups.

Information communicated should be accurate, from the most recent reporting period, and be presented in appropriate timelines for decision making.

Section 2

The Rehabilitation and Service Process for the Persons Served

The fundamental responsibilities of the organization are to effect positive change in functional ability and independence and self-reliance across environments, while protecting and promoting the rights of the persons served. The persons served should be treated with dignity and respect at all times. All personnel are able to demonstrate their awareness of the rights of the persons served as well as their own rights. The rehabilitation and service process is delivered by an integrated team that includes the person served. The process focuses on clarity of information, efficient use of resources, reduction of redundancy in service delivery, achievement of predicted outcomes, and reintegration of the person served into his or her community of choice.

Applicable Standards

The following table identifies the standards in Section 2 that are applicable to the program(s) for which an organization is seeking accreditation based on the accreditation sought and the diagnostic categories and populations served.

Program Seeking Accreditation	2.A. Program/ Service Structure	2.B. Rehabilitation/ Service Process	2.C. Service Process for Home and Community Services (HCS)	2.D. Rehabilitation/ Service Process for Specific Diagnostic Categories	2.E. Rehabilitation Process for Children/ Adolescents
Section 3. Program Standards					
3.A. Comprehensive Integrated Inpatient Rehabilitation Program	Apply all	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Apply*
3.B. Outpatient Medical Rehabilitation Program	Apply all	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Apply*
3.C. Home and Community Services	Apply all	Not applicable	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Not applicable
3.D. Residential Rehabilitation Program	Apply all	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Apply*
3.E. Vocational Services	Apply 2.A.1.–19.	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Not applicable
3.F. Interdisciplinary Pain Rehabilitation Program	Apply all	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Apply*
3.G. Occupational Rehabilitation Program	Apply all	Apply according to guidelines on page 117	Not applicable	Apply according to guidelines on page 157	Apply if any children/ adolescents served
3.H. Independent Evaluation Services	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
3.I. Case Management	Apply all	Not applicable	Not applicable	Apply according to guidelines on page 157	Apply*

*Apply Section 2.E. if *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation.

Program Seeking Accreditation	2.A. Program/ Service Structure	2.B. Rehabilitation/ Service Process	2.C. Service Process for Home and Community Services (HCS)	2.D. Rehabilitation/ Service Process for Specific Diagnostic Categories	2.E. Rehabilitation Process for Children/ Adolescents
Section 4. Specialty Program Designation Standards					
4.A. Pediatric Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Not applicable
4.B. Amputation Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Apply*
4.C. Brain Injury Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Apply*
4.D. Cancer Rehabilitation Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Apply*
4.E. Spinal Cord Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Apply*
4.F. Stroke Specialty Program	Apply all	Apply according to guidelines on page 117	Apply according to guidelines on page 143	Apply according to guidelines on page 157	Apply*

*Apply Section 2.E. if any children/adolescents served and not seeking Pediatric Specialty Program accreditation (unless linked to Home and Community Services). If the specialty program in linked to Home and Community Services, Section 2.E. does not apply; refer to Section 2.C. applicable standards guidelines.

A. Program/Service Structure for all Medical Rehabilitation Programs

2.A. **1. Each program/service:**

- **a. Documents the following parameters regarding its scope of services:**
  - **(1) Population(s) served.**
  - **(2) Settings.**
  - **(3) Hours of services.**
  - **(4) Days of services.**
  - **(5) Frequency of services.**
  - **(6) Payer sources.**
  - **(7) Fees.**
  - **(8) Referral sources.**
  - **(9) The specific services offered, including whether the services are provided directly, by contract, or by referral.**
- **b. Shares information about the scope of services with:**
  - **(1) The persons served.**
  - **(2) Families/support systems, in accordance with the choices of the persons served.**
  - **(3) Referral sources.**
  - **(4) Payers and funding sources.**
  - **(5) Other relevant stakeholders.**
  - **(6) The general public.**
- **c. Reviews the scope of services at least annually and updates it as necessary.**

Intent Statements

The scope is defined at the level of the program/service and provides the persons served, families/support systems, referral sources, payers, and other relevant stakeholders with information that helps them understand what the program/service has to offer and determine whether it will meet the needs of the persons served. If the program is part of a continuum of services, the scope is defined for each program or specialty program within the continuum.

Examples

This standard applies to all medical rehabilitation programs and specialty programs and is related to Standards 2.B.1. and 4.E.1., which address additional components of the scope of services to be defined for specific medical rehabilitation programs.

1.a. An organization that is seeking accreditation for comprehensive integrated inpatient rehabilitation programs provided in both hospital and skilled nursing facility settings defines its scope in such a way that the distinctions between the programs and settings can be clearly understood. Similarly, an organization that provides a brain injury continuum of services defines the scope of each component of the continuum provided, e.g., brain injury specialty program in a residential rehabilitation setting, a home or community setting, and a vocational services setting.

1.a.(6) Payers and funding sources could include private payers, such as third party payers; auto insurance companies; HMOs; self-insured employers; or public payers, such as state/provincial or other jurisdictional payers. As part of the identification of primary payer sources, the program/service might also identify payer requirements that could affect the provision of services.

1.b.(5) Please refer to the Glossary for a definition of *stakeholders*.

Resources

1.b. Please refer to Appendix D for resources related to health literacy.

2.A. **2. The organization provides the resources needed to support the overall scope of each program/service.**

Intent Statements

The ability to provide the program/services defined in the scope statement is evidenced by adequate materials, equipment, supplies, space, finances, training, and human resources.

Examples

The resources include, but are not limited to, personnel; finances; leadership; space, materials, and equipment; continuing education for personnel; and education for the persons served, their families/support systems, and the community.

Internal resources for an amputation specialty program could include personnel who have expertise in assessment and treatment of persons with limb loss. External or referral resources might include providers of durable medical equipment (DME), prosthetists, orthotists, Meals on Wheels, adaptive driving programs, vocational rehabilitation services, and the local area agency on aging.

Internal resources for a stroke specialty program could include splinting materials, positioning devices, and personnel who have expertise in assessment and treatment of persons who have sustained a stroke. External resources might include DME, orthotists, Meals on Wheels, and the local area agency on aging.

2.A. **3. Based on the scope of each program/service provided, the organization documents its:**

- **a. Entry criteria.**
- **b. Transition criteria, if applicable.**
- **c. Exit criteria.**

Intent Statements

The organization determines which persons it is qualified and able to serve and identifies conditions/time/events for transition and/or exit. This includes transitions to other levels of care/services as well as transitions within a program/service. Transition criteria may also address continuing stay criteria. Transition may not always occur based on the nature of the program/service.

Examples

While a program/service may use terms that are different than those above, the concepts are the same.

3.a. Entry criteria may also be called admission criteria, enrollment criteria, or move-in criteria.

3.b. Transition criteria may also be called transfer guidelines.

3.c. Exit criteria may also be called agreement termination criteria, contract termination criteria, discharge criteria, or move-out criteria.

2.A. **4. When a person served is found ineligible for services:**

- **a. The person served is informed as to the reasons.**
- **b. In accordance with the choice of the person served:**
  - **(1) The family/support system is informed as to the reasons.**
  - **(2) The referral source is informed as to the reasons.**
- **c. Recommendations are made for alternative services.**

2.A. **5. Each program/service implements procedures that address unanticipated service modification, reduction, or exits/transitions precipitated by funding or other resource issues.**

Intent Statements

The program/service demonstrates its knowledge of funding sources and their expectations and timeframes for discontinuing or changing the program/service. While funding issues impact entry and exit decisions, the program/service consistently advocates for needs of the persons served.

Examples

A funding issue might be a change in the funding level of a contract for services, or, in Canada, a change in the government-imposed status of a person served. Other resource issues might include the unavailability of staffing due to an unexpected illness or inability of the person served to attend the program/service because a family member who usually provides transportation suffers an injury that temporarily prevents driving.

2.A. **6. Service delivery models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**

Intent Statements

The service delivery model and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes.

Examples

Evidence of conformance to this standard may be demonstrated through minutes of meetings in which these topics were discussed, literature available to the personnel in a program library, development of care paths or treatment guidelines, etc. Resources used in this process might include access to evidence-based practice databases and reviews, journal subscriptions, on-line access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, in-service programs, journal clubs, collaborative resources, or education efforts with other area providers of services. The organization uses field-recognized practices and, ideally, adopts evidence-based or research-supported practices where the evidence and research are sound.

Resources

Please refer to Appendix D for resources related to evidence-based practice and research.

2.A. **7. To facilitate integrated service delivery, each program/service implements communication mechanisms regarding the person served that:**

- **a. Address:**
  - **(1) Emergent issues.**
  - **(2) Ongoing issues.**
  - **(3) Continuity of services, including:**
    - **(a) Contingency planning.**
    - **(b) Future planning.**
  - **(4) Decisions concerning the person served.**
- **b. Ensure the exchange of information regarding the person-centered plan.**

Intent Statements

This standard addresses the need for timely communication to ensure that services and programs are consistently provided, whether provided 24 hours a day, 7 days a week or on a part-time, scheduled basis.

Examples

Communication mechanisms are designed to facilitate program/service collaboration, responsiveness, and integration of information for effective service provision. Communication methods may include written or oral communication, electronic formats, log books, face-to-face meetings, records of the persons served, hand-held devices or computers. Consideration is given to communication between shifts, team members, providers, persons served and family/support systems. Systems for communication of emergent issues facilitate timely decision making and response.

2.A. **8. The program/service demonstrates:**

- **a. Knowledge of the legal decision-making authority of the persons served.**
- **b. When applicable, the provision of information to the persons served regarding resources related to legal decision-making authority.**

Intent Statements

The person served may not have the capacity or be of the age to make decisions in his or her own best interests. An individual may need to be assigned to make decisions regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from jurisdiction to jurisdiction; e.g., healthcare power of attorney, power of attorney, and guardianship. The program/service should be able to discuss how it addresses the issue of the legal decision-making authority of the persons served.

8.b. Any limitation on a person's legal decision-making authority should be continued only as long as is appropriate and necessary. The program/service assists the person served and his or her family members/support system to access resources, such as attorneys with expertise

in this area, who can assist with facilitating changes, if appropriate, in legal autonomy status.

Examples

8.a. The legal decision-making authority of the persons served may be addressed by someone in the organization who has expertise in competency determination, through a screening process, in team conferences, etc. A provider could demonstrate knowledge of legal decision-making authority through a discussion with the surveyor of legal decision-making authority issues pertinent to existing jurisdictional law, policies that outline levels of legal autonomy, inservices on issues of legal decision-making authority, and materials for personnel and the persons served that explain legal decision-making authority.

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

- **a. Responsibilities of:**
  - **(1) Drivers.**
  - **(2) Service providers.**
- **b. Confidentiality of:**
  - **(1) Records of persons served.**
  - **(2) Communication.**
- **c. Privacy related to service delivery.**
- **d. Accessibility.**
- **e. Availability of information on resources to address needs unable to be met at the mobile setting.**
- **f. Security of:**
  - **(1) Medications provided from or within the mobile unit, when applicable.**
  - **(2) Equipment and supplies used in service provision.**
  - **(3) The mobile unit when not in use.**
- **g. Safety of:**
  - **(1) Records of persons served.**
  - **(2) Personnel.**
- **h. Maintenance of:**
  - **(1) Equipment.**
  - **(2) Vehicles.**

Intent Statements

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

Examples

Services that may be provided from a mobile unit include, but are not limited to, functional capacity evaluations provided at a worksite as part of an occupational rehabilitation program, lymphedema therapy provided to persons receiving cancer rehabilitation services, or pediatric outpatient medical rehabilitation program services provided to children/adolescents in a rural geographic area.

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

9.d. The mobile unit:

- Provides adequate space for persons served to approach and move around inside of it.
- Is equipped with a ramp, handrails, and adaptive equipment for use by personnel and/or persons served.
- Operates from a location where there is ample parking.
- Operates from a location that limits exposure to the sun and noise in the environment such as traffic noise.

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

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

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

2.A. **10. The program's system for orientation of personnel addresses its:**

- **a. Scope.**
- **b. System of communication to maintain the interdisciplinary team process.**

2.A. **11. Based on established competencies, the organization determines for members of the team with limited or no prior experience in the specific program area:**

- **a. The intensity of the collaboration required with experienced team members.**
- **b. The length of the collaboration required with experienced team members.**
- **c. The need for discipline-specific collaboration with experienced team members.**

Intent Statements

When healthcare providers who have limited or no experience in a program area are added to the rehabilitation team, the organization outlines a system of mentorship or training through collaboration with an experienced team member(s). The collaboration focuses on activities designed to facilitate the learning of the required competencies.

Examples

The intensity of the collaboration is outlined (e.g., side-by-side collaboration, on-site collaboration, collaboration via telephone). The length of the collaboration is determined (e.g., one week, one month, several months). Finally, it is determined if it is necessary to have the collaboration conducted by an individual of a specific healthcare discipline.

2.A. **12. The organization provides documented personnel training:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes information on:**
  - **(1) The psychological issues of the persons served.**
  - **(2) The social/cultural issues of the persons served.**
  - **(3) Performance measurement, management, and improvement, including:**
    - **(a) Development of performance improvement system.**
    - **(b) Performance measurement tools.**
    - **(c) Data collection methods.**
    - **(d) Comparative data.**
    - **(e) Use of outcomes information.**
  - **(4) Legal requirements affecting the organization or the personnel.**
  - **(5) Documentation and record keeping requirements of the organization as appropriate to the job.**
  - **(6) Suicide prevention.**
  - **(7) Specific training directly related to the program.**

Intent Statements

This training expands upon the training addressed in Standard 1.I.5.

12.b.(3) The education supports understanding and encourages personnel involvement in the performance measurement, management and improvement activities in Sections 1.M. Performance Measurement and Management and 1.N. Performance Improvement; in standards requiring gathering, analyzing and using data; and standards requiring the sharing of outcomes information with persons served and other stakeholders. The organization's educational efforts are directed toward giving personnel the information necessary for them to understand the value of performance measurement, to

collect data accurately and efficiently, and to interpret and use such data correctly, including how to share performance information with the persons served and other stakeholders. It is intended that personnel will understand basic concepts, not that they will become experts in performance measurement and management.

12.b.(6) All programs have the potential to encounter persons who are at risk of suicide, including a person served, member of the family/support system, or other personnel. In order to protect rights, dignity, health, and safety, personnel are trained to recognize the signs that someone is at risk or in crisis and to intervene accordingly.

Examples

This information may be shared in a variety of ways, including, but not limited to, providing inservices at the organization, placing materials in libraries at the program site, providing videos and audio recordings, facilitating guest lectures and grand rounds, and facilitating attendance at seminars and conferences off site.

12.b.(1)–(2) Topics could include family interaction, delineation of roles, depression, and coping with activity limitations/loss of function.

12.b.(4) Topics could include state/provincial or other jurisdictional requirements for reporting suspected abuse or neglect, privacy legislation, the Americans with Disabilities Act (ADA), and supervision requirements for the use of extenders.

12.b.(5) Topics could include regulatory requirements or organizational requirements regarding the frequency of documentation; style or format of documentation; if used, training on computerized systems; and legal confidentiality and record keeping.

12.b.(6) Depending on the type of program and competencies of personnel, training on suicide prevention may include:

- Suicide concepts and facts, including suicide risk and protective factors, legal and regulatory requirements, documentation requirements, follow-up and transition, and cultural and local factors.
- Protecting the rights and dignity of the person served and recognizing individual preferences, needs, and activities (establishing a safe environment).
- Suicide first aid and risk assessment.
- Intervention, including determining risk level, issues related to imminent harm, and development of safety plans.
- Developing a continuity of care plan.

Resources

12.b.(6) Please refer to Appendix D for resources related to suicide prevention training.

2.A. **13. Leadership fosters a continuous learning environment for personnel that:**

- **a. Recognizes and respects individual:**
  - **(1) Learning styles.**
  - **(2) Needs.**
  - **(3) Strengths.**
- **b. Provides education opportunities that reflect the:**
  - **(1) Learning styles of personnel.**
  - **(2) Needs of personnel.**
  - **(3) Strengths of personnel.**
- **c. Measures the satisfaction of personnel with the learning opportunities.**
- **d. Measures the effectiveness of the learning opportunities provided.**
- **e. Addresses performance improvement of the learning environment as needed.**

Intent Statements

CARF standards support the identification of competencies as well as opportunities for personnel to learn and grow in their jobs. For personnel to optimize these opportunities it is critical that there is recognition of how individuals learn. There are many ways that an organization can offer educational opportunities to meet the needs of personnel. These may be through technology or computer-based sessions, face-to-face, audio recordings, videos, literature reviews, classes, etc. Human resources research shows that if personnel feel valued they are more likely to stay at that place of employment. Recognizing individual styles shows that the program values their skills and is a good retention mechanism as well.

2.A. **14. To enhance professional development, recruitment, and retention of personnel, the program provides:**

- **a. Opportunities for career development.**
- **b. Mechanisms for personnel to:**
  - **(1) Recognize successes.**
  - **(2) Acknowledge challenges.**
  - **(3) Solve problems.**
  - **(4) Participate in care.**
  - **(5) Participate in program development.**

Intent Statements

The program offers career development opportunities for personnel and provides opportunities for them to work together to identify the challenges they face, share solutions, and recognize their successes.

Examples

14.a. Career ladders and support for seeking specialty certifications such as the Academy of Certified Brain Injury Specialists (ACBIS) and Certified Rehabilitation Registered Nurse (CRRN) support and encourage the growth and development of personnel.

14.b.(2) The program might provide education on personal self-care and the challenges of working with oncology populations. Ongoing support groups or services may be provided for personnel to decrease burnout and workplace stress.

2.A. **15. A written analysis is provided to or conducted by leadership:**

- **a. At least annually.**
- **b. Of all denials.**
- **c. Of service referrals determined to be ineligible.**
- **d. Of all interrupted services.**
- **e. That addresses:**
  - **(1) Causes.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Personnel.**
    - **(b) Payers.**
    - **(c) Regulatory agencies.**

Intent Statements

As a component of service access for the persons served, the organization analyzes information about denials, service referrals determined to be ineligible, and interrupted services. This information is used in efforts to improve service access.

Examples

15.b. Service denials include referrals that are not accepted by the program and payer denials for admission into the program or to continue services.

15.e.(5) Education of personnel might address appropriate documentation to support the provision of services. Education of payers might include a cost benefit analysis.

2.A. **16. An individual is identified by the organization who has the responsibility and authority to direct and maintain the operation of the program.**

Intent Statements

The job description and job title will vary with each organization. The organization identifies the title of this person and his/her responsibilities.

2.A. **17. The organization maintains a documented preventive maintenance program that includes:**

- **a. Calibration of equipment in accordance with manufacturers' recommendations.**
- **b. Maintenance of equipment in accordance with manufacturers' recommendations.**

2.A. **18. The organization implements a policy that addresses:**

- **a. Advance directives, if applicable.**
- **b. Resuscitation.**
- **c. For inpatient and residential programs, resuscitation orders, including:**
  - **(1) Provision of sufficient information for making decisions.**
  - **(2) The right to refuse resuscitation.**

Intent Statements

Information about these policies is provided in such a manner that the persons served will be able to make informed decisions and understand the consequences of those decisions. The information that is shared will vary based on programs provided, populations served, and the organization's policy.

Examples

An outpatient program has a policy that 911 is called for all medical emergencies. Advance directives are identified in the policy as not applicable to the organization.

2.A. **19. If the program serves any persons who require ventilatory assistance, it demonstrates:**

- **a. The establishment of personnel competencies.**
- **b. A mechanism to demonstrate the level of competency achieved.**
- **c. The availability of appropriate equipment, including:**
  - **(1) Portable ventilators.**
  - **(2) Cough assistance devices.**
  - **(3) Suctioning equipment.**
- **d. The utilization of appropriate equipment.**
- **e. The maintenance of appropriate equipment.**
- **f. The availability of a pulmonologist.**
- **g. The availability of respiratory therapy services 24 hours a day, 7 days a week.**
- **h. Training for:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **i. Emergency plans that take into consideration the unique needs of persons who require ventilatory assistance.**
- **j. Ventilator weaning capability.**
- **k. Ongoing assessment of the need for ventilatory support.**

Skin Integrity and Wound Care Standards

Applicable Standards

These standards are applicable to all programs seeking accreditation in Sections 3 and 4, with the exception of Vocational Services and Independent Evaluation Services.

2.A. **20. Initial and ongoing assessments of each person served document information about:**

- **a. Skin integrity, including:**
  - **(1) Edema.**
  - **(2) Pain.**
  - **(3) Pulses.**
  - **(4) Skin appearance.**
  - **(5) Skin turgor.**
  - **(6) Wounds, including:**
    - **(a) Location.**
    - **(b) Description of base.**
    - **(c) Measurement.**
    - **(d) Exudates.**
    - **(e) Progression.**
    - **(f) Causes.**
- **b. Risks to skin integrity.**
- **c. Results of previous interventions, if applicable.**

Intent Statements

20.a.(6) This includes surgical and nonsurgical wounds, pressure sores, and other types of sores from injuries or other causes.

20.c. This includes interventions implemented by the team to address current skin integrity issues as well as interventions to address previous skin integrity issues.

Examples

The frequency of reassessment may be based on the needs of individual persons served, the program's written protocols, evidence-based practices, in accordance with regulatory requirements, or other considerations.

20.a. Assessments may be head to toe, e.g., if someone is diabetic, or focus on a body area, e.g., a person served who is wearing a splint following a wrist injury.

20.a.(5) Skin turgor refers to the elasticity of the skin and may indicate dehydration in the person served.

20.a.(6)(e) Progression may include staging of a pressure sore.

20.a.(6)(f) Causes of wounds may include infection; hematoma; comorbid conditions such as diabetes or vascular disease; immobility; poor sensation; and external factors such as pressure, sheer, puncture, laceration or blunt force.

20.b. Risks to skin integrity may include continence issues; pressure areas; comorbid conditions such as diabetes; substance use, including tobacco and alcohol; nutrition and hydration status; bony prominences or deformities; and loss of protective sensation.

2.A. **21. When skin integrity risks are identified through the assessment of the person served, the interdisciplinary team:**

- **a. Addresses identified needs that are within the scope of the program, including:**
  - **(1) Interventions to prevent or reduce the risk of a wound developing.**
  - **(2) Standards of practice.**
  - **(3) Nutritional needs.**
  - **(4) Equipment.**
  - **(5) Supplies.**
  - **(6) Education needs of:**
    - **(a) The person served.**
    - **(b) The family/support system.**
    - **(c) Personnel.**
- **b. Refers the person served to an appropriate healthcare professional to address identified needs that are outside the scope of program.**

Intent Statements

Measures to address the skin integrity risks of the person served are intended to prevent a wound from developing.

Examples

Evidence of the team addressing the skin integrity needs of the person served may be found in the individual plan of the person served; team or family conference summaries; and equipment, supply, or medication orders. The way that the team addresses the skin integrity needs should be aligned with the scope of the program, meaning that some teams may address the needs directly, other teams may make referrals to clinicians, or there may be a combination of approaches depending on the skin integrity need.

21.a.(4) Equipment may include orthotics, prosthetics, seating cushions and supports, bed support surfaces, and wheelchairs.

2.A. **22. If a wound is present, the interdisciplinary team for each person served implements written protocols that address:**

- **a. When the wound care needed is within the scope of the program:**
  - **(1) Interventions to reduce and/or eliminate the wound.**
  - **(2) Standards of practice.**
  - **(3) Nutritional needs.**
  - **(4) Equipment.**
  - **(5) Supplies.**
  - **(6) Education needs of:**
    - **(a) The person served.**
    - **(b) The family/support system.**
    - **(c) Personnel.**
  - **(7) A plan for follow-up care.**

b. When the wound care needed is outside of the scope of the program, referrals to or coordination with appropriate wound care specialists.

Examples

22.a.(1) Interventions may include, but are not limited to, the use of medications, recommendations for surgery, topical treatment, lifestyle change, shoe adaptation, seating and positioning, infection management, and the use of modalities such as negative pressure wound therapy.

2.A. **23. The program identifies and utilizes local, regional, provincial, national, or international resources to facilitate wound care.**

2.A. **24. The interdisciplinary team demonstrates efforts to optimize outcomes for the persons served, including, but not limited to:**

- **a. Exchange of information on factors facilitating skin integrity and wound management.**
- **b. Exchange of information on barriers to skin integrity and wound management.**
- **c. Education of other healthcare providers.**
- **d. Collaboration with other healthcare providers on the timing of interventions.**
- **e. Arrangement of follow-up with other healthcare providers at the time of discharge/transition from the program to facilitate ongoing assessment and management of skin integrity and wound issues.**

Examples

24.d. Collaboration may be among providers on the program's service delivery team and with consulting, concurrent, or follow-up providers.

2.A. **25. Personnel who provide services related to skin integrity and wound management receive documented, competency-based training:**

- **a. At:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. That includes, but is not limited to:**
  - **(1) Assessment protocols for skin integrity and wound management.**
  - **(2) Strategies and interventions for skin integrity and wound management that are based on accepted practices in the field and current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**
  - **(3) Education techniques to facilitate behavior change in persons served.**

Examples

25.b.(2) This may include the use of evidence-based wound products and supplies.

2.A. **26. The program:**

- **a. Gathers information on each person served, including information on:**
  - **(1) Wounds that developed during the program.**
  - **(2) Wounds that worsened during the program.**
- **b. At least annually conducts a written analysis that includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Wounds that developed during the program.**
    - **(b) Wounds that worsened during the program.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**

(4) Results of performance improvement plans.

(5) Necessary education and training of:

(a) Persons served.

(b) Families/support systems.

(c) Personnel.

B. The Rehabilitation and Service Process for the Persons Served

Applicable Standards

Section 2.B. standards are applicable to the programs in Section 3 as follows:

- Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program: Standards 2.B.1.–12., 14.–34., and 36.–46.
- Section 3.B. Outpatient Medical Rehabilitation Program: Standards 2.B.1.–10., 13.–33., and 35.–46.
- Section 3.D. Residential Rehabilitation Program: 2.B.1.–10., 13.–34., and 36.–46.
- Section 3.E. Vocational Services: 2.B.1.–10., 13.–33., and 35.–46.
- Section 3.F. Interdisciplinary Pain Rehabilitation Program: 2.B.1.–10., 14.–34., and 36.–46.
- Section 3.G. Occupational Rehabilitation Program: 2.B.1.–10., 13.–33., and 35.–46.

Note: *Section 2.B. is not applicable to Sections 3.C. Home and Community Services, 3.H. Independent Evaluation Services, and 3.I. Case Management.*

Section 2.B. standards are applicable to optional specialty program designations in Section 4 as follows:

- Section 4.A. Pediatric Specialty Program: 2.B.1.–10., 14.–34., and 36.–46.
- Section 4.B. Amputation Specialty Program: 2.B.1.–10., 14.–34., and 36.–49.
- Section 4.C. Brain Injury Specialty Program: 2.B.1.–10., 14.–34., and 36.–48.
- Section 4.D. Cancer Rehabilitation Specialty Program: 2.B.1.–10., 14.–34., and 36.–48.
- Section 4.E. Spinal Cord Specialty Program: 2.B.1.–10., 14.–34., 36.–48., and 50.
- Section 4.F. Stroke Specialty Program: 2.B.1.–10., 14.–34., and 36.–48.

2.B. **1. To facilitate the disclosure of accurate information, the program documents its scope including the following parameters regarding the persons served:**

- **a. Ages.**
- **b. Activity limitations.**
- **c. Behavioral status.**
- **d. Cultural needs.**
- **e. Impairments.**
- **f. Intended discharge/transition environments.**
- **g. Medical acuity.**
- **h. Medical stability.**
- **i. Participation restrictions.**
- **j. Psychological status.**

Intent Statements

This standard expands on Standard 1. in Section 2.A. Program/Service Structure, which addresses the scope of the program. The program should document its scope regarding parameters of the persons served and share this information with all groups identified in that standard.

Examples

CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). The term *functioning* refers to all body functions, activities, and participation, while *disability* is similarly an umbrella term for impairments, activity limitations, and participation restrictions. Environmental factors, which may be facilitators or barriers, interact with all of these components. ICF offers the following definitions:

- *Body functions* are physiological functions of body systems (including psychological functions).
- *Body structures* are anatomical parts of the body such as organs, limbs, and their components.
- *Impairments* are problems in body function or structure such as a significant deviation or loss (e.g., the loss of a limb, loss of vision).
- *Activity* is the execution of a task or action by an individual.

- *Activity limitations* are difficulties an individual may have in executing activities. Activities may be limited in nature, duration, and quality (e.g., taking care of oneself or performing the activities of a job).
- *Participation* is involvement in a life situation.
- *Participation restrictions* are problems an individual may experience in involvement in life situations. Participation may be restricted in nature, duration, and quality (e.g., being employed, participating in community activities, or obtaining a driver's license).
- *Environmental factors* make up the physical, social, and attitudinal environments in which people live and conduct their lives (e.g., stairs, terrain, and climate; availability of adaptive equipment and transportation; willingness of an employer to have an injured worker return to work).

1.d. Please refer to the Glossary for a definition of *culture*.

1.e. Impairments may include comorbidities.

1.i. Participation restrictions could include restrictions related to participation in community events, occupational activities, school, homemaking activities, etc.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology.

2.B. **2. The organization makes available opportunities to orient and educate potential persons served about the rehabilitation program(s).**

Intent Statements

All information is provided in language and a format that is understandable to the persons served and their families/support systems and in sufficient time to allow them to make informed decisions.

Examples

Opportunities to learn about the rehabilitation program could include visiting the program, a video or virtual tour, the provision of printed materials via mail or in person, reviewing information available on the organization's website, telephone calls between program personnel and the person served and/or family, and audio recordings about the program.

Resources

Please refer to Appendix D for resources related to health literacy.

2.B. **3. The program provides information on admission and discharge/transition criteria to:**

- **a. The persons served.**
- **b. Families/support systems.**
- **c. Other relevant stakeholders.**

Intent Statements

Information regarding admission and discharge/transition criteria is presented in a way that is understandable to the audience for which it is intended. Information may be provided in writing, verbally, or other means as appropriate.

2.B. **4. Appropriate placement of each person served is addressed through:**

- **a. The admission criteria.**
- **b. The discharge/transition criteria.**
- **c. The resources available.**
- **d. Any resources previously used.**
- **e. Ongoing reassessment.**
- **f. The person's potential to benefit.**
- **g. The person's personal preferences.**

Intent Statements

The surveyors will address throughout the survey process whether the persons served are in the appropriate portion of the continuum of services and whether the program has explored the options for the most appropriate use of resources as well as the needs of the persons served in placement. The preadmission information gathered will be valuable in this placement process.

Examples

4.a. In accordance with regulatory rules, an inpatient rehabilitation facility (IRF) serving a Medicare population reconfirms or reconciles medical appropriateness for the inpatient stay within 24 hours of admission.

4.e. Ongoing reassessment is part of the team process and discussions that occur on a regular basis.

4.g. Given several options to obtain outpatient medical rehabilitation an individual seeks services at a location close to his place of work so that appointments can be scheduled during lunch or immediately before or after work, minimizing time away from the work place.

An individual, in collaboration with family members, chooses an inpatient rehabilitation program close to where her daughter's family resides so that the daughter can spend more time at the rehabilitation program, bring the grandchildren to visit, and keep other family members informed.

When being discharged from an inpatient rehabilitation program it is the team's recommendation that the person served would benefit from a residential rehabilitation program for a brief period of time prior to going home to live with his family. Several options are presented to the person served and his wife and they are encouraged to visit the various organizations to decide which one they prefer.

2.B. **5. The program demonstrates the involvement of the following individuals in the rehabilitation programs of the persons served:**

- **a. The person served.**
- **b. Treating physicians.**
- **c. Healthcare professionals.**
- **d. Representatives of the person served, as appropriate.**
- **e. The employer/employer designee, as appropriate.**
- **f. Members of the family/support system, as appropriate.**
- **g. Other stakeholders, as appropriate.**

Examples

This involvement may be demonstrated by attendance and participation in team meetings or conferences, written communication, visits by personnel to the offices of stakeholders or work sites, etc.

5.d. Representatives of the person served might include legal counsel, case managers, union representatives, advocates, and other representatives identified by the person served to participate in the process.

5.e. Employer designees might include supervisors, union representatives, human resource representatives, and benefits coordinators.

2.B. **6. Admission and ongoing assessments:**

- **a. Are relevant to the needs of the persons served.**
- **b. Predict outcomes that include:**
  - **(1) Functional status at discharge/transition.**
  - **(2) Disposition at discharge/transition.**
  - **(3) Duration of services.**
- **c. Consider health status.**
- **d. Address resource needs and utilization.**
- **e. Address discharge/transition planning.**
- **f. Address the integration of available resources.**
- **g. Identify:**
  - **(1) Factors facilitating the achievement of predicted outcomes.**
  - **(2) Barriers to the achievement of predicted outcomes.**

Examples

In accordance with regulatory rules inpatient programs serving a Medicare population in an inpatient rehabilitation facility (IRF) begin rehabilitation therapy within 36 hours of midnight of the day of admission. The Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) is completed by 72 hours after admission to the IRF, and an Individualized Overall Plan of Care (IOPC) is created by the rehabilitation physician within 96 hours of admission with input from the interdisciplinary team.

2.B. **7. The program provides sufficient information for the persons served to understand:**

- **a. The procedures for nonvoluntary discharge.**
- **b. The procedures for discharge against medical advice.**
- **c. The procedures for security of personal possessions.**
- **d. Their rights with regard to advance directives, if applicable.**
- **e. The rules and regulations of the program.**
- **f. Requirements from regulatory agencies, if applicable.**

Intent Statements

CARF does not expect that information on these areas is provided at specific times. The intent is that the persons served will have adequate information that is relevant to their individual needs and circumstances and, when applicable, timely to make decisions.

Examples

7.a. Nonvoluntary discharge might include when a person served is asked to leave the program due to unacceptable behaviors that are keeping him or her from making progress or when he or she is transferred to another level of care due to an acute illness or exacerbation of his or her injury.

7.c. Security of possessions in an outpatient setting might include the use of locks on lockers in the changing area, the recommendation to secure personal belongings by carrying them from one treatment area to another, and encouragement to avoid bringing or wearing valuable jewelry, outerwear, or items that are sentimental in nature. Persons served are encouraged to label their belongings to assist if anything becomes lost.

7.e. The rules and regulations of the occupational rehabilitation program address hours of attendance and expectations related to absences, the safe use of exercise and work simulation equipment, when phone calls can be made, and whether smoking is allowed.

7.f. An example of a regulatory requirement is the Important Message (IM) required by the Centers for Medicare and Medicaid Services, a letter that all hospitals are required to give to Medicare beneficiaries at admission, and the Details of Discharge letter, which hospitals are required to give to Medicare beneficiaries shortly before discharge advising them of their rights regarding discharge.

2.B. **8. To ensure that the person served has current information, the program provides an individualized written disclosure statement to each person served through the stay that includes information to address:**

- **a. The scope of services that will be provided.**
- **b. The intensity of services that will be provided.**
- **c. Estimated length of stay.**
- **d. Insurance coverage.**
- **e. Alternative resources to address additional identified needs.**

Intent Statements

This standard requires that each person served be provided with individualized, written information that is specific to his or her situation. All the information does not have to be in one document. Each person should have the information presented in such a way that he or she clearly understands what services will be provided and for how long, what will not be provided, and what, if anything, the program will cost him or her.

Examples

Individualized information specific to the person served is provided following assessment.

8.b. The intensity of services refers to how much and at what frequency specific services will be provided to address the individual's assessed needs. For example, a person served may receive rehabilitation nursing services around the clock; physical therapy one hour a day, three days a week; etc. Intensity also includes the complement of services provided one on one, concurrently, or in groups.

8.c. Depending upon the type of program being provided, estimated length of stay may be given in days, weeks, hours of services, or number of visits.

8.d. Examples of information shared related to insurance coverage may be that the payer will fund only five days of inpatient rehabilitation and then will reassess, that a co-pay is required, or that there is a maximum dollar amount available for the program.

8.e. Alternative resources might address current needs of the person served as well as needs anticipated in the future. Examples of such resources might include referral to another portion of the continuum of services or another provider; different funding sources such as charitable foundations or Medicaid waivers; Veterans' benefits; advocacy and support groups such as the National Spinal Cord Injury Association or Brain Injury Association of America and its state affiliates; and community providers of durable medical equipment and transportation.

2.B. **9. The team:**

- **a. Is determined by:**
  - **(1) The assessment.**
  - **(2) The individual planning process.**
  - **(3) The predicted outcomes of the person served.**
  - **(4) The strategies utilized to achieve the outcomes predicted.**
- **b. Includes:**
  - **(1) The person served.**
  - **(2) Members of the family/support system, as appropriate.**
  - **(3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas:**
    - **(a) Behavior.**
    - **(b) Cognition.**
    - **(c) Communication.**
    - **(d) Functional.**
    - **(e) Medical.**
    - **(f) Pain management.**
    - **(g) Physical.**
    - **(h) Psychological.**
    - **(i) Recreation and leisure.**
    - **(j) Social.**
    - **(k) Spiritual.**
    - **(l) Vocational.**
- **c. Provides services that address:**
  - **(1) Impairments.**
  - **(2) Activity limitations.**
  - **(3) Participation restrictions.**
  - **(4) Environmental needs.**
  - **(5) The personal preferences of the person served.**

Intent Statements

The team composition is determined for each person served through the assessment and individual planning processes. The team is a dynamic group of individuals that may change as the person served progresses through the program. Some professionals may be active team members for the entire length of a person's stay or for a portion of the stay, while other professionals may become active members of the team as the need for their services is identified.

9.c. CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

Examples

9.b.(3)(e) Medical needs might include nursing, pharmacy, or nutrition needs in addition to needs that would be addressed by a physician.

9.c. An example of how these concepts interrelate might be a personal chef who sustains a cervical spinal cord injury in a motorcycle accident. Her impairment is paralysis of all four extremities. During rehabilitation she articulates her desire to continue operating her business. Once she returns home, she chooses recipes, instructs personal assistants who perform the manual activities related to preparing, cooking, and delivering the food, and she tastes the foods as they are being prepared. Mirrors are installed in the kitchen so that she can see all food preparation. While she experiences a number of activity limitations related to her role as a personal chef, she

has a high level of participation in communicating with customers, preparing the foods, and running her business. The environment of her home provides sufficient space for assistants to work with her in all aspects of her business and her excellent reputation facilitates her continued success with customers.

9.c.(5) Although the occupational therapist has identified dressing skills as an area to be addressed in the individual plan, the person served indicates that his wife will be home with him in the mornings before she goes to work and will assist him with dressing, so he prefers to work on other areas.

The speech-language pathologist is working with the person served on a dysphagia management program and instead of eating meals in the common dining area it is the preference of the person served to eat in her room.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology.

2.B. **10. To ensure the achievement of predicted outcomes, the person who coordinates the provision of care for each person served:**

- **a. Demonstrates appropriate competencies as defined by the program.**
- **b. Is identified to:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **c. Has the authority to coordinate the provision of care.**
- **d. Is knowledgeable about the rehabilitation program being provided to the person served.**
- **e. Is available to interact with:**
  - **(1) The person served.**
  - **(2) The team of the person served.**
  - **(3) The family/support system.**
  - **(4) Other stakeholders.**
- **f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.**
- **g. Is responsible for ensuring communication with:**
  - **(1) External sources.**
  - **(2) Internal sources.**
- **h. Brings forward to the team the available financial information to facilitate decision making about the following processes:**
  - **(1) Intake.**
  - **(2) Assessment.**
  - **(3) Service planning.**
  - **(4) Service provision.**
  - **(5) Discharge/transition planning.**
  - **(6) Long-term follow-up.**
- **i. Facilitates the involvement of the person served throughout the rehabilitation process.**
- **j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.**
- **k. Ensures that discharge/transition arrangements are completed.**
- **l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders.**
- **m. Facilitates the implementation of discharge/transition recommendations.**

Intent Statements

The program determines the individual who will fulfill these responsibilities. CARF does not expect to see someone from any one discipline or any specific number of these individuals. The number will depend on the size and type of the program. If these responsibilities are shared by more than one person for a person served, the program should identify who has ultimate responsibility for the areas that may be delegated and how efforts will be coordinated on behalf of the person served.

The surveyors should be able to ask the persons served and their families/support systems about these individuals and get responses that indicate they know who is coordinating the provision of care for the person served.

Examples

10.h.(1) Financial information that might affect placement decisions for the person served during the intake process is shared with the admitting physician and any team members involved in making recommendations for placement of the person served into the program or referral to a different level of the continuum of services.

2.B. **11. The medical director for the inpatient program:**

- **a. Is certified in his or her specialty area by a nationally recognized board.**
- **b. Demonstrates appropriate experience and training to provide rehabilitation physician services through one or more of the following:**
  - **(1) A formal residency in physical medicine and rehabilitation.**
  - **(2) A fellowship in rehabilitation for a minimum of one year.**
  - **(3) A minimum of two years' experience as a collaborative team member providing rehabilitation services in an inpatient rehabilitation program.**
- **c. Maintains his or her:**
  - **(1) Licensure.**
  - **(2) Certification.**
  - **(3) Privileges in the organization.**
- **d. Participates in active clinical practice that relates to the population served.**
- **e. Demonstrates currency in medical practice concerning the persons served.**
- **f. Demonstrates active learning and involvement in the professional community.**

Intent Statements

11.c.(3) The privileging process authorizes professionals to provide clinical services granted by a governing authority or in accordance with clinical staff bylaws.

11.d.–e. The physician participates in active clinical practice that includes but may not be exclusive to persons served similar to those of the program to which he is providing medical input, e.g., for a brain injury specialty program the physician's clinical practice includes persons with acquired brain injury, for a stroke specialty program the practice includes people who have sustained a stroke, etc.

Examples

11.e. The medical director for the inpatient program demonstrates knowledge and use of evidence-based practice to ensure currency in medical practice. This is also reflected in the medical director's choice of continuing medical education events to attend and pursue. This could also be evidenced through participation in research or demonstration projects that would enhance knowledge in certain areas that may affect his or her practice.

11.f. The medical director of the inpatient program demonstrates active learning and involvement through participation in fellowships, certification in subspecialties, participation in grand rounds in local acute hospitals, active participation in special interest groups in his or her physician professional groups, board membership or involvement in consumer advocacy groups, integration of evidence-based practices and medical advances relevant to the population served.

2.B. **12. The medical director for the inpatient program:**

- **a. Has a written agreement with the organization that outlines his or her responsibilities.**
- **b. Actively participates in:**
  - **(1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.**
  - **(2) The development of ongoing relationships with the medical community.**
  - **(3) Educational activities with the program personnel.**

(4) The establishment of policies and written procedures that identify the functions and responsibilities of the rehabilitation physician.
(5) Performance improvement activities.
(6) Advocacy activities.
(7) Program development and modification.
(8) Establishing the program's policies and procedures.
(9) Resource utilization management.
(10) Stakeholder relationship management.
(11) Marketing and promoting the program.
(12) Strategic planning.
(13) Financial planning and decision making.

Examples

12.b.(4) The policies for inpatient rehabilitation physicians clearly address their role and responsibilities in processes from preadmission through admission, continuing stay determination and discharge.

12.b.(10) Stakeholder relationship management includes the development of and participation with stakeholders of the program, such as the medical directors of insurance companies the program works with and other physicians in the organization who refer to the rehabilitation program or would benefit from education about the program.

2.B. **13. For programs other than inpatient programs, ongoing medical input:**

a. Is provided by a physician who:
(1) Is qualified by virtue of his or her training and experience in rehabilitation.
(2) Serves the program as at least one of the following:
(a) Medical director.
(b) Chair or member of a professional advisory committee.
(c) A consultant with a formal arrangement.
(d) Medical liaison.
(3) Participates in active clinical practice that relates to the population served.
(4) Demonstrates currency in medical practice concerning the persons served.
(5) Demonstrates active learning and involvement in the professional community.

b. Addresses, but is not limited to:
(1) Development of ongoing relationships with the medical community.
(2) Establishment of policies and written procedures that address health issues, including surveillance.
(3) Performance improvement activities.

Intent Statements

13.a.(3)–(4) The physician participates in active clinical practice that includes but may not be exclusive to persons served similar to those of the program to which he is providing medical input, e.g., for a brain injury specialty program the physician's clinical practice includes persons with acquired brain injury, for a stroke specialty program the practice includes people who have sustained a stroke, etc.

Examples

13.a.(2)(b) An outpatient pediatric specialty program has a professional advisory committee including a developmental specialist, educators, a pediatric nurse specialist, and a pediatrician with experience in pediatric rehabilitation. The pediatrician provides ongoing medical input to the program.

13.b.(1) The program establishes a medical liaison relationship with a physician who has a clear understanding of what the program offers and to whom. He establishes links and maintains contact with other physicians in the community who might refer to the program or be able to assist

in meeting the needs of persons who participate in the program.

13.b.(2) Surveillance includes the monitoring of health issues of the persons served. The physician consultant assists the program in exploring why there has been an increase in the number of people coming to the program from inpatient settings with infections, why persons served with orthopedic diagnoses from a certain orthopedic group have a higher rate of subluxations of new hips, etc. With input from program personnel the physician can determine the need to address these issues in a constructive manner with referring physicians.

2.B. **14. The persons served have the benefit of consistently assigned personnel from each of the disciplines appropriate to their needs.**

Intent Statements

The consistency of staffing provides for program and treatment continuity, provides team-building opportunities, and prevents confusion of the persons served about the identity of their clinicians. The concept of consistently assigned personnel does not exclude a system of rotation. Each discipline may have a system whereby assignments of individual staff members are rotated through the rehabilitation services continuum to enhance the expertise of personnel in all the areas in which they might provide therapy (e.g., outpatient, acute, and home health services). If such a system is used, the persons served are notified before a rotation ends and are introduced and oriented to any new personnel assigned to care for them.

When scheduling does not permit consistent assignments providers demonstrate to the persons served that they have knowledge of other team members' work through their follow through with the treatment plan that has been established. If an organization utilizes temporary, contract, or per diem personnel, it strives for maximum consistency and continuity of care through personnel assignments and scheduling.

2.B. **15. The responsibilities of the team include:**

- **a. Reviewing relevant reports to facilitate assessment.**
- **b. Identifying resources.**
- **c. Integrating information on resources into:**
  - **(1) Program planning.**
  - **(2) Program implementation.**
- **d. Conducting assessments.**
- **e. Predicting outcomes.**
- **f. Establishing the treatment plan.**
- **g. Establishing the discharge/transition plan.**
- **h. Providing services.**
- **i. Modifying the treatment plan.**
- **j. Ensuring that the disciplines change based on the needs of the person served.**
- **k. Achieving the predicted outcomes.**
- **l. Transferring the persons served to the most appropriate level of care, based on need.**
- **m. Providing education and training.**
- **n. Referring the persons served to other services/programs as needed.**
- **o. Communicating with relevant stakeholders.**
- **p. Participating in performance improvement activities.**

2.B. **16. Discharge/transition planning is done in collaboration with:**

- **a. The persons served.**
- **b. Families/support systems.**
- **c. Providers in the continuum of services.**
- **d. Other relevant stakeholders.**

2.B. **17. In its discharge/transition planning the program strives to achieve the most integrated setting appropriate to the person served.**

Intent Statements

The most integrated setting is the environment most closely related to the environment where the person served would choose to engage in life roles if he or she did not have activity limitations or participation restrictions.

2.B. **18. When there is a change in the discharge/transition plan there is a mechanism to notify:**

- **a. The persons served.**
- **b. Their families/support systems.**
- **c. Other relevant stakeholders.**

Examples

18.a.–b. The discharge plan for the person served has been to go home with her family. However, during the training process it becomes evident that the family is not prepared to meet the needs of person served at the time of discharge. The team revises its recommendation to discharge the person served to a residential program for a period of time. This change, including the rationale, is clearly communicated and explained to the person served and the family.

18.c. The program contacts the vendor who is supplying a walker to let him know that the person's discharge has been delayed 24 hours until his blood pressure is stable.

The occupational rehabilitation program contacts the human resources department of the person's employer to recommend return to work part time for the first two weeks instead of resuming full time work immediately upon return.

2.B. **19. Decisions reflect the personal preferences of the person served and are:**

- **a. Made in collaboration with the persons served.**
- **b. Formulated with input from a variety of sources.**
- **c. Documented in the records of the persons served.**

Examples

19.a. The person served prefers to stay awake late into the evening, so the therapy schedule begins mid-morning instead of early morning.

The person's insurance will cover a standard walker but the person prefers to pay independently for a more expensive model that has wheels and a built-in seat. After determining the model will meet the needs of the person served, the team arranges for the purchase and delivery of the preferred walker.

2.B. **20. In order to communicate and facilitate an integrated approach, the interdisciplinary team, including team members working on all shifts and days, as well as the person served and his or her family/support system:**

- **a. Are:**
  - **(1) Aware of the plan of care for the person served.**
  - **(2) Implementing the plan of care for the person served.**
  - **(3) Modifying the plan of care as the status of the person served changes.**
- **b. Participates in making interdisciplinary team decisions concerning the rehabilitation process for the person served.**
- **c. Ensures that decisions are communicated to the entire interdisciplinary team.**
- **d. Considers the impact of its decisions on:**
  - **(1) The individual care plan of the person served.**
  - **(2) The entire interdisciplinary team.**
  - **(3) The family/support system.**

Intent Statements

This standard describes and identifies the essence of rehabilitation programming, whether it is provided 24 hours a day, 7 days a week as in inpatient and residential settings or on a part-time, scheduled basis as in other settings. This standard expands on Standard 7. in Section 2.A. Program/Service Structure.

Examples

The survey team may look, for example, at when admissions occur; how therapy skill sets and new techniques are learned; how adaptive equipment is used when therapy personnel are not available (e.g., on late-night shifts and on some weekend shifts); how communication and collaboration occur in the program between team members, including the persons served and family/support systems; methods for sharing information such as written communication, log books, face-to-face meetings, or inservices; whether education and the assessment of educational needs are provided in writing or orally; how education is provided to various groups—via lectures, videos, audio recordings, one-on-one teaching, or written information.

2.B. **21. The program addresses the impact of the following areas on the rehabilitation process of each person served:**

- **a. Allergies.**
- **b. Current medications, including:**
  - **(1) Medication sensitivities and adverse reactions.**
  - **(2) Why each medication is prescribed.**
  - **(3) Side effects.**
  - **(4) Drug interactions.**
  - **(5) Implications of abrupt discontinuation of medications.**
  - **(6) Compliance.**
- **c. The etiology of the impairment.**
- **d. The results of relevant diagnostic interventions.**
- **e. The results of relevant therapeutic interventions.**
- **f. Comorbid conditions.**
- **g. Nutrition.**
- **h. Pain.**
- **i. Risk factors.**
- **j. Signs and symptoms of emergent medical conditions.**

Intent Statements

To ensure the safety of the persons served and determine the most appropriate and beneficial interventions, knowledge of each person's health and medical status and history are important. This knowledge will allow the program to minimize unnecessary interventions, establish an accurate baseline of health and functional status, set realistic goals, and optimize results.

21.b. The program is aware of the effects of medications currently taken by the person served on his or her ability to participate in the program and tolerate therapeutic activity.

Examples

21.a. Allergies include medication allergies, food allergies, latex allergies, and any other allergies the program needs to be aware of to ensure the safety of the person served.

21.b. In tailoring an exercise program for a person with diabetes, the physical therapist understands the impact of insulin action on the timing, frequency, and duration of exercise. The therapist educates the person served about the importance of self-monitoring of blood glucose (SMBG) and recognizing symptoms such as shakiness or sweating to avoid risks associated with hypoglycemia while exercising.

21.f. Examples include diabetes, hypertension, and obesity.

21.g. Nutrition includes a person's diet as well as the consistency of his or her diet.

21.i. Risk factors may include that the person smokes, is overweight, is unsteady and therefore at risk of falling, can't afford the medications that are prescribed, has labile hypertension, or expresses the potential to harm himself/herself or others.

2.B. **22. Written communication regarding the team process:**

- **a. Is:**
  - **(1) Accurate.**
  - **(2) Complete.**
  - **(3) Accessible.**
- **b. Demonstrates:**
  - **(1) Avoidance of unnecessary duplication of information.**
  - **(2) Efficient movement through the continuum of services.**

Intent Statements

22.a.(3) Written communication regarding the team process is accessible to internal and external stakeholders in accordance with their needs and responsibilities in the rehabilitation process of the person served.

22.b.(1) The organization strives to lessen the duplication in written information, such as assessments, daily notes, progress notes, team conference notes, and discharge/transition summaries while at the same time complying with the legal and regulatory requirements to which it is subject.

2.B. **23. The team meets at a frequency appropriate to meet the needs of:**

- **a. The persons served.**
- **b. The program.**
- **c. External stakeholders.**

Intent Statements

Team meetings can occur in a variety of settings and through a variety of mechanisms. In some programs, such as outpatient medical rehabilitation programs, the team may simply consist of the person served and one individual with a health-related degree. The setting for a team meeting in this scenario may be an office or at the side of the mat table, with attention given to issues of privacy and confidentiality.

Examples

23.c. In accordance with regulatory rules, an inpatient program serving a Medicare population in an inpatient rehabilitation facility (IRF) conducts the rehabilitation team meeting within seven days of admission and weekly thereafter.

2.B. **24. The program demonstrates that the persons served make measurable progress toward accomplishment of their predicted outcomes in accordance with predicted timeframes.**

Intent Statements

Predicted outcomes are actively pursued and measured on a regular basis to determine their achievement in the anticipated timeframes and/or the need for modification. If progress toward predicted outcomes is not demonstrated in the anticipated timeframes, the program identifies issues or barriers to outcomes achievement and makes appropriate modifications.

Examples

Conformance may be demonstrated through documentation in the records of the persons served as well as discussion and interviews with personnel, referral sources, payers, and the persons served.

2.B. **25. The interdisciplinary team involves and considers the family/support system, as appropriate, as a partner throughout the rehabilitation process through the following:**

- **a. Ongoing assessments that consider:**
  - **(1) The family/support system's:**
    - **(a) Ability and willingness to support and participate in the plan.**
    - **(b) Composition.**
    - **(c) Communication.**
    - **(d) Contingency plans for care.**
    - **(e) Coping.**
    - **(f) Expectations of the program.**
    - **(g) Expectations regarding transition of the person served to other components of the continuum of services or the discharge location.**
    - **(h) Educational needs.**
    - **(i) Insight.**
    - **(j) Interpersonal dynamics.**
    - **(k) Learning style.**
    - **(l) Problem solving.**
    - **(m) Responsibilities.**
  - **(2) Cultural, financial, literacy, or social factors that might influence the program.**
  - **(3) The health status of the primary caregiver.**

b. The provision or arrangement of services for each family/support system, as needed, including:
- **(1) Advocacy education.**
- **(2) Assistive technology.**
- **(3) Counseling/support services.**
- **(4) Education.**
- **(5) Reasonable accommodations.**
- **(6) Respite.**
- **(7) Support, including:**
  - **(a) Spouse-to-spouse interactions.**
  - **(b) Family-to-family interactions.**

Intent Statements

25.a.(1)(j) Interpersonal dynamics refers to the interactions between the person served and his or her spouse/significant other, friends, peers, coworkers, employer, and community.

25.a.(2) Cultural, financial, literacy, or social factors may influence the program in areas such as setting goals for the person served, the provision of information and services, and discharge/transition options.

Information provided by the program to the families/support systems of the persons served, both written and oral, is understandable and accessible. This might include, but is not limited to, questionnaires and surveys; family conferences; disclosure statements; outcomes and performance information; instructions, home programs, or discharge recommendations; web pages; etc. The input of families/support systems is sought in preparing and adapting materials to meet their needs and the needs of families/support systems entering into the rehabilitation process in the future.

Examples

25.a.(1)(a) Ability and willingness to participate in the plan might include asking questions and providing input to decisions regarding the person served; involvement in family conferences and training sessions; willingness to support the goals of the team, including the person served, even if they differ from those of the family/support system; and accessing information and resources as recommended by the team.

25.a.(1)(e) An assessment of coping might consider both adaptive and maladaptive coping methods, including sleep, nutrition, consumption of alcohol and/or illicit substances, recognizing and accepting the support of others when appropriate, interactions with others such as providers on the team and other members of the family/support system, and members of the family/support system taking care of their own health, e.g., exercising, adherence to medications, appointments with health professionals, etc.

25.a.(1)(i) An assessment of insight might consider whether members of the family/support system are able to identify cognitive, functional, and/or physical limitations of the person served as well as areas of preservation consistent with what providers on the team identify. The assessment might also consider whether members of the family/support system seek assistance and/or resources consistent with identified needs of the person served and/or family/support system.

25.a.(1)(m) Responsibilities may include work and family-related responsibilities such as being the caregiver for young children or elderly parents.

25.a.(3) The health status of the primary caregiver may include coping, being at risk of a crisis, etc.

25.b.(1) Advocacy education could include educating families about how to advocate for payment for services or equipment, inclusion in community activities, or in the schools for the Individual Education Plan process.

Resources

25.b.(4) Please refer to Appendix D for resources related to education resources for persons served, families/support systems, and caregivers.

2.B. **26. Family/support system conferences, if appropriate:**
- **a. Are documented.**
- **b. Are held at a frequency consistent with the needs of:**
  - **(1) The person served.**
  - **(2) The family/support system.**

c. Are scheduled at a time that is convenient for:
- **(1) The person served.**
- **(2) The family/support system.**

d. Include those team members who are necessary to communicate:
- **(1) Diagnoses.**
- **(2) Impairments, activity limitations, participation restrictions, and environmental needs.**
- **(3) Results of treatment.**
- **(4) Recommendations for further care required.**
- **(5) Issues of importance to the family/support system.**

Examples

Family/support system conferences may be conducted with the family present on site or through other mechanisms such as telephone conferences.

26.a. To facilitate implementation of decisions, address educational needs of family members, and share relevant information, the program documents key content of family conferences. Documentation might include items discussed, decisions made, modifications to the individualized plan, identification of conference participants, and areas and responsibilities for follow-up.

2.B. **27. Information is made available by the program:**

a. Regarding local or regional resources for:
- **(1) Support.**
- **(2) Advocacy.**
- **(3) Civil rights.**

b. To:
- **(1) The persons served.**
- **(2) Their families/support systems.**

Examples

The spinal cord specialty program provides information to the persons served regarding voting rights and accessibility. This includes resources to obtain and receive assistance in completing voter registration applications and who to contact with questions about accessibility to cast a ballot.

The pediatric specialty program provides resources to assist parents in understanding the civil rights of their children and the services for which they are eligible.

The program provides resources to assist the person served and her spouse with information about retirement and disability supports and what their rights are concerning benefits.

Resources

27.a.(3) Please refer to Appendix D for resources related to accessibility.

2.B. **28. As appropriate, the program has information available regarding local options for:**

a. Lodging.

b. Transportation.

2.B. **29. The program fosters a continuous learning environment:**

a. By providing educational opportunities for:
- **(1) The persons served.**
- **(2) Families/support systems.**

b. That recognizes and respects individual:
- **(1) Learning styles.**
- **(2) Needs.**
- **(3) Strengths.**
- **(4) Preferences.**

c. That assesses the effectiveness of the education provided.

d. That addresses performance improvement, as needed.

Examples

Information about the effectiveness of the education provided could be obtained through formal and informal feedback from the persons served or family members during the provision of services or at the time of discharge from the program. On an immediate basis, the person served could perform a return demonstration

of the exercises included in the written home program or the spouse of the person served could perform a return demonstration of a transfer technique to demonstrate learning.

2.B. **30. Depending upon individual needs, the program provides education and training to each person served that addresses:**

- **a. Prevention related to:**
  - **(1) Recurrence of the impairment, injury, or illness.**
  - **(2) Potential risks and complications due to impairment.**
- **b. Primary healthcare.**
- **c. Utilization of healthcare resources.**
- **d. Health promotion.**
- **e. The skill sets necessary to be successful in the discharge/transition environment for:**
  - **(1) The persons served.**
  - **(2) Their families/support systems.**
- **f. A mechanism to demonstrate the skills achieved prior to discharge/transition by:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **g. Transition to other components of the continuum of services or discharge location.**

Examples

30.c. Education on utilization of healthcare resources might include decision making related to which healthcare provider is the most appropriate to seek advice from on specific health issues or how to use insurance funding most effectively to meet individual needs.

2.B. **31. The program provides education on medication, as appropriate:**

- **a. To:**
  - **(1) The persons served.**
  - **(2) Their families/support systems.**
- **b. That addresses:**
  - **(1) Actions to take in case of an emergency.**
  - **(2) Administration.**
  - **(3) Dispensing.**
  - **(4) Errors.**
  - **(5) Identification, including why each medication is prescribed.**
  - **(6) Implications for management of multiple medications.**
  - **(7) Implications of abrupt discontinuation.**
  - **(8) Indications and contraindications.**
  - **(9) Obtaining medication.**
  - **(10) Side effects.**
  - **(11) Storage.**
  - **(12) Understanding of the education provided.**

Examples

Education is provided as appropriate to the needs of the persons served and families, the scope of the program, and in accordance with any relevant practice acts or standards of practice.

31.b.(3) A person has difficulty opening medication bottles so the program educates him and his family about requesting blister packs or easy to open bottles. The person served has vision limitations so the program educates her to request labels with enlarged print.

31.b.(5) The nurse identifies each medication and the reason it was prescribed to the person served when dispensing medications.

31.b.(6) The program identifies that the person served is taking several medications that are prescribed by different physicians. It educates the person served regarding the importance of notifying each prescribing physician about all of the medications currently being taken, not just

those related to the condition being managed by each physician.

31.b.(9) The program explains the process for obtaining medications to the person served and their family at the time of admission to a brain injury residential rehabilitation program.

Resources

Please refer to Appendix D for resources related to education resources for persons served, families/support systems, and caregivers.

2.B. **32. The program assists the person served to:**

- **a. Access community resources.**
- **b. Use community systems that support or enhance the progress achieved by the person served.**

Intent Statements

There is evidence of an active effort to ensure that the persons served are aware of how to get the services that they need in the community.

Examples

32.a. Examples of community services include Meals on Wheels, transportation, senior discounts, the services of senior citizens' centers, parks and recreation programs for people with special needs, and tutoring in the school systems.

2.B. **33. Regarding the equipment and supplies needed for each person served, the program:**

- **a. Implements procedures for acquisition.**
- **b. Ensures communication with relevant stakeholders regarding:**
  - **(1) Costs.**
  - **(2) Purchase/rental options.**
  - **(3) Contingency plans if equipment or supplies are not available by the time of discharge/transition.**
- **c. Assists individuals with acquisition of equipment and supplies as prescribed.**
- **d. Provides or arranges for instruction and training about equipment and supplies commensurate with and related to:**
  - **(1) Their use.**
  - **(2) Maintenance.**
  - **(3) Troubleshooting.**
  - **(4) Safety considerations.**
  - **(5) Infection control issues.**
  - **(6) Risks.**
  - **(7) Complexity.**
  - **(8) Manufacturer instructions or specifications.**
- **e. Provides for referrals for expertise in equipment and supplies, as appropriate.**
- **f. Verifies that the equipment and supplies ordered:**
  - **(1) Were received.**
  - **(2) Match what was ordered or prescribed.**
  - **(3) Function properly.**
  - **(4) Achieve the intended purpose.**

Examples

33.d.(7) The person served will be using a sophisticated system of assistive technology when he returns to work. The instruction and training that accompany provision of the equipment reflect its complexity. The program arranges for the vendor to be involved in the instruction and work with the clinician to train the person served about its use, including troubleshooting problems.

Applicable Standards

See the guidelines on page 117 for applicability of Standard 34.

2.B. **34. The program:**

- **a. Determines whether each person served has a system in place to record personal health information to provide to healthcare providers and/or in case of an emergency.**
- **b. If the person served has a system or tool in place, assists with updating relevant personal health information.**
- **c. If the person served does not have a system or tool in place:**
  - **(1) Provides education on the importance of having such a system or tool to the:**
    - **(a) Persons served.**
    - **(b) Family or support system.**
  - **(2) Assists the person served to develop a system or tool to record personal health information.**

Intent Statements

Having a system or tool to record one's personal health information helps ensure that the person served receives ongoing quality healthcare through ease of access to current information that will meet his or her needs and assist in future interactions with individual healthcare providers. Such information empowers persons served to be responsible for the next important step in their care and lessens fragmentation of care among healthcare providers. In support of a person-centered approach, the system or tool is individualized for each person served. The program, in conjunction with the person served, determines whether it will be developing a new system or tool or updating an existing one.

Examples

The system or tool may be called many things; e.g., a portable profile, medical passport, patient care notebook, shared care plan, smartcard, and healthcare folder. Offering the person served a choice of formats may improve the actual use of the system or tool. The format facilitates ease of access and ready availability in case of an emergency. Formats might include:

- Index cards with clear writing.
- An eight-by-eleven inch piece of paper.
- Folders.
- Notebooks.
- Flash drive.
- CD.
- Bracelet with information.
- Web-based application accessible through mobile devices.

In accordance with the unique needs of the person served, personal health information might include, but is not limited to:

- Advance directives.
- Allergies.
- Cognition.
- Communication needs.
- Emergency contact information.
- Equipment and devices, e.g., the vendor, vendor's contact number, description of the equipment, and date of last service.
- Functional status.
- Healthcare providers involved with care.
- Hospital preference.
- Immunization status.
- Insurance information, e.g., insurance benefits currently in place; pending, such as an application that has been submitted but not yet accepted; due to end, such as COBRA; or denied.
- Legal health representative, e.g., guardian, power of attorney, healthcare power of attorney.
- Medical diagnoses/conditions.
- Medications, e.g., all medications taken (prescribed and over the counter), prescribing physicians, medication sensitivities, and current dosages.
- Physicians involved with care.
- Prosthetic and orthotics information, e.g., the provider, components, history, and dates of service.

- Risk factors.
- Swallowing.
- Vision and hearing.

The person served already has a system in place to store and track personal health information that he finds works well. The program assists with updating the developed system. The updating activities are incorporated into therapy and rehabilitation nursing sessions to encourage the understanding and appreciation of the person served that ongoing revisions will be necessary to keep the information current.

The person served has used a notebook to track personal health information but desires to transition to a web-based application that can be accessed through her smart phone. The program assists with updating the information in the new preferred format.

The person served has never stored or tracked her personal health information in a manner that could be accessed and available for appointments with healthcare providers and health encounters such as filling new prescriptions or seeking repairs of medical devices. The program assists with the development of a system that is appropriate for the person served. Discussions and activities related to developing the system are incorporated into rehabilitation nursing and therapy sessions. The system is updated throughout the person's rehabilitation program as health information changes to ensure that the person served understands how to use the tool.

Determination of an appropriate system considers who will be responsible for maintaining the system and the skills, resources, and time required for maintenance. For example, the responsible person might be a daughter who prefers use of a computer to update information, a spouse who will keep a notebook, or the person served who prefers use of a single sheet of paper that can be carried in a wallet.

Resources

Please refer to Appendix D for resources related to personal health information systems and tools.

Applicable Standards

See the guidelines on page 117 for applicability of Standard 35.

2.B. **35. The program educates each person served about the importance of developing and updating a record of personal health information that addresses his or her needs.**

Intent Statements

Outpatient medical and occupational rehabilitation programs and vocational services might assist the persons served in developing a personal health information record system or tool by providing education on the importance and value of this and, if the persons served express an interest in completing a personal health information record, referring them to appropriate resources.

2.B. **36. Written discharge/transition recommendations:**

- **a. Are provided, as appropriate, to:**
  - **(1) The person served.**
  - **(2) Providers in the continuum of services.**
  - **(3) Primary care physicians.**
  - **(4) The referral source.**
  - **(5) The family/support system.**
  - **(6) Personal care assistants.**
  - **(7) Payers.**
  - **(8) Case managers.**
  - **(9) Caregivers.**
  - **(10) Other stakeholders.**
- **b. Depending upon the needs of the person served, address:**
  - **(1) Aging issues.**
  - **(2) Behavior.**
  - **(3) Case management.**
  - **(4) Substance use.**
  - **(5) Cognition.**
  - **(6) Communication.**
  - **(7) Community integration services.**
  - **(8) Education and training.**

(9) Emergency preparedness.
(10) The environment.
(11) Equipment.
(12) Family support.
(13) Functional issues.
(14) Medical/physiological issues.
(15) Medications, as appropriate.
(16) Ongoing treatment recommendations.
(17) Pain management.
(18) Precautions.
(19) Psychosocial issues.
(20) Recreation and leisure.
(21) Relationship issues.
(22) Resource management.
(23) Risks.
(24) Safety issues.
(25) Secondary prevention.
(26) Supervision needs.
(27) Transition planning.
(28) Time management.
(29) Transportation.
(30) Vocational issues.

Examples

36.b.(11) Equipment might include walkers, dressing aides, communication devices, etc.

36.b.(23) Risks might be that the family situation is not stable and there will be an ongoing need to verify whether the family member who was trained by the program to assist the person served is still in the home.

Another type of risk may be that the person served lives alone and has judgment issues that might increase the risk of injury but the person is still making her own decisions and refuses assistance in the home.

The bariatric person served has additional risks to consider with both the equipment and environment. These individuals may have difficulty getting appropriate equipment. Environmental factors such as low seating, steps/stairs, and reaching may increase the person's risk of falling.

36.b.(25) Secondary prevention might include activity, dietary, or medication modifications aimed at preventing additional impairments or medical complications/conditions.

36.b.(27) Transition planning may include transition from one level of care to another level; e.g., inpatient to outpatient, supervised to a skilled residential setting, or outpatient rehabilitation setting to a fitness center.

36.b.(28) Time management might include pacing and energy conservation, the scheduling of appointments when the person served can get a ride, and the availability of caregiver support to meet the needs of the person served.

2.B. **37. The program:**

a. Gathers input from the persons served about their information needs concerning rehabilitation.
b. Responds to the stated information needs of the persons served.

Examples

The program may use surveys, questionnaires, patient councils, support groups, or other mechanisms to gather input from persons served about their information needs regarding rehabilitation.

2.B. **38. The program provides information from the performance measurement and outcomes management system to the persons served that:**

a. Addresses, at a minimum, each of the following areas by relevant diagnostic category:
(1) The characteristics of the persons served.
(2) The number of persons served within a stated period of time.
(3) The average number of hours of treatment per day (for inpatient and residential programs).
(4) The average number of visits per service (for outpatient, vocational, interdisciplinary pain, and occupational rehabilitation programs).
(5) Disposition at discharge/transition.

(6) Effectiveness of the program.

(7) Satisfaction of the persons served with the services received.

(8) Unplanned transfers to acute medical facilities.

b. Addresses other information as requested by persons served.

c. Is updated at least annually.

Intent Statements

This standard was driven by consumer input to have a quick way for persons served and their families/support systems to know what happened for a person like themselves in a program. Providing them with information from the performance measurement and outcomes management system allows them to learn about the program's track record serving people with similar diagnoses and to determine whether the program is appropriate to their needs and preferences.

Examples

There are a variety of ways that the information may be shared and which of these ways are used will depend upon the individual needs of the persons served. Some information may be written in different languages, at different reading levels, in larger print size, etc. Some information may be shared orally or through a video presentation.

38.a.(1) The characteristics of the person served may include impairment, activity limitations, level of participation, age, or gender.

38.a.(6) Information shared about effectiveness reflects the type of program provided and the focus of the program. An occupational rehabilitation program might share information on persons served who returned to work or returned to the same occupation. A residential brain injury specialty program might share information on quality of life measures or increased community participation. An inpatient rehabilitation program might share information on amount of improvement in activities of daily living or functional status.

38.a.(8) An outpatient program might consider unplanned transfers to acute medical facilities in terms of injuries or medical complications that occurred during or as a result of the therapeutic intervention provided or transfer to an emergency room for a cardiac event. This information might be available from the program's critical incident reporting system.

2.B. **39. Based on an assessment of the learning needs and desires of the person served, the availability of a computer, and access to the internet, the organization provides or arranges for:**

a. Formal and informal educational opportunities.

b. Access to:

(1) Information of interest.

(2) Health information.

(3) Other media.

(4) Reliable resources for research information.

Examples

The organization may be set up with computer and internet access on-site or may identify community resources such as the library, recreation center, or senior center where persons served may go for instruction and to use a computer.

The person served has worked extensively using computer technology and desires to use the internet to learn more about his spinal cord injury and current research. The spinal cord specialty program works with him to access appropriate information.

The retired woman in the outpatient program indicates she does not use computers and has no desire to research her condition using the internet. Therefore, the program does not pursue educational opportunities using the computer for her.

Education provided might include how to safely use and access online information such as checking the source of the information, not asking for specific medical advice, and not consulting sites that are promoting or selling specific products or services.

Resources

Please refer to Appendix D for resources related to education for persons served, families/support systems, and caregivers.

2.B. **40. The physical plant of the program:**

- **a. Is adequate in:**
  - **(1) Size.**
  - **(2) Design.**
  - **(3) Accessibility.**
  - **(4) Usability.**
  - **(5) Flexibility.**
- **b. Has equipment available to meet the individual needs of the persons served.**
- **c. Facilitates the appropriate use of therapeutic equipment.**
- **d. Facilitates infection control.**
- **e. Is designed to promote effective service delivery.**
- **f. Is designed to promote the dignity and self-worth of the persons served.**
- **g. Is designed to provide opportunities for and facilitate interaction between persons with like activity limitations.**

Intent Statements

The physical environment facilitates the accomplishment of the individual plans and predicted outcomes of the persons served; promotes their dignity, self-worth, privacy, and quality of life; and it supports their ability to make choices in their daily routines. The design of the physical environment, the equipment needed, and other aspects of the environment vary depending upon the ages of the persons served.

40.a.(4) ISO 9241-11 (1998) Guidance on Usability, issued by the International Organization for Standardization, defines usability as "the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use."

The terms and definitions taken from ISO 9241-11:1998 Ergonomic requirements for office work with visual display terminals (VDTs) - Part 11: guidance on usability, clause 3.1, are reproduced with permission of the International Organization for Standardization, ISO.

Usability ensures that all people will be comfortable, safe, and able to function at their optimal level.

Examples

On the pediatric unit the areas used for family and peer visitation include games, children's books, and toys.

The patio area accommodates those with mobility issues. It has been designed for usability, with protection from the elements.

In all reading areas, there is sufficient lighting for those with low vision.

The organization has space for parties to celebrate holidays, birthdays, anniversaries, and events of family importance.

The bathrooms are designed to accommodate the use of wheelchairs.

The beds on the inpatient unit provide for the safety and comfort of persons served in the bariatric program.

2.B. **41. The program's safety and security practices:**

- **a. Are consistent with:**
  - **(1) The behavioral needs of the persons served.**
  - **(2) The cognitive needs of the persons served.**
  - **(3) The physical needs of the persons served.**
- **b. Address, at a minimum:**
  - **(1) Substance use.**
  - **(2) Elopement risks.**
  - **(3) Mental health issues.**
  - **(4) Physically aggressive behaviors.**
  - **(5) Self-injurious behaviors.**
  - **(6) Sexually inappropriate behaviors.**
  - **(7) Suicidal ideation.**
  - **(8) Suspected neglect and abuse.**

Intent Statements

These measures are reflected in the functioning of personnel. Specific policies and written procedures are not required.

2.B. **42. The program promotes a positive, consistent, therapeutic approach to behavior management that addresses:**

- **a. Education through modeling of socially and culturally acceptable behaviors for:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
  - **(3) Members of the community with whom the persons served regularly interact.**
- **b. Environmental factors to enhance the socially and culturally acceptable behaviors of the persons served.**
- **c. Environmental modifications.**
- **d. Medication management.**
- **e. Training in the implementation of behavior management programs for:**
  - **(1) Personnel.**
  - **(2) Families/support systems.**

Examples

42.a.(3) Members of the community with whom the persons served regularly interact might include a taxi or transportation driver who regularly drives the persons served to their vocational services location; a hair stylist or barber who regularly provides services to the persons served, or wait staff at the local coffee shop frequented by persons served.

42.c. Environmental modifications might include the use of noise-reducing materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and door bells; limiting or controlling where and when people may visit persons served; reducing noxious stimuli such as bright sunlight or odors; and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

2.B. **43. When there is a need to manage challenging behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of the family/support system.**
  - **(3) From the perspective of personnel.**
  - **(4) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the approach, treatment, and/or supports necessary.**
- **f. Address the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
  - **(5) Other persons involved with the person served.**
- **g. Implement the appropriate actions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other personnel.**
  - **(3) The family/support system, as appropriate.**

Intent Statements

Persons served may act in ways personnel find difficult to understand, yet all behavior has meaning. It is important to try to recognize what prompts these behaviors and what can be done on the part of the personnel to avoid precipitating them in the future. Members of the family/support system may be involved to help determine interventions. Interventions are shared with personnel and included in the individual program plan. The decision to use any type of pharmacological intervention, if appropriate, is evaluated for potential side effects and interactions.

Examples

This is a dynamic process that should be evident to the surveyors. A variety of different policies, procedures, records of the persons served, inservice agendas, minutes of meetings, phone logs of discussions with family members, and other

media could be used to demonstrate conformance to this standard.

Behavior is a way to communicate. It is important to assess for the possible causes of challenging behaviors, such as infection, pain, confusion, hunger, cold, sleeplessness, loneliness, or other unmet needs. Behavioral events may be precipitated by the way care is given, as in using a shower for a person with cognitive impairment who is frightened by running water. Thus, personnel can avoid precipitating behavioral events by identifying unmet needs and implementing approaches to care that address the comfort of the person served.

For example, every day at 5:00 p.m., an individual with a brain injury becomes agitated and paces. Personnel have tried various strategies to calm him, without success. During a family conference, the team learns that when the man came home from work he had dinner while he watched the evening news. Personnel spoke with the dietary department and arranged to have his dinner available each evening in time for the 5:00 p.m. news. This is now part of his routine.

2.B. **44. When crisis management is necessary to handle challenging behaviors, the program demonstrates appropriate use of emergency crisis procedures.**

Intent Statements

In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would respond to challenging behaviors of the persons served

Examples

Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

2.B. **45. The records of the persons served include:**

- **a. Identification data.**
- **b. If they have been appointed for the persons served, adequate information to facilitate contact of:**
  - **(1) Personal representatives.**
  - **(2) Conservators/trustees.**
  - **(3) Guardians.**
  - **(4) Representative payees.**
- **c. Pertinent histories.**
- **d. Information on impairments.**
- **e. Information on activity limitations.**
- **f. Information on participation restrictions.**
- **g. Information on environmental needs.**
- **h. Information on special communication needs.**
- **i. Personal preferences.**
- **j. Predicted outcomes.**
- **k. Prescribed medications.**
- **l. Evidence of understanding of medication education provided, by:**
  - **(1) The persons served.**
  - **(2) Families/support systems, as appropriate.**
- **m. If the program is not an inpatient program:**
  - **(1) The names of the physicians or other licensed independent practitioners who are prescribing medications.**
  - **(2) The phone numbers of the physicians or other licensed independent practitioners who are prescribing medications.**
- **n. Relevant medical information.**
- **o. Reports of admission assessments.**
- **p. Reports of ongoing assessments.**
- **q. Reports from referral sources.**
- **r. Reports of service referrals by the organization.**
- **s. Reports from outside consultants.**

t. Designation of the individual coordinating the provision of care.

u. Evidence of the direct involvement of the persons served in the rehabilitation process.

v. Documentation of communication within the team throughout the rehabilitation process.

w. Documentation of communication with the families throughout the rehabilitation process, if applicable.

x. The treatment plans of the persons served.

y. Identification of audiovisual records, if applicable.

z. The location of audiovisual records, if applicable.

aa. Clinical entries related to the rehabilitation process.

ab. Release forms.

ac. Discharge/transition summaries.

ad. Evidence of understanding of discharge instructions by:

(1) The persons served.

(2) Families/support systems, as appropriate.

Examples

45.b.(2) Legal terminology may vary by jurisdiction; for example, in Canada the term trustee is used.

2.B. **46. A written analysis of a representative sample of records of the persons served is conducted:**

a. At least annually.

b. To include:

(1) Documentation completed in accordance with the organization's policies.

(2) Regulatory requirements, if applicable.

(3) CARF documentation requirements.

c. That includes:

(1) Performance in relationship to established targets in each area.

(2) Trends.

(3) Actions for improvement.

(4) Results of performance improvement plans.

(5) Necessary education and training of personnel.

Intent Statements

Please refer to the Glossary for a definition of *representative sample*.

Examples

46.b.(1) Program personnel review and analyze a representative sample of records to determine consistent completion of record content areas, record entries in accordance with established timeframes, and review of discharge recommendations with the persons served and other stakeholders as appropriate.

46.b.(2) The organization identifies its key regulatory agencies and reviews and analyzes a representative sample of records of the persons served to determine if documentation meets identified requirements. Results of the review are used in education and training activities to facilitate compliance with regulatory obligations.

Resources

46.b.(3) Refer to Appendix A for identification of CARF required documentation in the records of the persons served for each program.

Applicable Standards

See the guidelines on page 117 for applicability of Standards 47. and 48.

2.B. **47. To meet the needs of persons served, the program identifies the services/programs that it provides directly or with which it links in each of the following areas:**

- **a. Emergent care.**
- **b. Acute hospitalization.**
- **c. Inpatient rehabilitation program.**
- **d. Long-term care hospital.**
- **e. Skilled nursing care.**
- **f. Home care.**
- **g. Hospice.**
- **h. Day hospital.**
- **i. Outpatient programs.**
- **j. Community-based services.**
- **k. Adult day programs.**
- **l. Residential services.**
- **m. Vocational services.**
- **n. Primary care.**
- **o. Specialty consultants.**
- **p. Long-term care.**

Intent Statements

The program provides or links with services/programs in a variety of ways. Some programs may have a full continuum within their own health systems, some may have most but not all services and link with other providers in the community, and some may link with programs or services outside of their local community such as nationally recognized centers or services for persons served. At a minimum, the program should be knowledgeable about available community resources and either contract with or assist the persons served to access information about the services/programs available in each of the areas listed in the standard.

Examples

The program might compile a resource guide that addresses each of the programs/services, including contact information.

47.j. Community-based services might include independent living, transportation services, city parks and recreation, home and community services, and emergency services for disaster preparedness.

2.B. **48. For all services/programs provided directly or with which it links, the program:**

- **a. Defines its relationships with the services/programs.**
- **b. Defines responsibilities of the services/programs.**
- **c. Identifies key communication contacts within the services/programs.**
- **d. Acts as a resource in establishing personnel competencies for the services/programs identified related to the specialized needs of the persons served.**

Examples

48.d. Acting as a resource to services/programs in establishing personnel competencies might include providing inservice training and education for providers, articles, case studies, etc.

Applicable Standards

See the guidelines on page 117 for applicability of Standard 49.

2.B. **49. The amputation specialty program identifies the services/programs that it provides directly or with which it links in the following areas:**

- **a. Renal dialysis centers.**
- **b. Prosthetic services.**
- **c. Orthotic services.**
- **d. Pedorthic services.**
- **e. Foot care services.**

Intent Statements

This standard expands upon Standard 2.B.47., which addresses services/programs that the program provides directly or with which it links.

Applicable Standards

See the guidelines on page 117 for applicability of Standard 50.

2.B. **50. The spinal cord specialty program identifies the programs/services that it provides directly or with which it links in the following areas:**

- **a. Behavioral health.**
- **b. Independent living centers.**
- **c. Clinical research centers.**
- **d. Consumer advocacy organizations.**
- **e. Driver rehabilitation.**

Intent Statements

This standard expands upon Standard 2.B.47., which addresses services/programs that the program provides directly or with which it links.

Examples

50.e. Driver rehabilitation might include assessment, training, and retraining.

C. The Service Process for the Persons Served in Home and Community Services

Applicable Standards

The standards in Section 2.C. are applicable as follows:

- All organizations seeking accreditation for Home and Community Services (Section 3.C.) apply Standards 2.C.1.–11.
- If *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation, Standards 2.C.12.–21. are also applied.

Section 2.B. The Rehabilitation and Service Process for the Persons Served is not applicable to Home and Community Services.

Note: *A person served is defined as a child/adolescent if the individual is under the age at which one is legally recognized as an adult in a given state/province or other jurisdiction. Refer to the Glossary for a definition of* child/adolescent.

Emancipated minors are individuals who are under the age at which a state or province would legally recognize them as adults but who have had parental control over them legally terminated. In those states or provinces that recognize emancipated minors, those individuals are considered adults for the purposes of the CARF standards.

If seeking accreditation for an optional specialty program designation in Section 4 linked to Home and Community Services, additional Section 2.C. standards apply as follows:

- Pediatric Specialty Program: Standards 2.C.25.–27.
- Amputation Specialty Program: Standards 2.C.25.–30.
- Brain Injury Specialty Program: Standards 2.C.22.–29.
- Cancer Rehabilitation Specialty Program: Standards 2.C.25.–29.
- Spinal Cord Specialty Program: Standards 2.C.25.–29. and 31.
- Stroke Specialty Program: Standards 2.C.24.–29.

Applicable Standards

All Home and Community Services must meet Standards 1.–11.

2.C. **1. The service provides information on admission and discharge/transition criteria to:**

- **a. The persons served.**
- **b. Families/support systems.**
- **c. Other relevant stakeholders.**

Intent Statements

Information regarding admission and discharge/transition criteria is presented in a way that is understandable to the audience for which it is intended. Information may be provided in writing, verbally, or other means as appropriate.

2.C. **2. Appropriate placement of each person served is addressed through:**

- **a. The admission criteria.**
- **b. The discharge/transition criteria.**
- **c. The resources available.**
- **d. Any resources previously used.**
- **e. Ongoing reassessment.**
- **f. The person's potential to benefit.**
- **g. The person's personal preferences.**

Intent Statements

The surveyors will address throughout the survey process whether the persons served are in the appropriate portion of the continuum of services and whether the program has explored the options for the most appropriate use of resources as well as the needs of the persons served in placement. The preadmission information gathered will be valuable in this placement process.

2.C. **3. The service demonstrates the involvement of the following individuals in the services of the persons served:**

- **a. The person served.**
- **b. Treating physicians.**
- **c. Healthcare professionals.**
- **d. Representatives of the person served, as appropriate.**
- **e. The employer/employer designee, as appropriate.**
- **f. Members of the family/support system, as appropriate.**
- **g. Other stakeholders, as appropriate.**

Examples

This involvement may be demonstrated by attendance and participation in team meetings or conferences, written communication, visits by personnel to the offices of stakeholders or community locations, etc.

3.d. Representatives of the person served might include legal counsel, case managers, union representatives, advocates, and other representatives identified by the person served to participate in the process.

3.e. Employer designees might include supervisors, union representatives, human resource representatives, and benefits coordinators.

2.C. **4. Admission and ongoing assessments:**

- **a. Are relevant to the needs of the persons served.**
- **b. Consider health status.**
- **c. Address resource needs and utilization.**
- **d. Address discharge/transition planning.**
- **e. Address the integration of available resources.**

2.C. **5. The team:**

- **a. Is determined by:**
  - **(1) The assessment.**
  - **(2) The individual planning process.**
- **b. Includes:**
  - **(1) The person served.**
  - **(2) Members of the family/support system, as appropriate.**
  - **(3) Personnel necessary to evaluate, provide services, and facilitate services.**

Intent Statements

The team composition is determined for each person served through the assessment and individual planning processes. The team is a dynamic group of individuals that may change as the person served progresses through the program. Some professionals may be active team members for the entire length of a person's stay or for a portion of the stay, while other professionals may become active members of the team as the need for their services is identified.

2.C. **6. The responsibilities of the team include:**

- **a. Reviewing relevant reports to facilitate assessment.**
- **b. Identifying resources.**
- **c. Integrating information on resources into:**
  - **(1) Service planning.**
  - **(2) Service implementation.**
- **d. Conducting assessments.**
- **e. Establishing the service plan.**
- **f. Providing services.**
- **g. Modifying the service plan.**
- **h. Ensuring that the disciplines change based on the needs of the person served.**
- **i. Providing education and training.**
- **j. Referring the persons served to other services/programs as needed.**
- **k. Communicating with relevant stakeholders.**
- **l. Participating in performance improvement activities.**

2.C. **7. Written communication regarding the service process is:**

- **a. Accurate.**
- **b. Complete.**
- **c. Accessible.**

Intent Statements

7.c. Written communication regarding the service process is accessible to internal and external stakeholders in accordance with their needs and responsibilities in the service process of the person served.

2.C. **8. When crisis management is necessary to handle challenging behaviors, the service demonstrates appropriate use of emergency crisis procedures.**

Intent Statements

In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would respond to challenging behaviors of the persons served.

Examples

Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

2.C. **9. The service establishes requirements for the records of the persons served including, but not limited to:**

- **a. What will be documented.**
- **b. Who will document.**

2.C. **10. The records of the persons served include, when applicable:**

- **a. Identification data.**
- **b. Advance directives.**
- **c. Emergency contact information.**
- **d. Substitute decision maker who has been appointed for the person served, including his or her:**
  - **(1) Name.**
  - **(2) Contact information.**
  - **(3) Verification of the appointment.**
- **e. Medication information.**

f. Healthcare providers involved in the care of the person served, including:
- **(1) Name.**
- **(2) Contact information.**

g. Medical information.
h. Reports for initial assessments.
i. Reports for ongoing assessments.
j. Reports from referral sources.
k. Reports of service referrals by the program.
l. Reports from outside consultants.
m. The service plan of the persons served.
n. Clinical entries related to the services received, as appropriate.
o. Release forms.
p. Discharge/transition summaries, as appropriate.

2.C. **11. A written analysis of a representative sample of records of the persons served is conducted:**
- **a. At least annually.**
- **b. To include:**
  - **(1) Documentation completed in accordance with the organization's policies.**
  - **(2) Regulatory requirements, if applicable.**
  - **(3) CARF documentation requirements.**
- **c. That includes:**
  - **(1) Performance in relationship to established targets in each area.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of personnel.**

Intent Statements

Please refer to the Glossary for a definition of *representative sample*.

Examples

11.b.(1) Program personnel review and analyze a representative sample of records to determine consistent completion of record content areas, record entries in accordance with established timeframes, and review of discharge recommendations with the persons served and other stakeholders as appropriate.

11.b.(2) The organization identifies its key regulatory agencies and reviews and analyzes a representative sample of records of the persons served to determine if documentation meets identified requirements. Results of the review are used in education and training activities to facilitate compliance with regulatory obligations.

Resources

11.b.(3) Refer to Appendix A for identification of CARF required documentation in the records of the persons served.

Applicable Standards

Home and Community Services that serve *any* children/adolescents and are not seeking accreditation as a Pediatric Specialty Program must meet Standards 12.–21. (See guidelines on page 143.)

2.C. **12. Information shared with the public, prospective persons served and their families/support systems, and other relevant stakeholders specifies:**
- **a. The age range of the children/adolescents served.**
- **b. The number of children/adolescents served annually by age group.**

Intent Statements

This information is pertinent to the decision-making process related to whether a program is appropriate to meet the needs of a prospective child/adolescent served.

Examples

Information could be found in brochures, marketing information, outcomes information, admission criteria, or on the organization's website.

2.C. **13. Based on the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the persons served, the following are provided:**

- **a. Appropriate assessments.**
- **b. Equipment.**
- **c. Materials.**
- **d. Schedules that reflect the needs of each child/adolescent served.**

Intent Statements

13.d. Schedules might be adjusted to accommodate visits from peers after school hours, rest or nap times, etc.

2.C. **14. Personnel who serve children/adolescents demonstrate competencies in the following areas as appropriate to the population served:**

- **a. Normal growth and development.**
- **b. Family-centered care, including:**
  - **(1) Communication with families/support systems.**
  - **(2) Facilitating active involvement of the family/support system in the rehabilitation process.**
- **c. Behavior management.**
- **d. Sexuality, including:**
  - **(1) Normal development.**
  - **(2) After the onset of injury, illness, or impairment.**
- **e. Knowledge of the education system and resources.**
- **f. Recognition and reporting of suspected abuse and neglect.**
- **g. Setting boundaries.**
- **h. The use of play to facilitate therapeutic interventions.**

Examples

These competencies can be obtained through formal education or continuing education focused on children/adolescents; on-the-job training; mentorship by experienced personnel; and ongoing access to books, periodicals, videos, and audio recordings.

14.d. Personnel competencies might address normal sexual exploration and expression across the developmental span, e.g., body image, flirting, and relationships; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

14.g. The therapeutic relationship requires the establishment of rapport as well as appropriate limits on behaviors. Education might include topics such as refraining from establishing a degree of friendship with a child/adolescent served such that the provider's role as an adult and/or the parents' authority is compromised, recognizing that even though providers and family members may disagree about what is best for the child the parent is the final authority regarding the child, and the adaptive balance of emotional engagement and distance in a child and family's care so that providers are invested in the persons served but their roles as professionals are not compromised.

2.C. **15. Because the family system is the focal point of services, members of the family/support system are considered and involved as partners in all phases of the services, except where exclusion is justified and appropriate.**

Intent Statements

Exclusion may be justified when legal parental rights have been terminated, when there are restrictions on visitation or involvement with the child/adolescent, or when a family member's involvement in the particular phase of the program is deemed by the professional providing services to be detrimental to the child/adolescent.

2.C. **16. Based on the individual needs of the child/adolescent served and as appropriate to the services provided, educational services reflect an appropriate education plan that complies with current state, provincial, and federal laws.**

Examples

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

2.C. **17. If appropriate to the services provided, to facilitate communication and transition of the child/adolescent served to the community school, information is exchanged between the service and the school system:**

- **a. At critical decision-making points in the service process of the child/adolescent served.**
- **b. Including, but not limited to:**
  - **(1) Preonset school and/or work records.**
  - **(2) Preparation of the school for transition of the child/adolescent from the service to school.**
  - **(3) Assessment of modifications and adaptations of the environment.**
  - **(4) Preparation for transition from school to work and/or vocational training.**
  - **(5) Involvement in planning for transitional or supported living programs.**

Examples

17.a. Critical decision-making points might include the time of initial assessment to help determine premorbid skills, at development of the plan to support a return to the classroom, or at the time of significant changes that might require a change in the availability of classroom support.

2.C. **18. The service has access to local, regional, provincial, national or international networks or agreements to facilitate pediatric service delivery.**

Intent Statements

These networks encompass community, medical, educational, and evaluative linkages.

2.C. **19. To facilitate transition to the community, an individualized plan is established for each child/adolescent served that includes:**

- **a. As appropriate, identification of other resources in the community that are or will be involved with the child/adolescent served.**
- **b. A plan for transition from the services, including mechanisms for interagency coordination.**

Examples

19.b. The plan for transition of the child/adolescent to the community might address coordination with agencies such as city parks and recreation, girl scouts and boy scouts, boys and girls clubs, youth groups, church groups, and group sports.

2.C. **20. The tools used to measure satisfaction and feedback are age and developmentally appropriate to elicit input from the children/adolescents served.**

Intent Statements

The service strives to capture information that is meaningful to the children/adolescents served and their families/support systems as well as to the service itself for use in performance improvement efforts. Depending upon the ages and developmental levels of the children/adolescents served, the service may need to use more than one tool to elicit input on satisfaction and feedback.

2.C. **21. The education and training program for the family/support system addresses:**

- **a. Knowledge of and capacity to describe and discuss ability.**
- **b. Transition to:**
  - **(1) School.**
  - **(2) The community.**
- **c. Normal growth and development, including age-appropriate:**
  - **(1) Social skills.**
  - **(2) Behaviors.**
- **d. Accessing emergency care if necessary.**
- **e. Specific healthcare procedures and techniques.**
- **f. Sexuality, including:**
  - **(1) Normal development.**
  - **(2) After the onset of injury, illness, or impairment.**
- **g. Therapeutic home programs.**
- **h. Realistic goals.**
- **i. Information on respite care.**
- **j. Passenger safety, including:**
  - **(1) Laws.**
  - **(2) Appropriate use of equipment.**
- **k. The anticipated long-term issues of the child/adolescent.**

Examples

The education program could be provided using a variety of methods such as one-on-one teaching, formal groups, and lectures; videos or audio recordings; written information; and computerized programs.

21.d. Education on emergency care might address knowing when the child/adolescent needs emergency care versus when contacting the primary care physician or nurses advice line is more appropriate, when other children in the family need emergency care, or how to dial 911.

21.f. Education for the family/support system might address normal sexual exploration and expression across the developmental span; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

Applicable Standards

If Home and Community Services is seeking accreditation as a Brain Injury Specialty Program, Standards 22.–29. must be met.

2.C. **22. To facilitate the disclosure of accurate information, the service documents its scope including the following parameters regarding the persons served:**

- **a. Ages.**
- **b. Activity limitations.**
- **c. Behavioral status.**
- **d. Cultural needs.**
- **e. Impairments.**
- **f. Intended discharge/transition environments.**
- **g. Medical acuity.**
- **h. Medical stability.**
- **i. Participation restrictions.**
- **j. Psychological status.**

Intent Statements

This standard expands on Standard 1. in Section 2.A. Program/Service Structure, which addresses the scope of the program. The service should document its scope regarding parameters of the persons served and share this information with all groups identified in that standard.

Examples

CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

22.d. Please refer to the Glossary for a definition of *culture*.

22.e. Impairments may include comorbidities.

22.i. Participation restrictions could include restrictions related to participation in

community events, occupational activities, school, homemaking activities, etc.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology

2.C. **23. Ongoing medical input:**

- **a. Is provided by a physician who:**
  - **(1) Is qualified by virtue of his or her training and experience in rehabilitation.**
  - **(2) Serves the program as at least one of the following:**
    - **(a) Medical director.**
    - **(b) Chair or member of a professional advisory committee.**
    - **(c) A consultant with a formal arrangement.**
    - **(d) Medical liaison.**
  - **(3) Participates in active clinical practice that relates to the population served.**
  - **(4) Demonstrates currency in medical practice concerning the persons served.**
  - **(5) Demonstrates active learning and involvement in the professional community.**
- **b. Addresses, but is not limited to:**
  - **(1) Development of ongoing relationships with the medical community.**
  - **(2) Establishment of policies and written procedures that address health issues, including surveillance.**
  - **(3) Performance improvement activities.**

Intent Statements

23.a.(3)–(4) The physician participates in active clinical practice that includes but may not be exclusive to persons served similar to those of the program to which he is providing medical input, e.g., for a brain injury specialty program the physician's clinical practice includes persons with acquired brain injury.

Examples

23.a.(2)(b) The home and community services brain injury program serving children and adolescents has a professional advisory committee including a developmental specialist, educators, a pediatric nurse specialist, and a pediatrician with experience in pediatric rehabilitation. The pediatrician provides ongoing medical input to the program.

23.b.(1) The program establishes a medical liaison relationship with a physician who has a clear understanding of what the program offers and to whom. He establishes links and maintains contact with other physicians in the community who might refer to the program or be able to assist in meeting the needs of persons who participate in the program.

23.b.(2) Surveillance includes the monitoring of health issues of the persons served. The physician consultant assists the program in exploring why there has been an increase in the number of people coming to the program from inpatient settings with infections, why persons served with orthopedic diagnoses from a certain orthopedic group have a higher rate of subluxations of new hips, etc. With input from program personnel the physician can determine the need to address these issues in a constructive manner with referring physicians.

Applicable Standards

See the guidelines on page 143 for applicability of Standard 24.

2.C. **24. The interdisciplinary team involves and considers the family/support system, as appropriate, as a partner throughout the rehabilitation process through the following:**

- **a. Ongoing assessments that consider:**
  - **(1) The family/support system's:**
    - **(a) Ability and willingness to support and participate in the plan.**
    - **(b) Composition.**
    - **(c) Communication.**

(d) Contingency plans for care.
(e) Coping.
(f) Expectations of the program.
(g) Expectations regarding transition of the person served to other components of the continuum of services or the discharge location.
(h) Educational needs.
(i) Insight.
(j) Interpersonal dynamics.
(k) Learning style.
(l) Problem solving.
(m) Responsibilities.

(2) Cultural, financial, literacy, or social factors that might influence the program.

(3) The health status of the primary caregiver.

b. The provision or arrangement of services for each family/support system, as needed, including:

(1) Advocacy education.
(2) Assistive technology.
(3) Counseling/support services.
(4) Education.
(5) Reasonable accommodations.
(6) Respite.
(7) Support, including:
(a) Spouse-to-spouse interactions.
(b) Family-to-family interactions.

Intent Statements

24.a.(1)(j) Interpersonal dynamics refers to the interactions between the person served and his or her spouse/significant other, friends, peers, coworkers, employer, and community.

24.a.(2) Cultural, financial, literacy, or social factors may influence the program in areas such as setting goals for the person served, the provision of information and services, and discharge/transition options.

Information provided by the program to the families/support systems of the persons served, both written and oral, is understandable and accessible. This might include, but is not limited to, questionnaires and surveys; family conferences; disclosure statements; outcomes and performance information; instructions, home programs, or discharge recommendations; web pages; etc. The input of families/support systems is sought in preparing and adapting materials to meet their needs and the needs of families/support systems entering into the rehabilitation process in the future.

Examples

24.a.(1)(a) Ability and willingness to participate in the plan might include asking questions and providing input to decisions regarding the person served; involvement in family conferences and training sessions; willingness to support the goals of the team, including the person served, even if they differ from those of the family/support system; and accessing information and resources as recommended by the team.

24.a.(1)(e) An assessment of coping might consider both adaptive and maladaptive coping methods, including sleep, nutrition, consumption of alcohol and/or illicit substances, recognizing and accepting the support of others when appropriate, interactions with others such as providers on the team and other members of the family/support system, and members of the family/support system taking care of their own health, e.g., exercising, adherence to medications, appointments with health professionals, etc.

24.a.(1)(i) An assessment of insight might consider whether members of the family/support system are able to identify cognitive, functional, and/or physical limitations of the person served as well as areas of preservation consistent with what providers on the team identify. The assessment might also consider whether members of the family/support system seek assistance and/or resources consistent with identified needs of the person served and/or family/support system.

24.a.(1)(m) Responsibilities may include work and family-related responsibilities such as being the caregiver for young children or elderly parents.

24.a.(3) The health status of the primary caregiver may include coping, being at risk of a crisis, etc.

24.b.(1) Advocacy education could include educating families about how to advocate for payment for services or equipment, inclusion in community activities, or in the schools for the Individual Education Plan process.

Resources

24.b.(4) Please refer to Appendix D for resources related to education resources for persons served, families/support systems, and caregivers.

Applicable Standards

See the guidelines on page 143 for applicability of Standards 25.–26.

2.C. **25. The service promotes a positive, consistent, therapeutic approach to behavior management that addresses:**

- **a. Education through modeling of socially and culturally acceptable behaviors for:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
  - **(3) Members of the community with whom the persons served regularly interact.**
- **b. Environmental factors to enhance the socially and culturally acceptable behaviors of the persons served.**
- **c. Environmental modifications.**
- **d. Medication management.**
- **e. Training in the implementation of behavior management programs for:**
  - **(1) Personnel.**
  - **(2) Families/support systems.**

Examples

25.a.(3) Members of the community with whom the person served regularly interacts might include a taxi or transportation driver who regularly drives the persons served to their vocational services location; a hair stylist or barber who regularly provides services to the persons served, or wait staff at the local coffee shop frequented by persons served.

25.c. Environmental modifications might include the use of noise-reducing materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and door bells; limiting or controlling where and when people may visit persons served; reducing noxious stimuli such as bright sunlight or odors, and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

2.C. **26. When there is a need to manage challenging behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of the family/support system.**
  - **(3) From the perspective of personnel.**
  - **(4) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the approach, treatment, and/or supports necessary.**
- **f. Addresses the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
  - **(5) Other persons involved with the person served.**
- **g. Implement the appropriate actions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other personnel.**
  - **(3) The family/support system, as appropriate.**

Intent Statements

Persons served may act in ways personnel find difficult to understand, yet all behavior has meaning. It is important to try to recognize what prompts these behaviors and what can be done on the part of the personnel to avoid

precipitating them in the future. Members of the family/support system may be involved to help determine interventions. Interventions are shared with personnel and included in the individual program plan. The decision to use any type of pharmacological intervention, if appropriate, is evaluated for potential side effects and interactions.

Examples

This is a dynamic process that should be evident to the surveyors. A variety of different policies, procedures, records of the persons served, inservice agendas, minutes of meetings, phone logs of discussions with family members, and other media could be used to demonstrate conformance to this standard.

Behavior is a way to communicate. It is important to assess for the possible causes of challenging behaviors, such as infection, pain, confusion, hunger, cold, sleeplessness, loneliness, or other unmet needs. Behavioral events may be precipitated by the way care is given, as in using a shower for a person with cognitive impairment who is frightened by running water. Thus, personnel can avoid precipitating behavioral events by identifying unmet needs and implementing approaches to care that address the comfort of the person served.

For example, every day at 3:00 p.m., an individual with a brain injury becomes agitated and paces. Various strategies to calm him have been unsuccessful. Family members discover from neighbors of the person served that he routinely went for a walk in the neighborhood daily at 3:00 p.m. Personnel arrange scheduled visits so that the person served can resume this activity with supervision of family members.

Applicable Standards

See the guidelines on page 143 for applicability of Standard 27.

2.C. **27. The program:**

- **a. Determines whether each person served has a system in place to record personal health information to provide to healthcare providers and/or in case of an emergency.**
- **b. If the person served has a system or tool in place, assists with updating relevant personal health information.**
- **c. If the person served does not have a system or tool in place:**
  - **(1) Provides education on the importance of having such a system or tool to the:**
    - **(a) Persons served.**
    - **(b) Family or support system.**
  - **(2) Assists the person served to develop a system or tool to record personal health information.**

Intent Statements

Having a system or tool to record one's personal health information helps ensure that the person served receives ongoing quality healthcare through ease of access to current information that will meet his or her needs and assist in future interactions with individual healthcare providers. Such information empowers persons served to be responsible for the next important step in their care and lessens fragmentation of care among healthcare providers. In support of a person-centered approach, the system or tool is individualized for each person served. The program, in conjunction with the person served, determines whether it will be developing a new system or tool or updating an existing one.

Examples

The system or tool may be called many things; e.g., a portable profile, medical passport, patient care notebook, shared care plan, smartcard, and healthcare folder. Offering the person served a choice of formats may improve the actual use

of the system or tool. The format facilitates ease of access and ready availability in case of an emergency. Formats might include:

- Index cards with clear writing.
- An eight-by-eleven inch piece of paper.
- Folders.
- Notebooks.
- Flash drive.
- CD.
- Bracelet with information.
- Web-based applications accessible from mobile devices.

In accordance with the unique needs of the person served, personal health information might include, but is not limited to:

- Advance directives.
- Allergies.
- Cognition.
- Communication needs.
- Emergency contact information.
- Equipment and devices, e.g., the vendor, vendor's contact number, description of the equipment, and date of last service.
- Functional status.
- Healthcare providers involved with care.
- Hospital preference.
- Immunization status.
- Insurance information, e.g., insurance benefits currently in place; pending, such as an application that has been submitted but not yet accepted; due to end, such as COBRA; or denied.
- Legal health representative, e.g., guardian, power of attorney, healthcare power of attorney.
- Medical diagnoses/conditions.
- Medications, e.g., all medications taken (prescribed and over the counter), prescribing physicians, medication sensitivities, and current dosages.
- Physicians involved with care.
- Prosthetic and orthotics information, e.g., the provider, components, history, and dates of service.
- Risk factors.
- Swallowing.
- Vision and hearing.

The person served already has a system in place to store and track personal health information that he finds works well. The program assists with updating the developed system. The updating activities are incorporated into therapy and rehabilitation nursing sessions to encourage the understanding and appreciation of the person served that ongoing revisions will be necessary to keep the information current.

The person served has used a notebook to track personal health information but desires to transition to a web-based application that can be accessed through her smart phone. The program assists with updating the information in the new preferred format.

The person served has never stored or tracked her personal health information in a manner that could be accessed and available for appointments with healthcare providers and health encounters such as filling new prescriptions or seeking repairs of medical devices. The program assists with the development of a system that is appropriate for the person served. Discussions and activities related to developing the system are incorporated into rehabilitation nursing and therapy sessions. The system is updated throughout the person's rehabilitation program as health information changes to ensure that the person served understands how to use the tool.

Determination of an appropriate system considers who will be responsible for maintaining the system and the skills, resources, and time required for maintenance. For example, the responsible person might be a daughter who prefers use of a computer to update information, a spouse who will keep a notebook, or the person served who prefers use of a single sheet of paper that can be carried in a wallet.

Resources

Please refer to Appendix D for resources related to personal health information systems and tools.

Applicable Standards

See the guidelines on page 143 for applicability of Standards 28.–29.

2.C. **28. To meet the needs of persons served, the service identifies the services/programs that it provides directly or with which it links in each of the following areas:**

- **a. Emergent care.**
- **b. Acute hospitalization.**
- **c. Inpatient rehabilitation program.**
- **d. Long-term care hospital.**
- **e. Skilled nursing care.**
- **f. Home care.**
- **g. Hospice.**
- **h. Day hospital.**
- **i. Outpatient programs.**
- **j. Community-based services.**
- **k. Adult day programs.**
- **l. Residential services.**
- **m. Vocational services.**
- **n. Primary care.**
- **o. Specialty consultants.**
- **p. Long-term care.**

Intent Statements

The service provides or links with services/programs in a variety of ways. Some services may have a full continuum within their own health systems, some may have most but not all services and link with other providers in the community, and some may link with programs or services outside of their local community such as nationally recognized centers or services for persons served. At a minimum, the service should be knowledgeable about available community resources and either contract with or assist the persons served to access information about the services/programs available in each of the areas listed in the standard.

Examples

The service might compile a resource guide that addresses each of the programs/services, including contact information.

28.j. Community-based services might include independent living, transportation services, city parks and recreation, home and community-based services, and emergency services for disaster preparedness.

2.C. **29. For all services/programs provided directly or with which it links, the service:**

- **a. Defines its relationships with the services/programs.**
- **b. Defines responsibilities of the services/programs.**
- **c. Identifies key communication contacts within the services/programs.**
- **d. Acts as a resource in establishing personnel competencies for the services/programs identified related to the specialized needs of the persons served.**

Examples

29.d. Acting as a resource to services/programs in establishing personnel competencies might include providing inservice training and education for providers, articles, case studies, etc.

Applicable Standards

If seeking accreditation for an Amputation Specialty Program, Standard 30. must be met.

2.C. **30. The amputation specialty program identifies the services/programs that it provides directly or with which it links in the following areas:**

- **a. Renal dialysis centers.**
- **b. Prosthetic services.**
- **c. Orthotic services.**
- **d. Pedorthic services.**
- **e. Foot care services.**

Intent Statements

This standard expands upon Standard 2.C.28., which addresses services/programs that the program provides directly or with which it links.

Applicable Standards

If seeking accreditation for a Spinal Cord Specialty Program, Standard 31. must be met.

2.C. **31. The spinal cord specialty program identifies the programs/services that it provides directly or with which it links in the following areas:**

- **a. Behavioral health.**
- **b. Independent living centers.**
- **c. Clinical research centers.**
- **d. Consumer advocacy organizations.**
- **e. Driver rehabilitation.**

Intent Statements

This standard expands upon Standard 2.C.28., which addresses services/programs that the program provides directly or with which it links.

Examples

50.e. Driver rehabilitation might include assessment, training, and retraining.

D. The Rehabilitation and Service Process for Specific Diagnostic Categories

Applicable Standards

The standards in this section are applicable to the following programs in Section 3, based on the diagnostic categories of persons served in the program:

- Comprehensive Integrated Inpatient Rehabilitation Program
- Outpatient Medical Rehabilitation Program
- Residential Rehabilitation Program
- Home and Community Services, if providing therapeutic or nursing interventions as part of the individualized service plan
- Vocational Services
- Interdisciplinary Pain Rehabilitation
- Occupational Rehabilitation
- Case Management

Applicable standards for these programs are as follows:

- Standards 2.D.1.–4. if the program serves *any* persons with limb loss and Amputation Specialty Program accreditation is not sought
- Standards 2.D.5.–11. if the program serves *any* persons with acquired brain injury and accreditation as a Brain Injury Specialty Program is not sought
- Standards 2.D.12.–24. if the program serves *any* persons with spinal cord dysfunction and accreditation as a Spinal Cord Specialty Program is not sought

Standards for Persons Served with Limb Loss

Applicable Standards

Standards 1.–4. must be met if the program/service serves *any* persons with limb loss and is not seeking accreditation as an Amputation Specialty Program.

2.D. **1. If the program/service serves any persons with limb loss, depending on the needs of the persons served, the program/service provides or makes arrangements for:**

- **a. Limb loss education regarding self-management, including, but not limited to:**
  - **(1) Management of secondary complications.**
  - **(2) Skin care.**
  - **(3) Prosthetic options.**
  - **(4) Fit of the prosthesis.**
  - **(5) Accuracy of information received regarding prosthetic issues.**
- **b. Peer support.**
- **c. Family/support system support.**
- **d. Prosthetic services.**
- **e. Orthotic services.**
- **f. Pedorthic services.**
- **g. Environmental modification.**
- **h. The provision of durable medical equipment.**
- **i. Training in the use of durable medical equipment.**
- **j. Psychological services.**
- **k. Sexual counseling.**
- **l. Specialty consultants.**
- **m. Substance use counseling and treatment.**
- **n. Smoking cessation.**
- **o. Strategies that address health and medical conditions, including, but not limited to:**
  - **(1) Diabetes management.**
  - **(2) Pain management.**
  - **(3) Regular preventive:**
    - **(a) Foot care.**
    - **(b) Limb care.**
  - **(4) Cardiovascular management.**
  - **(5) Risk reduction.**
  - **(6) Wound care.**
  - **(7) Skin care/integrity.**
  - **(8) Fitness and exercise promotion.**
  - **(9) Nutrition.**

Examples

1.a.(3) Information provided might include whether or not a prosthesis is appropriate or indicated and prosthetic options best suited to the individual's lifestyle.

1.a.(4) Information provided might include what to expect in a comfortable prosthetic fit, impact on gait, and management of the residual limb.

1.a.(5) Persons served could be educated on how to determine the accuracy of information obtained from sources such as internet websites.

1.b. Peer support might facilitate successful life transitions, adjusting to disability, and awareness of and access to community resources and activities.

1.g. Environmental modification could include home or workplace modifications, bathrooms, ramps, appliances, clothing, or automobile adaptations.

1.l. Specialty consultants could include vascular surgeons, plastic or reconstructive surgeons, endocrinologists, and diabetes specialists.

1.o.(2) Persons served may experience phantom pain as well as skin, muscular, nerve, or bone pain. Examples of approaches to pain management include cognitive strategies, desensitization, pharmacologic intervention, and modalities such as transcutaneous electrical nerve stimulation (TENS) units.

2.D. **2. If the program/service serves any persons with limb loss, depending on the needs of the persons served, the program/service provides or arranges for diagnostic services, including, but not limited to, the following areas:**

- **a. Vascular disease.**
- **b. Diabetes management.**
- **c. Trauma.**
- **d. Oncology.**

Intent Statements

Diagnostic services may be required to assess or prevent complications, prevent further limb loss, assess comorbidities, or determine effectiveness of treatments for conditions underlying or contributing to limb loss.

Examples

2.c. Diagnostic services might be related to complications of traumatic amputation or comorbidities associated with the trauma. Examples include radiology services to verify or exclude sources of residual limb pain such as improper bone contouring, disproportionate bone lengths in transtibial or transradial amputation, or heterotopic bone formation. Comorbidities associated with trauma of blast injuries or automobile accidents might include brain injury with resultant cognitive impairments, multiple fractures, or post-traumatic stress.

2.D. **3. Personnel who serve any persons with limb loss demonstrate competencies in amputation management.**

Examples

These competencies can be obtained through formal education; continuing education focused on limb loss and management of amputation; on-the-job training; mentorship by experienced personnel; and ongoing access to books, periodicals, videos, and audio recordings.

Resources to enhance or improve personnel competencies through educational opportunities include the Amputee Coalition of America, American Academy of Orthotists and Prosthetists, professional organizations, and professional journals.

2.D. **4. The program/service has access to local, regional, provincial, national, or international networks or agreements to facilitate specialized amputation management.**

Intent Statements

These networks encompass community, medical, educational, and evaluative linkages.

Examples

The American Academy of Orthotists and Prosthetists, Amputee Coalition of America, and National Limb Loss Information Center are examples of networks that could be accessed by the program/service as appropriate.

Standards for Persons Served with Acquired Brain Injury

Applicable Standards

Standards 5.–11. must be met if the program/service serves *any* persons with acquired brain injury and is not seeking accreditation as a Brain Injury Specialty Program.

2.D. **5. For each person served the program/service addresses the impact of behavior, cognition, communication, medical, and sensory deficits on the following areas:**

- **a. Physical function.**
- **b. Psychological function.**
- **c. Social function.**
- **d. Vocational function.**
- **e. Education.**
- **f. Family dynamics.**
- **g. Participation.**

Examples

Sensory deficits might include visual, auditory, or vestibular deficits or the inability to regulate one's body temperature.

5.e. This might involve determining how to provide education to the person served. Education might also involve identifying and making

recommendations to community schools regarding the best way to provide information or special accommodations to be made if the person served will be returning to school, college, or vocational training.

5.f. Family dynamics might address changes in roles and relationships within the family.

5.g. Participation might include the person's ability to return to school or work, play with grandchildren, participate in a poker or bridge group, volunteer in the community, eat out with friends, or attend worship services.

2.D. **6. Initial and ongoing risk assessments for each person served:**

- **a. Address the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Developmental.**
  - **(5) Emotional.**
  - **(6) Environmental.**
  - **(7) Medical.**
  - **(8) Physical.**
  - **(9) Capability of the family/support system.**
  - **(10) Financial resources.**
  - **(11) Legal.**
  - **(12) Other, as appropriate.**
- **b. Are incorporated into:**
  - **(1) The assessment process.**
  - **(2) Individual program planning.**
  - **(3) Discharge/transition planning.**

Intent Statements

Initial and ongoing risk assessments allow the team to address the changing needs of the person served throughout the program/service and in its planning for discharge or transition to the next level of care.

Examples

Risk assessments may be incorporated into individual assessments by team members or addressed by the team at meetings about the person served.

6.a.(1) A behavioral risk may be the risk of a person served attempting to elope from an inpatient or residential program or leave home without supervision, or a person who expresses the potential to harm himself/herself or others.

6.a.(6) Environmental risks may include safety risks in the home such as stairs, throw rugs, a lack of grab bars in the shower, or balconies without proper barriers.

6.a.(7) An example of a medical risk might be lack of sleep or nutrition compromise related to swallowing problems, the person's inability to safely prepare meals when home alone, lack of money or transportation to shop for food, and/or lack of appetite.

6.a.(8) A person served with obesity may be at a higher risk for falling or causing injury to a caregiver.

6.a.(10) Addressing risks related to financial resources might include education on conserving or managing financial resources to ensure the most effective use of resources to meet ongoing needs.

6.a.(11) Legal risks may include a person's history of driving under the influence of alcohol, as a sex offender, or the need to address legal status related to decision making.

2.D. **7. The program/service demonstrates knowledge of and coordination with local, regional, provincial, national, or international networks or agreements to facilitate:**

- **a. Specialized brain injury services.**
- **b. Use of appropriate subspecialties.**
- **c. Advocacy.**

2.D. **8. The program/service addresses the impact of brain injury on the family/support system of the person with brain injury, including, but not limited to the person's:**

- **a. Children.**
- **b. Siblings.**
- **c. Spouse/significant other.**

d. Parents.

e. Other members of the support system.

Intent Statements

Please refer to the Glossary for a definition of *family/support system*.

The impact on various members of the person's family/support system may include anger, depression, denial, financial hardship, embarrassment, fear, abandonment, or divorce/separation.

2.D. **9. The program/service creates an environment that supports appropriate relationships between personnel and the persons served.**

Intent Statements

In accordance with the organization's ethical codes of conduct, personnel maintain professional relationships and appropriate boundaries with persons served.

Examples

Persons served are referred to by their preferred form of address rather than other informal terms or names.

Personnel socialize with persons served in the context of therapeutic activities provided by the program but do not involve persons served in personal relationships or activities.

The therapist providing services in the community does not ask the person served who is a mechanic to do her a favor and work on her car.

The director of the residential program does not ask the person served who is an electrician to do repairs on the residence in order to save on expenses.

The residential aide who works overnight wears appropriate clothing rather than pajamas.

2.D. **10. The program/service minimizes complications related to:**

a. Family/support system dynamics.

b. Discharge/transition planning.

c. Follow-up.

Examples

10.b.–c. For the person served to make a successful transition to the next level of services or home, potential complications are anticipated and addressed. For example, if the discharge plan involves the person going home it is important to ensure that members of the family/support system are available and prepared to address the needs of the person served in the home environment. Or, if home adaptations are necessary they are identified and planned in advance so they can be completed by the time of discharge or soon thereafter.

Follow-up plans are clearly communicated to all parties and appointments, arrangements, and expectations are specified and followed through. If transportation is not available, community resources to assist with transportation to appointments are provided.

2.D. **11. Education for personnel that addresses the unique needs of persons with brain injury:**

a. Is provided at:

(1) Orientation.

(2) Regular intervals.

b. Includes, but is not limited to:

(1) Neuroanatomy.

(2) Etiology and epidemiology of acquired brain injury.

(3) Facilitating behavioral supports.

(4) Facilitating cognitive interventions.

(5) Facilitating communication interventions.

(6) Recognition and reporting of suspected abuse and neglect.

(7) Setting and maintaining professional boundaries.

(8) Medical complications.

(9) Risks associated with brain injury.

Intent Statements

Education is provided to both clinical and non-clinical personnel who have regular contact with persons served and their families/support systems.

Standards for Persons Served with Spinal Cord Dysfunction

Applicable Standards

Standards 12.–24. must be met if the program/service serves *any* persons with spinal cord dysfunction but is not seeking accreditation as a Spinal Cord Specialty Program.

Spinal cord dysfunction could be caused by trauma; cancer involving the spinal cord; inflammatory conditions, such as multiple sclerosis; and nontraumatic etiologies, such as myelopathies, vascular events, or infections.

2.D. **12. The documented scope of the program addresses:**

- **a. The etiology of spinal cord dysfunction.**
- **b. Levels of spinal cord injury.**
- **c. Completeness of spinal cord dysfunction.**
- **d. Comorbidities.**

Intent Statements

This standard expands upon Standards 2.A.1. and 2.B.1., which address the scope of the program.

Defining the scope provides the program with an opportunity to carefully consider its expertise and resources to meet the needs of persons with spinal cord dysfunction. Sharing the scope with potential persons served, families/support systems, referral sources, payers, and other relevant stakeholders provides information that helps them understand what the program has to offer and determine whether it will meet the needs of the persons served.

Note: *A Comprehensive Integrated Inpatient Rehabilitation Program would meet Standard 3.A.8. in place of Standard 2.D.13.*

2.D. **13. To meet the needs of the persons served, the program provides or arranges for diagnostic services to screen for and assess the status of:**

- **a. Bladder function.**
- **b. Bowel function.**
- **c. Cardiac function.**
- **d. Cognitive function.**
- **e. Metabolic function.**
- **f. Musculoskeletal function.**
- **g. Neurological function.**
- **h. Psychological function.**
- **i. Respiratory function.**
- **j. Sexual function.**
- **k. Skin integrity.**
- **l. Swallowing.**
- **m. Thromboembolic disease.**
- **n. Other common secondary health conditions.**

Examples

13.d. Assessment may address the presence of traumatic brain injury, dementia, learning disabilities, etc.

13.h. The program may screen for anxiety, depression, PTSD, anger issues, substance use, or other psychological conditions to determine whether additional assessments or services are indicated.

13.n. Other common secondary conditions might include traumatic brain injury, pain, substance use, comorbid conditions such as diabetes or high blood pressure, etc.

2.D. **14. On an ongoing basis, the program addresses the impact of spinal cord dysfunction on the family/support system of the person served, including, but not limited to his or her:**

- **a. Children.**
- **b. Parents.**
- **c. Siblings.**
- **d. Spouse/significant other.**
- **e. Other members of the support system.**

Intent Statements

Please refer to the Glossary for the definition of *family/support system.*

Examples

The impact on various members of the person's family/support system may include abandonment, anger, denial, depression, divorce,

separation, embarrassment, fear, and/or financial hardship.

14.a. Children may be self-conscious about having a parent who uses a power wheelchair attend parent-teacher conferences or their sports events.

14.b. Parents are trying to balance the needs of their child with spinal cord dysfunction and the needs of their other children and family members.

14.c. A young child may not understand why her older sister with a spinal cord injury cannot play with her the same way she used to.

14.d. The spouse/significant other of the person served may be resentful of having to take on additional responsibilities related to childcare and/or household upkeep.

14.e. Other members of the support system might include friends and colleagues who are concerned but limit conversation about the person served in order to maintain her privacy. In the case of a person served who is elderly, caregivers who already had a relationship with the person might wonder if they could have done something to prevent the injury or worry whether they have the skills to continue providing support.

2.D. **15. The program addresses the mobility needs of the persons served, including practice in home and community settings.**

Intent Statements

This standard expands upon Standard 2.B.33., which addresses the equipment and supplies needed for each person served. Instruction and training in the use of postural and seating supports, wheeled mobility, ambulation aids, etc. includes practice in the settings in which the person served functions.

2.D. **16. As desired by the persons served and their families/support systems, individual plans address:**

- **a. Intimacy.**
- **b. Sexual health issues.**

Examples

Individual plans may address:

- Referrals to urology, OB/GYN, or sexual counseling.
- Couples counseling.
- Education on the impact of spinal cord dysfunction on relationships, sexual desire and function, fertility and birth control, and the body's response to intimacy, e.g., neurological, skin, vital signs, and bowel and bladder response.
- Opportunities for intimacy for the person served and his or her partner during rehabilitation.

2.D. **17. The program provides a systematic education program about spinal cord dysfunction that:**

- **a. Is appropriate to the needs of:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **b. Considers the readiness of the person served and the family/support system to receive the education.**
- **c. Is reinforced:**
  - **(1) Among members of the interdisciplinary team.**
  - **(2) Throughout the rehabilitation process.**
- **d. Provides for, but is not limited to, education regarding:**
  - **(1) Medical/physiological sequelae.**
  - **(2) Function.**
  - **(3) Psychosocial issues.**
  - **(4) Transitions across the lifespan.**
  - **(5) Resource management.**
  - **(6) Health promotion and wellness.**
  - **(7) Independent living and community integration.**
  - **(8) Prevention related to potential risks and secondary health conditions.**
  - **(9) Safety for persons served in the environments in which they participate.**

Examples

Education can occur in a variety of ways, such as classroom/lecture style, one-on-one, peer supporter, videos, audio recordings, or written information.

17.c. The rehabilitation nurse, rehabilitation physician, occupational therapist, physical therapist, recreation therapist, and peer supporter reinforce the importance of relieving pressure on the skin during their individual encounters with the person served and his or her family/support system.

Proper transfer techniques are reinforced by team members during all therapy sessions and bedside activities with the person served.

17.d.(3) Psychosocial issues might include prognosis for recovery, adjustment to disability, role changes, mental health needs, cultural adjustment issues, delineation of roles, and social perceptions.

17.d.(9) Education might include risks to be aware of in the environment, use of wheeled mobility in a variety of settings, how members of the family/support system can safely and effectively assist the person served, and emergency preparedness at home and in the community.

2.D. **18. The program provides information to the persons served and their families/support systems about laws and regulations pertaining to the following, as appropriate:**

- **a. Accessibility.**
- **b. Education.**
- **c. Employment.**
- **d. Health.**
- **e. Rights.**
- **f. Social supports.**

2.D. **19. The program educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.**

Intent Statements

The health and safety of persons served is paramount. However, in a person-centered approach to service delivery, the preferences of the person served may take precedence over the advice of family members, providers, or others. Under these circumstances the program educates the persons served about the consequences associated with choices and behaviors that pose potential risks to their health or safety, providing the opportunity for the persons served to make an informed decision to engage or not engage in the behavior.

Examples

The program educates the person served about the risks of choosing to:

- Continue smoking cigarettes or drinking alcohol following a spinal cord injury.
- Not use a shower chair or walker when there are known issues with balance.
- Not follow through with changing positions to relieve pressure on the skin.
- Not follow through with the prescribed medication or bowel and bladder regimen.
- Continue using the stove when home alone despite sensory or cognitive deficits.

2.D. **20. In accordance with their needs, the program provides or arranges for education to the persons served about paid personal assistant services, including:**

- **a. The need for personal assistants.**
- **b. Access to funding.**
- **c. Hiring.**
- **d. Expectations of the person served.**
- **e. How to direct care.**
- **f. Training personal assistants.**
- **g. Boundaries.**
- **h. Recognizing and reporting:**
  - **(1) Abuse.**
  - **(2) Neglect.**
- **i. Termination.**

Intent Statements

The program may directly provide education about personal assistant services or partner with another resource to provide it.

Examples

20.c. The program may provide information about and links to websites and other resources where the person served can find qualified candidates.

20.d. Expectations of the person served may include both expectations of behavior and responsibilities of the paid personal assistant in the employer/employee relationship and expectations of the person served as an employer to treat the assistant respectfully.

20.g. Education on boundaries might address personal relationships between the person served and personal care assistant, witnessing or co-signing of legal or financial documents, social media engagement, and the personal care assistant entering into the person's family dynamics.

Resources

- Managing Personal Assistants: A Consumer Guide: **www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/persasstfc6d.pdf**
- Hiring and Management of Hiring and Management of Hiring and Management of Personal Care Assistants Personal Care Assistants for Individuals with Spinal Cord Injury: **www.tbi-sci.org/pdf/pas.pdf**
- Spinal Cord Injury or Disorder (SCI/D): Hiring a Caregiver/Personal Assistant: **www.veteranshealthlibrary.org/142,41199_VA**
- How to Successfully Hire and Manage a Personal Care Assistant—for People with Spinal Cord Injury: **www.sfphysio.fr//docs/2015131740_how-to-successfully-hire-and-manage-a-personal-care-assistant-for-people-with-spinal-cord-injury.pdf**

2.D. **21. The program:**

- **a. Provides peer support services that:**
  - **(1) Reflect the characteristics of the persons served.**
  - **(2) Address the preferences and choices of the persons served.**
  - **(3) Address the needs of the persons served.**
- **b. Engages peer supporters in the rehabilitation process of the persons served, including, but not limited to:**
  - **(1) Support.**
  - **(2) Education.**

Examples

21.a. Peer supporters assigned reflect the ages, characteristics, interests, and life roles of the persons served to facilitate effective guidance.

21.b. Peer support might facilitate successful life transitions; adjustment to disability; and awareness of and access to community resources, advocacy groups, and activities.

2.D. **22. The program minimizes barriers related to:**

- **a. Family/support system.**
- **b. Discharge/transition planning.**
- **c. Follow-up.**

Examples

22.a. Barriers could include the dynamics of the family/support system, family responsibilities or lack of transportation that prohibit involvement with program, financial issues that put the family at risk, and unrealistic family expectations for recovery.

22.b. Barriers could include lack of provider resources with expertise in spinal cord dysfunction in the local community of the person served, accessibility barriers in the person's home, and delays in obtaining needed durable medical equipment.

2.D. **23. Health and wellness for the persons served are promoted through activities that:**

- **a. Are based on input from the persons served.**
- **b. Reflect their choices.**
- **c. Consider input from families/ support systems.**
- **d. Consider prior level of participation of the persons served in health and wellness activities.**
- **e. Provide for structured and unstructured activities.**
- **f. Promote healthy attitudes and behavior.**
- **g. Align with their cognitive capabilities.**
- **h. Align with their communication capabilities.**
- **i. Align with their physical capabilities.**
- **j. Promote their personal growth.**
- **k. Promote self-responsibility.**
- **l. Enhance their self-image.**
- **m. Improve or maintain their functional levels.**
- **n. Allow for social interaction.**
- **o. Allow for autonomy.**
- **p. Facilitate opportunities for community inclusion.**
- **q. Are documented in the individual plan for each person served.**

Examples

Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

23.e. Examples of ways to provide for unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large-print and audio books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
- Persons served have access to websites and literature on volunteer opportunities in the community.
- Brochures and pamphlets listing activities offered at local community centers are available in the outpatient waiting room.

Resources

Please refer to Appendix D for resources related to wellness.

2.D. **24. Documented, competency-based education is provided to personnel that includes, but is not limited to:**

- **a. Medical/physiological sequelae.**
- **b. Function.**
- **c. Psychosocial issues.**
- **d. Transitions across the lifespan.**
- **e. Resource management.**
- **f. Health promotion and wellness.**
- **g. Resources for independent living and community integration.**
- **h. Prevention related to potential risks and secondary health conditions.**
- **i. Safety for persons served in the environments in which they participate.**

Intent Statements

Competency-based training for personnel relates to the scope of the program as defined in Standard 12. in this section and the personnel resources and expertise required to execute the scope.

E. The Rehabilitation and Service Process for Children and Adolescents Served

Applicable Standards

Section 2.E. standards are applicable to the following programs in Section 3 and optional specialty program designations in Section 4 if *any* children/adolescents are served in the program and the program is not seeking accreditation as a Pediatric Specialty Program:

- Section 3. Program Standards
  - 3.A. Comprehensive Integrated Inpatient Rehabilitation Program
  - 3.B. Outpatient Medical Rehabilitation Program
  - 3.D. Residential Rehabilitation Program
  - 3.F. Interdisciplinary Pain Rehabilitation Program
  - 3.G. Occupational Rehabilitation Program
  - 3.I. Case Management

Note: *Section 2.E. is not applicable to Sections 3.C. Home and Community Services, 3.E. Vocational Services, and 3.H. Independent Evaluation Services.*

- Section 4. Specialty Program Designation Standards
  - 4.B. Amputation Specialty Program
  - 4.C. Brain Injury Specialty Program
  - 4.D. Cancer Rehabilitation Specialty Program
  - 4.E. Spinal Cord Specialty Program
  - 4.F. Stroke Specialty Program

Note: *Section 2.E. is not applicable to Section 4.A. Pediatric Specialty Program or to specialty programs linked to Home and Community Services.*

A person served is defined as a child/adolescent if the individual is under the age at which one is legally recognized as an adult in a given state/province. Refer to the Glossary for a definition of child/adolescent.

Emancipated minors are individuals who are under the age at which a state or province would legally recognize them as adults but who have had parental control over them legally terminated. In those states or provinces that recognize emancipated minors, those individuals are considered adults for the purposes of the CARF standards.

2.E. **1. Information shared with the public, prospective persons served and their families/support systems, and other relevant stakeholders specifies:**

a. The age range of the children/adolescents served.

b. The number of children/adolescents served annually by age group.

Intent Statements

This information is pertinent to the decision-making process related to whether a program is appropriate to meet the needs of a prospective child/adolescent served.

Examples

Information could be found in brochures, marketing information, outcomes information, admission criteria, or on the organization's website.

2.E. **2. If the program is an inpatient or residential rehabilitation program, it has policies and written procedures that address the opportunity for families to remain with the children/adolescents served 24 hours a day if desired by both the family and the child/adolescent and deemed appropriate by the program.**

2.E. **3. Opportunities for visits are provided to:**

- **a. Members of the families/support systems, including siblings, of the children/adolescents served.**
- **b. Peers of the children/adolescents served.**

2.E. **4. Based on the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the persons served, the following are provided:**

- **a. Appropriate assessments.**
- **b. Designated space.**
- **c. Equipment.**
- **d. Furniture.**
- **e. Materials.**
- **f. Private areas for family and peer visitation, as appropriate.**
- **g. Schedules that reflect the needs of each child/adolescent served.**

Intent Statements

4.b. Providing designated space does not require that the space be exclusively used or maintained for children and adolescents. The expectation is that the organization, at a minimum, identifies space that can be adapted as needed to meet the needs of this population.

4.g. Schedules might be adjusted to accommodate visits from peers after school hours, rest or nap times, etc.

2.E. **5. The team serving children/adolescents includes, as needed:**

- **a. A developmental specialist.**
- **b. An educational specialist.**

Intent Statements

5.a. A developmental specialist is an individual who is competent in child/adolescent development.

Examples

5.a. A pediatrician, child psychologist, special educator, or child life specialist might fulfill the role of developmental specialist.

5.b. A special or regular education teacher would fulfill the role of the educational specialist.

2.E. **6. Personnel who serve children/adolescents demonstrate competencies in rehabilitation, including, but not limited to:**

- **a. Normal growth and development.**
- **b. Family-centered care, including:**
  - **(1) Communication with families/support systems.**
  - **(2) Facilitating active involvement of the family/support system in the rehabilitation process.**
- **c. Behavior management.**
- **d. Sexuality, including:**
  - **(1) Normal development.**
  - **(2) After the onset of injury, illness, or impairment.**
- **e. Knowledge of the education system and resources.**
- **f. Recognition and reporting of suspected abuse and neglect.**
- **g. Setting boundaries.**
- **h. The use of play to facilitate therapeutic interventions.**

Examples

These competencies can be obtained through formal education or continuing education focused on children/adolescents; on-the-job training; mentorship by experienced personnel; and ongoing access to books, periodicals, videos, and audio recordings.

6.d. Personnel competencies might address normal sexual exploration and expression across the developmental span, e.g., body image, flirting, and relationships; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

6.g. The therapeutic relationship requires the establishment of rapport as well as appropriate limits on behaviors. Education might include topics such as refraining from establishing a degree of friendship with a child/adolescent served such that the provider's role as an adult and/or the parents' authority is compromised, recognizing that even though providers and family members may disagree about what is best for the child the parent is the final authority regarding the child, and the adaptive balance of emotional engagement and distance in a child and family's care so that providers are invested in the persons served but their roles as professionals are not compromised.

2.E. **7. Because the family system is the focal point of services, members of the family/support system are considered and involved as partners in all phases of the program, except where exclusion is justified and appropriate.**

Intent Statements

Exclusion may be justified when legal parental rights have been terminated, when there are restrictions on visitation or involvement with the child/adolescent, or when a family member's involvement in the particular phase of the program is deemed by the professional providing services to be detrimental to the child/adolescent.

2.E. **8. Based on the individual needs of the child/adolescent served, educational services reflect an appropriate education plan that complies with current state, provincial, and federal laws.**

Examples

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

2.E. **9. To facilitate communication and transition of the child/adolescent served to the community school, information is exchanged between the program and the school system:**

- **a. At critical decision-making points in the rehabilitation process of the child/adolescent served.**
- **b. Including, but not limited to:**
  - **(1) Preonset school and/or work records.**
  - **(2) Preparation of the school for transition of the child/adolescent from the program to school.**
  - **(3) Assessment of modifications and adaptations of the environment.**
  - **(4) Preparation for transition from school to work and/or vocational training.**
  - **(5) Involvement in planning for transitional or supported living programs.**

Examples

9.a. Critical decision-making points might include the time of initial assessment to help determine premorbid skills, at development of the plan to support a return to the classroom, or at the time of significant changes that might require a change in the availability of classroom support.

2.E. **10. The program has access to local, regional, provincial, national, or international networks or agreements to facilitate:**

- **a. Specialized pediatric care.**
- **b. The use of pediatric subspecialties.**

Intent Statements

These networks encompass community, medical, educational, and evaluative linkages.

2.E. **11. To address the general healthcare needs of the children/adolescents served, the program provides or arranges for the services of a pediatrician or family practice physician.**

Examples

General healthcare needs might include immunizations or the monitoring of medications unrelated to the child/adolescent's participation in the rehabilitation program.

2.E. **12. To facilitate transition to the community, an individualized plan is established for each child/adolescent served that includes:**

- **a. As appropriate, identification of other resources in the community that are or will be involved with the child/adolescent served.**
- **b. A plan for transition from the program, including mechanisms for interagency coordination.**

Examples

12.b. The plan for transition of the child/adolescent to the community might address coordination with agencies such as city parks and recreation, girl scouts and boy scouts, boys and girls clubs, youth groups, church groups, and group sports.

2.E. **13. With the consent of the family/support system and the permission of the child/adolescent served, information about activity limitations and participation restrictions is provided to the:**

- **a. Siblings of the children/adolescents served.**
- **b. Peers of the children/adolescents served.**

Examples

Information on activity limitations may be provided to siblings who will be assisting the child/adolescent served with dressing or feeding activities. Information may be given to peers who will assist the child/adolescent served by being a companion in the classroom or pushing the child's wheelchair at recess so he or she can participate in games and activities.

2.E. **14. The tools used to measure satisfaction and feedback are age and developmentally appropriate to elicit input from the children/adolescents served.**

Intent Statements

The program strives to capture information that is meaningful to the children/adolescents served and their families/support systems as well as to the program itself for use in performance improvement efforts. Depending upon the ages and developmental levels of the children/adolescents served, the program may need to use more than one tool to elicit input on satisfaction and feedback.

2.E. **15. The education and training program for the family/support system addresses:**

- **a. Knowledge of and capacity to describe and discuss:**
  - **(1) Ability.**
  - **(2) Activity.**
  - **(3) Participation.**
- **b. Transition to:**
  - **(1) Home.**
  - **(2) School.**
  - **(3) The community.**
- **c. Normal growth and development, including age-appropriate:**
  - **(1) Social skills.**
  - **(2) Behaviors.**
- **d. Accessing emergency care if necessary.**
- **e. Specific healthcare procedures and techniques.**
- **f. Sexuality, including:**
  - **(1) Normal development.**
  - **(2) After the onset of injury, illness, or impairment.**
- **g. Therapeutic home programs.**
- **h. Prognoses.**
- **i. Realistic goals.**

j. Safety issues related to:
- **(1) Delivery of care.**
- **(2) The service delivery site.**

k. Information about:
- **(1) Allergies.**
- **(2) Precautions.**

l. Information on respite care.

m. Training in the use of assistive technology and adaptive devices and toys.

n. Passenger safety, including:
- **(1) Laws.**
- **(2) Appropriate use of equipment.**

o. The medical condition and anticipated long-term issues of the child/adolescent.

Examples

The education program could be provided using a variety of methods such as one-on-one teaching, formal groups, and lectures; videos or audio recordings; written information; and computerized programs.

15.d. Education on emergency care might address knowing when the child/adolescent needs emergency care versus when contacting the primary care physician or nurses advice line is more appropriate, when other children in the family need emergency care, or how to dial 911.

15.f. Education for the family/support system might address normal sexual exploration and expression across the developmental span, e.g., body image, flirting, and relationships; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

15.j.(1) Education on safety issues related to the delivery of care might address the importance of hand washing and maintaining a sterile field for dressing changes, or properly disposing of needles and syringes used in insulin injections.

15.j.(2) Education on safety issues related to the service delivery site might be instructing an adolescent to stay in a given spot when waiting for his parents to pick him up after outpatient therapy, or what to do if the sidewalks between the group home and the recreation building are covered with snow or ice.

15.k. Education on allergies might address allergies to latex, food, and the environment; signs and symptoms that would indicate an allergic reaction; information on precautions that could address where to buy products that will be needed; new ideas for preparing special diets; etc.

Section 3

Program Standards

A. Comprehensive Integrated Inpatient Rehabilitation Program

Description

A Comprehensive Integrated Inpatient Rehabilitation Program is a program of coordinated and integrated medical and rehabilitation services that is provided 24 hours a day and endorses the active participation and preferences of the person served throughout the entire program. The preadmission assessment of the person served determines the program and setting that will best meet the needs of the person served. The person served, in collaboration with the interdisciplinary team members, identifies and addresses his or her medical and rehabilitation needs. The individual resource needs and predicted outcomes of the person served drive the appropriate use of the rehabilitation continuum of services, the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice.

The scope and intensity of care provided are based on a medical and rehabilitation preadmission assessment of the person served. An integrated interdisciplinary team approach is reflected throughout all activities. To ensure the transparency of information the program provides a disclosure statement to each person served that addresses the scope and intensity of care that will be provided.

A Comprehensive Integrated Inpatient Rehabilitation Program clearly identifies the scope and value of the medical and rehabilitation services provided. Dependent on the medical stability and acuity of the person served, a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, skilled nursing facility, long-term care hospital, acute hospital (Canada), or hospital with transitional rehabilitation beds (Canada). Through a written scope of services, each program defines the services provided, intensity of services, frequency of services, variety of services, availability of services, and personnel skills and competencies. Information about the scope of services and outcomes achieved is shared by the program with stakeholders.

Applicable Standards

An organization seeking accreditation for a Comprehensive Integrated Inpatient Rehabilitation Program must meet the program description and all standards in this section.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.A. **1. To facilitate the disclosure of accurate information, the comprehensive integrated inpatient rehabilitation program documents and shares information about its specific arrangements for:**

a. Medical services.

b. Diagnostic imaging.

c. Laboratory services.

d. Pharmacy services.

e. Including for each:

(1) Availability on site.

(2) Capacity.

(3) Timeliness of response to orders.

(4) Timeliness of results to the clinician who is making a decision based on those results.

Intent Statements

This standard expands upon Standards 2.A.1. and 2.B.1., which address the scope of the program. In addition to the parameters in those standards, the program should document its arrangements for diagnostic imaging and for medical, laboratory, and pharmacy services and share this information with all groups listed in Standard 2.A.1.

A program clearly delineates where and how services are provided, e.g., at the facility where the program is located or through a contractual relationship with another provider in the community. The timeliness of information received, as well as the mechanism to get information to the appropriate party, is critical for decision making regarding the persons served.

Examples

1.e.(1) All services may be available through the same health system as the comprehensive integrated inpatient rehabilitation program; through a combination of on-site services and contractual services in the community; and/or, in some cases, services that require more sophisticated equipment may be remote.

1.e.(3)–(4) To allow an understanding of the responsiveness of these services, the timeliness of response to orders and results to the clinician might be expressed as a range.

3.A. **2. Policies and written procedures address:**

a. Physician services, including:

(1) Who provides medical management for the persons served.

(2) Who provides rehabilitation management for the persons served.

(3) When these are not the same physician, mechanisms for coordination, communication, and collaboration.

(4) Primary responsibility for medical management, including:

(a) Description of the role and responsibilities of the attending physician.

(b) Description of the roles and responsibilities of other physicians who provide concurrent medical services.

(c) Physician availability.

(d) Appropriate medical decision making.

(5) Availability of the rehabilitation physician or his or her designee 24 hours a day, 7 days a week.

(6) Access to consulting physicians to treat continuing, unstable, or complex medical conditions.

b. Rehabilitation nursing services, including assessment, implementation, and planning, as well as critical decision making regarding:

(1) Bowel and bladder.

(2) Carryover of skills newly acquired by the persons served.

(3) Education related to identified needs of persons served.

(4) Medical/surgical issues.

(5) Medications.

(6) Pain.

(7) Rehabilitation issues.

(8) Skin integrity.

c. Prevention, including:

(1) Prevention of further disability.

(2) Medical complications.

(3) Adverse events.

Intent Statements

The rehabilitation physician is a physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, pediatrician, etc.) who is qualified by virtue of specialized

training and experience in rehabilitation to provide rehabilitation management for the persons served. The rehabilitation physician clearly identifies medical necessity as well as continuing rehabilitation stay.

2.a.(5) A designee is another physician who is chosen by the rehabilitation physician to assist with providing coverage to meet the needs of the persons served.

Examples

Specialized training and experience for the rehabilitation physician may be demonstrated by a formal residency in physical medicine and rehabilitation, a fellowship in rehabilitation for a minimum of one year, or a minimum of two years' experience as a collaborative team member providing rehabilitation services.

2.a.(4)(c) The program addresses physician availability in the event the physician is ill, on vacation, called to jury duty, or attending CME.

2.b.(7) Rehabilitation issues may address the individual rehabilitation needs of the persons served in areas such as communication, activities of daily living, ambulation, durable medical equipment, etc., as well as issues such as regulations to which the program is subject, communication among nursing personnel and therapists on the interdisciplinary team, and training of temporary or float nursing personnel by nursing personnel who consistently work on the rehabilitation unit.

3.A. **3. The organization's privileging process defines:**

- **a. Which professionals require privileges to provide services in the comprehensive integrated inpatient rehabilitation program.**
- **b. Qualifications.**
- **c. Specific privileges granted.**
- **d. Specific responsibilities in accordance with the privileges granted.**
- **e. A system to monitor performance in executing the privileges granted.**
- **f. A system to address modification or withdrawal of privileges.**
- **g. A mechanism to demonstrate current competency relative to the privileges granted.**
- **h. A system to ensure that practice is consistent with the privileges granted.**

Intent Statements

The privileging process authorizes professionals to provide clinical services granted by a governing authority or in accordance with clinical staff bylaws. The organization determines which professionals are subject to the privileging process in order to provide services to persons served in the comprehensive integrated inpatient rehabilitation program. The privileging process may be implemented and monitored through the hospital or healthcare organization's credentialing system and medical or professional staff oversight. The credentialing and privileging process will clearly identify who the qualified rehabilitation physicians are and their role in preadmission, admission, continued stay and discharge/transition activities. This process should also assist with the identification of the roles of physician extenders, consulting physicians, residents/fellows and students.

3.A. **4. The program:**

- **a. Defines its admissions process.**
- **b. Defines its continuing stay criteria.**
- **c. Identifies the physician who is responsible for admission decisions.**
- **d. Communicates admission decisions to the referral source.**

Examples

4.a. In accordance with regulatory requirements, the admission process for a program serving a Medicare population in an inpatient rehabilitation facility (IRF) includes the clear and consistent documentation of the preadmission approval by the rehabilitation physician. Less than 48 hours prior to admission there is a review and a reconfirmation of the appropriateness of the admission by the physician. If individuals other than the physician gather the data there is evidence that the physician has supervised the licensed or certified professional. The appropriateness of the rehabilitation admission

is reaffirmed within 24 hours after admission. Confirmation of the appropriateness of admission is documented, for example, in the physician's history and physical.

3.A. **5. A documented preadmission assessment of each person served addresses:**

- **a. Diagnosis.**
- **b. Medical history and status.**
- **c. Comorbidities.**
- **d. Complications.**
- **e. Ongoing medical management needs.**
- **f. Mental status.**
- **g. Premorbid and current level of function.**
- **h. Support system.**
- **i. Prognosis.**
- **j. The scope of services recommended.**
- **k. The intensity of services recommended.**
- **l. Related to the scope and intensity of services recommended:**
  - **(1) The willingness of the person served to participate.**
  - **(2) The ability of the person served to tolerate the care proposed.**
  - **(3) Medical necessity for the level of care.**
  - **(4) The potential of the person served to benefit.**
- **m. Estimated length of stay.**
- **n. Additional needs, including:**
  - **(1) Cultural.**
  - **(2) Dietary.**
  - **(3) Equipment.**
  - **(4) Medications.**
  - **(5) Services.**
- **o. Funding.**
- **p. Alternative resources to address additional identified needs.**

Examples

5.n.(1) Please refer to the Glossary for a definition of *culture*.

3.A. **6. There is a process in place that ensures ongoing assessment of appropriate placement in the inpatient continuum of services.**

Examples

The surveyors will address throughout the survey process whether the persons served are in the appropriate portions of the continuum of services and whether the program has explored the options for the most appropriate use of resources as well as the needs of the persons served in placement. The preadmission information gathered will be valuable in this placement process.

Admission, continuing stay, and discharge/transition criteria; resources available and previously used; ongoing reassessment; and the person's potential to benefit might all be considered in the decision making process regarding placement in the continuum of services.

The following timeframes for assessment of appropriate placement in the inpatient service continuum are suggested in 2010 Medicare rules for inpatient rehabilitation facilities (IRF):

- Less than 48 hours prior to admission there is a review and approval or reconfirmation of appropriateness done by the rehabilitation physician. If the data have been gathered by others in the field then the rehabilitation physician must demonstrate how he or she has supervised those licensed or certified professionals.
- No later than 24 hours after admission, the rehabilitation physician must reaffirm the appropriateness of admission and the reconciliation of the preadmission review.
- Individualized Overall Plans of Care (IOPC) must be created by the rehabilitation physician within 96 hours of admission with input from the interdisciplinary team.

3.A. **7. Dependent on the needs of those served and their stated goals, the program provides or makes formal arrangements for:**

- **a. Assistive technology.**
- **b. Audiology services.**
- **c. Chaplaincy services.**
- **d. Substance use counseling and treatment.**
- **e. Dialysis.**
- **f. Driver rehabilitation.**
- **g. Dysphagia management.**
- **h. Environmental modification.**
- **i. Medical consultative services.**
- **j. Medical nutrition therapy.**
- **k. Orthotic services.**
- **l. Ostomy/wound care.**
- **m. Peer support.**
- **n. Prosthetic services.**
- **o. Rehabilitation engineering.**
- **p. Respiratory therapy.**
- **q. Sexual counseling.**
- **r. Sexual function and reproductive assessment and management.**
- **s. Spasticity management.**
- **t. Total parenteral nutrition.**
- **u. Visual assessment.**
- **v. Vocational rehabilitation.**

Examples

7.f. Driver rehabilitation might include assessment, training, or retraining.

7.h. Environmental modifications might include installing a ramp, widening doorways, or lowering counters for someone who will use a wheelchair upon return home; installing grab bars or materials that provide traction in the shower or tub; voice activated environmental control units to turn lights, televisions, or computers on and off or open curtains; and rearranging rugs and furniture to increase accessibility and reduce the risk of falling.

7.m. Peer support might facilitate successful life transitions, adjustment to disability, and awareness of and access to community resources, advocacy groups, and activities.

3.A. **8. To meet the needs of the persons served, the comprehensive integrated inpatient rehabilitation program provides or arranges for diagnostic services to screen for and assess the status of:**

- **a. Bladder function.**
- **b. Bowel function.**
- **c. Cardiac function.**
- **d. Cognitive function.**
- **e. Depression.**
- **f. Metabolic function.**
- **g. Musculoskeletal function.**
- **h. Neurologic function.**
- **i. Pulmonary function.**
- **j. Skin integrity.**
- **k. Swallowing.**
- **l. Thromboembolic disease.**
- **m. Other common secondary conditions.**

3.A. **9. Rehabilitation nursing services:**

- **a. Are provided 24 hours a day, 7 days a week.**
- **b. Include coverage by registered nurses with rehabilitation experience 24 hours a day, 7 days a week.**

Examples

Please refer to the Glossary for a definition of *rehabilitation nursing services*.

3.A. **10. The program communicates with the referring or primary care physician of each person served at the time of:**

- **a. Admission.**
- **b. Significant changes in the status of the person served.**
- **c. Discharge/transition.**

Intent Statements

Communication with the referring physician should be offered; however, the referring physician may indicate that he or she does not want ongoing communication. In these instances, communication would be directed to the primary care physician.

Examples

The referring physician may be a hospitalist who will not be following the person served for care after discharge from the acute hospital unit and who indicates that he or she does not want further communication about the person served. The program would note this in the record of the person served and direct ongoing communication to the primary care physician.

10.b. Examples of significant changes in the status of the person served include an acute illness that precipitates transfer to another level of care, recurrent stroke, a fall that results in significant injury, death, etc.

3.A. **11. The program addresses secondary prevention for each person served through:**

- **a. An assessment of potential risks in the following areas:**
  - **(1) Adverse drug reactions.**
  - **(2) Aspiration pneumonia.**
  - **(3) Contractures.**
  - **(4) Deep venous thrombosis.**
  - **(5) Depression.**
  - **(6) Falls.**
  - **(7) Nutrition.**
  - **(8) Skin breakdown.**
  - **(9) Urinary tract infections.**
  - **(10) High probability risks associated with specific diagnostic categories of persons served.**
- **b. Actions to reduce risks.**

Intent Statements

The program addresses secondary prevention through assessment and ongoing monitoring of the status of the person served, education of the person served and the family/support system, and training in self-management of health.

3.A. **12. To advance the field of rehabilitation, leadership supports the program's participation in research opportunities.**

Intent Statements

It is not expected that every inpatient program will have a research center. There are many opportunities that organizations have to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the rehabilitation program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes rehabilitation studies on its research agenda.

3.A. **13. The rehabilitation beds are:**

- **a. In a designated area.**
- **b. Contiguous.**

Intent Statements

Locating the rehabilitation beds in a designated area such that they are contiguous optimizes the effectiveness and efficiency of the team in its delivery of services as well as the opportunities for persons served to interact with each other. For the same reasons every effort is made by the program to congregate persons served with like impairments.

3.A. **14. The organization demonstrates:**

- **a. Knowledge of its:**
  - **(1) Case mix.**
  - **(2) Referral patterns.**
  - **(3) Denials.**
  - **(4) Referrals determined to be ineligible for services.**
- **b. A mechanism to appeal denials.**

Intent Statements

The organization is proactive in its knowledge and management of how these areas affect the viability of the comprehensive integrated inpatient rehabilitation program.

Examples

14.a.(1) Case mix includes several components that address type and complexity of persons served. The case mix is a factor in performance improvement, strategic planning, and resource utilization.

14.a.(3) Denials may include payment denials for the program as a whole or specific services or admission denials based on the complement of persons served in the program.

14.b. The program serving a Medicare population develops and implements an internal chart review process that aligns forms, activities and requirements contained in rules for Medicare. This facilitates appeals of denials and response to retrospective audits.

3.A. **15. A comprehensive integrated inpatient rehabilitation program:**

- **a. Gathers information on each person served, including information on:**
  - **(1) Unplanned transfers to acute medical facilities.**
  - **(2) Discharges to long-term care.**
  - **(3) Expiration.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Unplanned transfers to acute medical facilities.**
    - **(b) Discharges to long-term care.**
    - **(c) Expiration.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Personnel.**
    - **(b) Payers.**
    - **(c) Regulatory agencies.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed Section 1 of the standards. When applicable, the analysis is done at the level of the specialty program.

Examples

15.b.(5)(b)–(c) The program may provide individualized education to payers or representatives of regulatory agencies or it may partner with similar programs in its region to prepare informational materials that educate stakeholders about inpatient rehabilitation. An organization may also give testimony during regulatory hearings when changes are being proposed to rehabilitation regulations to increase the awareness of changes which could impact the person served.

3.A. **16. To assess the durability of the outcomes achieved, a comprehensive integrated inpatient rehabilitation program:**

- **a. Defines its timeframe(s) for collecting long-term, follow-up information on the persons served.**
- **b. Systematically gathers information on the persons served, including information on:**
  - **(1) Activity.**
  - **(2) Environment.**
  - **(3) Health status.**
  - **(4) Participation.**
- **c. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Activity.**
    - **(b) Environment.**
    - **(c) Health status.**
    - **(d) Participation.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**

(5) Necessary education and training of:

(a) Persons served.

(b) Families/support systems.

(c) Healthcare providers.

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards. When applicable, the analysis is done at the level of the specialty program.

16.a. Timeframes for collecting follow-up information may vary based on the type of program and the population served. Some programs may elect to follow-up at more than one point following discharge, and some programs may conduct life-long follow-up. The program should consider whether the timeframes selected are adequate to assess durability of outcomes and be prepared to discuss with the survey team why particular timeframes were selected.

16.b. CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

Examples

The organization's literature review identifies that timeframes for organizations to conduct follow-up vary from one to six months post-discharge. The program decides to collect follow-up information at three months post-discharge, the most frequently identified timeframe in the literature review.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology.

B. Outpatient Medical Rehabilitation Program

Description

An Outpatient Medical Rehabilitation Program is an individualized, coordinated, outcomes-focused program that promotes early intervention and optimizes the activities and participation of the persons served. The program, through its scope statement, defines the characteristics of the persons it serves. An assessment process initiates the individualized treatment approach for each person served, which includes making medical support available based on need. The program includes direct service provision, education, and consultations to achieve the predicted outcomes of the persons served. Information about the scope and value of services is shared with the persons served, the general public, and other relevant stakeholders.

The strategies utilized to achieve the predicted outcomes of each person served determine whether the individual program is single discipline or an interdisciplinary service. A Single Discipline Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served who require services by a professional with a health-related degree who can address the assessed needs of the person served. An Interdisciplinary Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served that are most effectively addressed through a coordinated service approach by more than one professional with a health-related degree who can address the assessed needs of the person served.

The settings for Outpatient Medical Rehabilitation Programs include, but are not limited to, health systems, hospitals, freestanding outpatient rehabilitation centers, day hospitals, private practices, and other community settings.

Applicable Standards

An organization seeking accreditation for an Outpatient Medical Rehabilitation (OMR) Program must meet the program description and standards in this section, as follows:

- All programs apply Standards 3.B.1.–9.
- Single-discipline OMR programs also apply Standards 3.B.10.–11.
- Interdisciplinary OMR programs also apply Standard 3.B.12.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

Applicable Standards

All Outpatient Medical Rehabilitation Programs must meet Standards 1.–9.

3.B. **1. The predicted outcomes for each person served determine the:**

- **a. Type(s) of services.**
- **b. Duration of services.**
- **c. Frequency of services.**

3.B. **2. The outpatient medical rehabilitation program demonstrates:**

- **a. Coordination of services to meet individual needs.**
- **b. Integration of services provided through interaction and feedback:**
  - **(1) Within its own organization.**
  - **(2) With other service providers/systems.**

Examples

Examples of service coordination and integration include:

- The occupational therapist in a single-discipline outpatient medical rehabilitation program coordinates with the durable medical equipment supplier for fitting of a post-operative splint and instruction of the family/support system in proper application of the splint.
- The speech language pathologist contacts the referring physician to discuss examination findings and recommend further swallow evaluation that may need to be completed at another organization.

3.B. **3. On a systematic, organized basis, and based on the needs of the persons served, the program facilitates self-management by the persons served.**

Intent Statements

The program provides education and resources to the persons served to promote successful management of and responsibility for their own health.

Examples

The health professional provides to a person served with a low back injury a home exercise program to strengthen the musculature and instruction in body mechanics to protect against re-injury. The home program is initiated while the person is active in therapy, and progress is reviewed at each session to facilitate incorporation of the home exercise program into daily routines.

Information about community resources to maintain or improve health status might include support groups, fitness centers, and community educational programs.

The persons served may be referred to resources in the community where health screenings and health fairs are held to seek basic health information.

The persons served may receive assistance to learn how to search the internet for reliable information on their impairment.

3.B. **4. A written analysis of no-shows, cancellations, and dropouts for each outpatient medical rehabilitation program:**

- **a. Is conducted at least annually.**
- **b. Addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) No-shows.**
    - **(b) Cancellations.**
    - **(c) Dropouts.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**

Intent Statements

The organization defines no-show, cancellation, and dropout. The consistent use of these definitions in all of its outpatient programs increases

the accuracy and validity of the information gathered.

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards. When applicable, the analysis is done at the level of the specialty program.

3.B. **5. In order to verify the backgrounds of all personnel, written procedures identify actions to occur:**

a. Prior to the delivery of services to the persons served or to the organization.

b. In response to the information received.

Intent Statements

To reduce risk and ensure the safety of the persons served, it is essential that the organization define its process to verify backgrounds of all personnel and take action when appropriate.

Examples

The physical therapist may attend orientation but not provide direct service to the persons served until background verification is complete.

3.B. **6. Personnel have access to and use local, regional, state/provincial, national, or international resources to facilitate effective service delivery.**

Examples

Personnel have access to and use computers and other resources to seek out information on strategies or interventions related to the populations served. Resources might include journals, professional organizations, research databases, community resources, and networks. Information is used to stay current in the field and is incorporated into service delivery.

Personnel use resources to obtain educational materials for persons served, and to make recommendations for assessment tools, equipment, and supplies to advance clinical practice.

Personnel may attend seminars at regional rehabilitation programs that specialize in specific impairments, or personnel from the specialty programs may come to the organization and provide training.

3.B. **7. Personnel demonstrate competency in the use of available technology to support operations and effective service delivery.**

Examples

Personnel are educated and have adequate skills and knowledge to accurately enter data into the electronic billing system to assist in timely billing for services.

Mechanisms in the electronic medical record documentation system are used by team members to ensure timely exchange of information for modifying the treatment plan.

Personnel know how to access and use the organization's intranet for mandatory web-based education and training.

Therapy personnel are able to competently instruct persons served and family members in computer-based devices for digitized speech output.

Personnel are able to use the internet to search websites for evidence-based practice information.

3.B. **8. The organization demonstrates:**

a. Knowledge of its:

(1) Payer mix.

(2) Referral patterns.

(3) Denials.

(4) Referrals determined to be ineligible for services.

b. A process to appeal denials.

Examples

8.a.(3) Denials may be payer denials for admission into the program or for continued services or for a specific intervention or modality.

8.a.(4) Persons referred to the program may be deemed ineligible for services because they do not meet the admission criteria or their needs are outside of the scope of the program.

8.b. The process to appeal denials may identify when an appeal will be made, responsibilities of personnel, and levels of appeal.

3.B. **9. The program provides information regarding the value of outpatient medical rehabilitation to:**

- **a. Persons served.**
- **b. The general public.**
- **c. External stakeholders.**

Examples

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

External stakeholders might be payers, other healthcare providers, or referral sources.

Outpatient Medical Rehabilitation Program–Single Discipline

Applicable Standards

A program seeking accreditation as a Single Discipline Outpatient Medical Rehabilitation Program must also meet Standards 10.–11.

3.B. **10. The persons served in a single discipline outpatient medical rehabilitation program receive services from a professional with a health-related degree who can address the assessed needs of the person served.**

3.B. **11. As the needs of the person served change or increase in complexity, the single discipline outpatient medical rehabilitation program provides or makes formal arrangements for the provision of services by additional healthcare professionals.**

Outpatient Medical Rehabilitation Program–Interdisciplinary

Applicable Standards

A program seeking accreditation as an Interdisciplinary Outpatient Medical Rehabilitation Program must also meet Standard 12.

3.B. **12. To meet the complex needs of each person served, the interdisciplinary outpatient medical rehabilitation program directly provides the services of more than one professional with a health-related degree who can address the assessed needs of the person served.**

Examples

The program provides the services with individuals employed full time, part time, or on a contract.

C. Home and Community Services

Description

Home and Community Services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The Home and Community Services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and Community Services must include at least one of the following service delivery areas:

- Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.
- Services for persons who need assistance to access and connect with family, friends, or coworkers within their homes and communities.
- Services for persons who need or want help with activities in their homes or other community settings.
- Services for caregivers that may include support, counseling, education, respite, or hospice.

Note: *A service provider seeking accreditation for Home and Community Services is not required to provide all four of the service delivery areas identified in the service description. However, it must include in the site survey all of the service delivery areas it provides that meet the service description.*

Applicable Standards

An organization seeking accreditation for Home and Community Services must meet the program description and the standards in this section, as follows:

- All programs apply Standards 3.C.1.–15.
- If specialized services and assistance due to illness, injury, impairment, disability, or specific age or developmental needs are provided, also apply Standards 3.C.16.–18.
- If specialized respite services are provided, also apply Standard 3.C.19.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.C. (see guidelines on page 143)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

Applicable Standards

All organizations seeking accreditation for Home and Community Services must meet Standards 1.–15.

3.C. **1. To facilitate the appropriate level of services/supports for the person served, the home and community services demonstrate knowledge of and the ability to identify appropriate service options/settings.**

Intent Statements

Services are individualized to the persons served. The home and community services may provide a full spectrum of services or only one type of service but demonstrate an awareness and use of community resources that may be used to support or enhance services to the person served.

3.C. **2. The home and community services identify and address gaps in service delivery.**

Intent Statements

The home and community services may address gaps in service at both the level of the person served and the level of the program/service.

Examples

Gaps in service delivery for a person served may be addressed by referring the person to another program/service in the local community or contracting with an external provider to engage with the team of the person served. For example a therapist working with a person served observes that the person is no longer able to do household chores because of pain and lack of mobility and as a result, there are now concerns about the safety and cleanliness of the home. The therapist could refer the person back to the primary physician for medical evaluation and a potential referral for homemaker services.

At the level of the program/service, the home and community services may explore developing a new service, partnering with another provider in the community to provide or develop additional services, or advocating with a payer to cover services that are not currently covered.

3.C. **3. To verify the backgrounds of all personnel, written procedures identify actions to occur:**

- **a. Prior to the delivery of services to the persons served or to the organization.**
- **b. At stated intervals throughout employment.**
- **c. In response to the information received.**

Intent Statements

This standard relates to Standard I.2. in Section 1. To reduce risk and ensure the safety of the persons served, the organization defines its process to verify backgrounds of all personnel and take action when appropriate. The organization has procedures in place in the event that backgrounds cannot be verified. Continued employment might be contingent upon positive verification for some positions; the organization determines when this is the case.

Examples

The physical therapist may attend orientation but not provide direct service to the persons served until background verification is complete.

3.C. **4. Personnel demonstrate competencies in the delivery of home and community services, including, but not limited to:**

- **a. Addressing the unique needs of persons served.**
- **b. Communication with persons served and their families/support systems.**
- **c. Communication with other providers serving the persons served.**
- **d. Facilitating active involvement of the persons served and families/support systems in the service delivery process.**
- **e. Facilitating behavioral supports.**
- **f. Facilitating cognitive interventions.**
- **g. Handling developmental/life transitions.**
- **h. Knowledge of community resources.**

i. Recognition and reporting of suspected abuse and neglect.

j. Setting and maintaining professional boundaries.

Intent Statements

In Section 1.I. Human Resources standards, organizations are asked to identify skill sets that would assist with the achievement of outcomes for the persons served as well as organizational mission and goals. This standard identifies areas that would be included in orientation as well as ongoing training as appropriate for the home and community services. These are not the only skill sets that a home and community services program may include but these should be evident.

Examples

These competencies can be obtained through formal education or continuing education; on-the-job training; mentorship by experienced personnel; and ongoing access to books, periodicals, videos, and audio recordings.

4.f. A person served may need to establish techniques to assist with memory of daily tasks that should be completed for health or safety purposes. These aids may be written, electronic, phone calls, etc. Personnel are able to appropriately use or encourage the person served to use the pertinent memory aid.

4.g. Transitions could be from home to job, school to supported or independent living, job to retirement, job to volunteering, or independent living to supported living.

4.j. The therapeutic relationship requires the establishment of rapport as well as appropriate limits on behaviors. Education might include topics such as refraining from establishing a friendship or relationship outside of the delivery of services; recognizing that even though providers and family members may disagree about what is best for a child, the parent is the final authority regarding the child; and the adaptive balance of emotional engagement and distance so that providers are invested in the persons served but their roles as professionals are not compromised.

3.C. **5. Policies and written procedures are implemented that address, at a minimum, the following service delivery issues:**

a. Availability of appropriate equipment, supplies, etc., at the service delivery site from initial service delivery through exit/transition.

b. Confidentiality and privacy of information concerning the persons served in the home and community environments.

c. Clarification of the roles and responsibilities of:

(1) Families/support systems.

(2) Service providers.

(3) Others, as appropriate.

d. Contingency plans if either the family/support system or the service provider is unable to deliver care.

e. Unsuccessful delivery of services.

f. Referral/transition to other services.

g. Assignment of personnel in accordance with the needs and choices of the persons served.

h. Safety of personnel, including:

(1) Personal safety while providing services.

(2) Communication systems.

(3) Weather conditions and other natural environmental events.

(4) The physical environment at the service delivery site.

i. Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

j. Within the scope of services, the availability of home and community services to respond to:

(1) Persons served.

(2) Families/support systems.

(3) Service providers.

(4) Other stakeholders.

Intent Statements

Home and community services are offered to persons served in a variety of settings. Policies and procedures address the uniqueness of the settings and types of situations personnel may encounter when decisions need to be made, potentially on an immediate basis, without the "on-site" support of supervisors or others who are typically available in a facility-based program.

Examples

5.e. Unsuccessful delivery of services may be the result of an issue on the part of the provider or the person served.

5.j.(1) The scope of the services may be focused only on therapeutic interventions and not include social reintegration activities.

5.j.(2) The scope of the services may include the availability of respite services for family/support systems.

3.C. **6. A risk assessment of each person served addresses the following areas:**

- **a. Behavioral.**
- **b. Cognitive.**
- **c. Communication.**
- **d. Developmental.**
- **e. Emotional.**
- **f. Environmental.**
- **g. Physical.**
- **h. Capability of the family/ support system.**
- **i. Other, as appropriate.**

Intent Statements

To decrease the potential of harm to the person served, risk assessments are an integral part of home and community services. The analysis of this information may result in changes to the person-centered plans as well as improvement at the level of the services.

Examples

6.a. A behavioral risk may be that the person served expresses the potential to harm himself/ herself or others.

6.c. Risks in communication may be the inability to communicate emergent needs, inability to understand verbal or written communication, or different languages being spoken by the person and staff.

6.d. Developmental delays may produce risk in social or work situations. Age of an individual may not match developmental level and increase his or her risk in daily activities.

6.g. Physical risks may include the potential for falls or impulsivity on the part of the person served when moving around his or her home.

6.h. Risk assessment related to the family/ support system might include the availability of the family/support system, its understanding of the health status of and safety precautions required for the persons served, and family/ support system dynamics.

3.C. **7. Service delivery is scheduled at an agreed-upon time that supports the person-centered plan.**

Intent Statements

There is a system in place to determine the most appropriate schedule for service delivery based on the lifestyle and preferences of the persons served and the scope of the home and community services.

3.C. **8. In accordance with the choice of the person served, the home and community services assist the person served to develop a disaster preparedness and emergency plan that considers the following:**

- **a. Assessment of the current knowledge of:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **b. Assessment of the physical environment where services are delivered, including accessibility of the environment.**
- **c. Identification of modifications necessary to ensure safety in the event of an emergency.**

d. Community resources, including:
- **(1) Identification of resources for:**
  - **(a) Evacuation.**
  - **(b) Shelter.**
  - **(c) Recovery.**
- **(2) Accessibility of resources for:**
  - **(a) Evacuation.**
  - **(b) Shelter.**
  - **(c) Recovery.**

e. Basic needs in the event of an emergency.

f. Identification of circumstances in which service delivery can be postponed or omitted.

g. Provisions for communication by personnel while providing services regarding decisions to continue or discontinue services.

h. Contingency plans for:
- **(1) The person served.**
- **(2) The family/support system.**
- **(3) Personnel.**

Intent Statements

Persons served by home and community services are at risk in emergent situations because of a variety of issues including age, developmental, cognitive, and physical levels of functioning. To address these risks persons served can seek, if they desire, to receive more information from the home and community services on how to address emergent situations.

8.d.(1)(c) and **8.d.(2)(c)** Recovery after a disaster means the return of the person served to his or her home or community setting.

Examples

8.d.(1)(c) and **8.d.(2)(c)** Recovery might include physical home repairs, utility recovery, water damage, or public health assessment for safe/healthy living conditions.

8.e. Basic needs may include food, water, utilities, etc. Utility needs might include back-up power for a person who uses a power wheelchair or ventilator, or telephone service to be able to call 911 or reach family members who are away from home.

Resources

Please refer to Appendix D for resources related to emergency preparedness education for persons served and other stakeholders.

3.C. **9. If the person served uses assistive technology, electronic aids to daily living, environmental controls, equipment, environmental modifications, and/or personal emergency response systems, the home and community services, on an ongoing basis:**

a. Determine that the technology and/or equipment:
- **(1) Functions properly.**
- **(2) Achieves the intended purpose.**

b. Notify the appropriate designee, as needed.

c. In accordance with the person-centered plan, incorporate the technology and/or equipment into service delivery.

Intent Statements

Technology has an ever-increasing presence in home and community services. It is important that service providers are attuned to the role and impact of technology on the lives of the persons served. The extent to which the service provider interacts in the environment in which technology is used by the person served guides the involvement of the service provider in the activities of this standard.

Examples

A driver who transports persons served to appointments in the community is unlikely to come into contact with environmental controls and adaptive equipment used by the person served in his or her home. However, because the person served may use a power mobility device (PMD), the driver would inquire about and observe whether the person is able to use the PMD safely and effectively. If the driver were to discover that the person served is not able to use the PMD as intended or was having some mechanical difficulty with it, it would be his responsibility to notify the appropriate person who could assist the person served.

"Smart homes" utilize information and communication technologies that assist with daily living activities, safety, falls, health monitoring, and environmental control. Smart homes allow and provide a way to record the activities or inactivity of an individual in a home and report the event to a caregiver or family member in accordance with the preference of the person served. Examples of smart home systems include emergency call systems, control of heating and air systems, health monitoring, safety devices, medication monitoring, video cameras, and keyless entry. A person served might communicate to the home health aide that a video camera is not working. The aide notifies the appropriate personnel in the home and community services, who then follow up with the appropriate family member or vendor.

3.C. **10. In accordance with the choice of the person served, the home and community services partner with the family/support system throughout the service delivery process, including ongoing consideration of:**

- **a. The family/support system's:**
  - **(1) Ability and willingness to support and participate in the plan.**
  - **(2) Composition.**
  - **(3) Interpersonal dynamics.**
  - **(4) Different methods of:**
    - **(a) Engagement.**
    - **(b) Communication.**
    - **(c) Coping.**
    - **(d) Problem solving.**
  - **(5) Strengths and limitations.**
  - **(6) Knowledge base.**
  - **(7) Expectations of the home and community services.**
  - **(8) Educational needs.**
  - **(9) Responsibilities, including legal responsibilities.**
  - **(10) Geographic proximity to the person served.**
- **b. Unique financial, social, or cultural factors that might influence the home and community services.**
- **c. Health status of the primary caregiver.**

Intent Statements

When the person served agrees to having members of the family/support system involved in the delivery of services, the home and community services assess the family/support system to include it effectively and optimally in the service delivery process. This assessment process can provide information that impacts the opportunity for the person to remain in his or her home or community setting.

Examples

Factors that might impact participation in service delivery or support include that members of the family/support system live at a distance, work during typical service delivery times, have limited resources to assist, etc.

10.a.(3) Interpersonal dynamics refers to the interactions between the person served and his or her spouse/significant other, friends, peers, coworkers, employer, and community.

10.a.(4) Engagement may include the ability of the family/support system to participate in training sessions, learn new skills, call or email questions or concerns to personnel when they live at a distance, and willingness to participate in the person-centered plan as appropriate.

10.a.(9) Responsibilities may include work and family-related responsibilities such as being the caregiver for young children or elderly parents.

10.b. Financial, social, or cultural factors may influence service delivery in areas such as setting goals for the person served, the provision of information and services, and exit/transition options.

3.C. **11. In accordance with the choice of the person served, policies and written procedures facilitate collaboration with the family/support system in decision making through the following:**

- **a. Accessible information.**
- **b. Timelines for exchange of information.**
- **c. Understanding of the information provided.**

Intent Statements

To facilitate the decision-making roles of the person served and family/support system, they are given information in a way that is understandable and in sufficient time to make informed decisions.

Examples

11.c. The level of understanding of information may be determined though the assessment processes, asking the person served or members of the family/support system to summarize the discussion and decisions made, or verification by the person responsible for coordinating services.

3.C. **12. The home and community services provide education:**

- **a. To:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
  - **(3) Other relevant stakeholders.**
- **b. In accordance with identified needs, that addresses, but is not limited to:**
  - **(1) Accessing emergency care if necessary.**
  - **(2) Communication with other service providers.**
  - **(3) Developing a system to record personal health information.**
  - **(4) Disease management.**
  - **(5) Information about community resources and how to access them.**
  - **(6) Preventive care.**
  - **(7) Procedures unique to the provision of home and community services.**
  - **(8) Safety issues related to the service delivery site.**
  - **(9) Specific healthcare procedures and techniques, as appropriate.**

Intent Statements

12.b.(3) Having a system or tool to record personal health information helps the persons served and their families/support systems ensure that they receive ongoing quality healthcare.

Such information empowers persons served to be responsible for an important step in their care, lessens the fragmentation of care among healthcare settings, and will likely decrease the risk of medical errors.

Examples

12.b.(2) Examples of other providers with whom the persons served, families/support systems, or other stakeholders may have to communicate might include the person's primary care physician, pharmacist, or other providers in the community such as a transportation provider.

12.b.(3) The system used provides a record of relevant personal health information and is portable for persons served so that they have the appropriate information at each health encounter and healthcare providers can be efficiently informed by more complete and accurate information than might otherwise be available.

The system or tool may be called many things; e.g., a portable profile, medical passport, patient care notebook, shared care plan, smartcard, and healthcare folder. Offering the person served a choice of formats may improve the actual use of the system or tool. The format facilitates ease of access and ready availability in case of an emergency. Formats might include:

- Index cards with clear writing.
- An eight-by-eleven inch piece of paper.
- Folders.
- Notebooks.
- Flash drive.
- CD.
- Bracelet with information.
- Web-based applications accessible from mobile devices.

12.b.(8) Examples of safety issues may include how to evacuate the service delivery site, environment modifications, and whether the service delivery site poses any safety risks to the providers of services.

Resources

Please refer to Appendix D for resources related to personal health information systems and tools.

3.C. **13. The home and community services have a mechanism to ensure that both the person served and the service provider can understand and communicate with each other.**

Examples

Hearing and language issues may pose barriers to communication between the person served and the service provider. The use of a translator or communication device may be necessary.

3.C. **14. Based on the scope of services, to enhance the involvement of the persons served in the community, the home and community services:**

- **a. Are knowledgeable about the options available for:**
  - **(1) Housing.**
  - **(2) Transportation.**
  - **(3) Technology.**
- **b. In accordance with the choice of the person served, advocate for the development of options for:**
  - **(1) Housing.**
  - **(2) Transportation.**
  - **(3) Technology.**

Intent Statements

Whether the home and community services address housing, transportation, and technology would be guided by the scope of services provided. Many times persons served may lack knowledge of options in their area. There may be the need for the home and community services provider to assist the person served to become aware of options and resources that they will need to tap into to develop their plan for housing, transportation and /or technology. This may be needed to allow the person served to remain in his or her home and/or community, to get to and from work, and/or to participate in social activities.

Examples

14.a.(1) Housing options may include supported housing, public housing, or general community housing that is accessible for persons who use a wheelchair.

14.a.(2) Public transportation options may address transportation that is convenient for a person served who has limited endurance, mobility, or cognition and para-transit systems for persons served who use assistive mobility equipment.

14.a.(3) Technology options may include off-the-shelf technology as well as resources for customized technology to be used by the person served in the home and other community settings.

3.C. **15. In accordance with the choice of the person served, the home and community services provide or arrange for financial assistance and planning that addresses:**

- **a. Benefits planning.**
- **b. Sustainability of services.**
- **c. Contingency planning.**
- **d. Education related to financial literacy.**
- **e. Short- and long-term planning for future services, including:**
  - **(1) Funding and supports available.**
  - **(2) Eligibility criteria.**
  - **(3) Range of services available.**
  - **(4) Amount of services available.**
  - **(5) Impact on continuing benefits.**

Intent Statements

An in-depth financial analysis of the short and long-term costs of living independently will take into consideration both the present ability and future service needs of the person served.

In assisting an individual to live independently in the community, it is important to evaluate present and future costs associated with the living situation.

Examples

Factors to be considered include how benefits of the person served might be impacted and the potential of changes of funding for services. It is important that the person served consider being responsible for his or her own finances if appropriate.

Training in financial literacy may be provided directly by the home and community services or referred to an appropriate resource in the community.

Applicable Standards

Home and Community Services that provide specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need must also meet Standards 16.–18.

3.C. **16. The home and community services address the impact of the following areas on the service delivery process for each person served:**

- **a. Allergies.**
- **b. Current medications, including:**
  - **(1) Medication sensitivities and adverse reactions.**
  - **(2) Why each medication is prescribed.**
  - **(3) Side effects.**
  - **(4) Drug interactions.**
  - **(5) Implications of abrupt discontinuation of medications.**
  - **(6) Compliance.**
  - **(7) Schedule for taking medications.**
- **c. The etiology and anticipated course of the illness, injury, impairment, disability, or a specific age or developmental need.**
- **d. The results of relevant diagnostic interventions.**
- **e. The results of relevant therapeutic interventions.**
- **f. Communication ability.**
- **g. Fatigue.**
- **h. Nutrition.**
- **i. Pain.**
- **j. Risk factors.**
- **k. Signs and symptoms of emergent medical or psychological conditions.**
- **l. Sleep.**

Intent Statements

To ensure the safety of the persons served and determine the most appropriate and beneficial interventions, knowledge of each person's health and medical status and history are important. This knowledge will allow the home and community services to minimize unnecessary interventions, establish an accurate baseline of health and functional status, set realistic goals, and optimize results. Whether services are provided by credentialed personnel or non-credentialed personnel, the impact of these areas on the service delivery for each person served is observed, considered, reported as applicable, and, as needed, addressed in the person-centered plan, including the involvement of additional team members as necessary.

16.b. The home and community services are aware of the effects of medications currently taken by the person served on his or her ability to participate in the services and tolerate therapeutic activity.

16.j. Risk factors may include that the person smokes, is overweight, is unsteady and therefore at risk of falling, can't afford the medications that are prescribed, has labile hypertension, or expresses the potential to harm himself/herself or others.

3.C. **17. Depending on individual needs, the home and community services provide ongoing education and training to each person served that addresses:**

- **a. Disease management.**
- **b. Health advocacy, including prompt communication about health issues.**
- **c. Prevention related to:**
  - **(1) Recurrence of the illness, injury, impairment, disability, or a specific age or developmental need.**

(2) **Potential risks and complications due to the illness, injury, impairment, disability, or a specific age or developmental need.**

d. **Primary healthcare.**

e. **Utilization of healthcare resources.**

f. **Wellness.**

Intent Statements

The ability for an individual to become engaged with wellness and management of their health issues is key to maintaining the ability to remain in home and community settings. Appropriate education and training is provided to persons based on their needs.

Examples

Persons served may take advantage of technology (computer, fitness trackers, DVD, CDs) to become better educated or engaged with exercise programs, etc. They may need education about areas such as how to be an advocate for their needs, physician appointments, screenings and their importance, how to become active in health issues, appropriate use of emergency/urgent care, etc.

17.b. It is important for persons served to be able to identify signs and symptoms and when it would be appropriate to contact their physician, home and community services provider, EMTs, etc. Signs and symptoms might include frequent falls, loss of consciousness, shortness of breath with chest pains, or increased inflammation of joints with inability to perform daily tasks. The sudden onset, abruptness, or increased intensity or frequency of these symptoms signal the person served to advocate for care, medications, additional services, etc.

17.e. Education on utilization of healthcare resources might include decision making related to which healthcare provider is the most appropriate to seek advice for specific health issues or how to use insurance funding most effectively to meet individual needs.

3.C. **18. The home and community services provide education on medication, as appropriate:**

a. **To:**

(1) **Persons served.**

(2) **Families/support systems.**

b. **That addresses:**

(1) **Actions to take in an emergency.**

(2) **Administration.**

(3) **Dispensing.**

(4) **Disposal.**

(5) **Errors.**

(6) **Expiration dates.**

(7) **Identification, including purpose of each medication prescribed.**

(8) **Implications for management of multiple medications.**

(9) **Implications of abrupt discontinuation.**

(10) **Indications and contraindications.**

(11) **Obtaining medication.**

(12) **Sharing medication.**

(13) **Side effects.**

(14) **Storage.**

Intent Statements

Medication management in home and community settings differs from facility-based settings in which medications are controlled by pharmacists, nurses, and physicians. The ability to assess the understanding and competency of a person served and his or her family/support system to manage medications is critical to the person's safety, health, and well-being.

Examples

Education is provided as appropriate to the needs of the persons served and families/support systems, the scope of the home and community services, and in accordance with any relevant practice acts or standards of practice.

18.b.(3) A person has difficulty opening medication bottles so the home and community services educate him and his spouse about requesting blister packs or easy-to-open bottles. The person served has vision limitations so the home and

community services educate her to request labels with large print.

18.b.(7) The nurse identifies each medication and the reason it was prescribed to the person served when dispensing medications.

18.b.(8) The home and community services identify that the person served is taking several medications that are prescribed by multiple physicians and educates the person regarding the importance of notifying each prescribing physician about all of the medications currently being taken, not just those related to the condition being managed by each physician.

Resources

Please refer to Appendix D for resources related to education for persons served, families/support systems, and caregivers.

Applicable Standards

Home and Community Services that provide specialized respite services must also meet Standard 19.

3.C. **19. When respite services are provided somewhere other than the person's own home, the person served brings the following with him or her, if applicable:**

- **a. Adaptive equipment.**
- **b. Assistive technology.**
- **c. Emergency contact information.**
- **d. Information on everyday routines.**
- **e. Information/instructions regarding any special needs.**
- **f. Instructions for specific healthcare procedures.**
- **g. Medications.**
- **h. Pertinent health/medical history.**

Intent Statements

The ability for the respite services to create an environment that will meet the needs of the person while in that setting is critical.

19.d. In order to maintain a person-centered approach, respite services are knowledgeable about the normal routine of the person served.

Examples

19.a.–b. Depending upon the types of persons served, respite providers may need to be able to use a variety of equipment and assistive technology and may need additional training to develop those competencies. Training might be provided by the family, vendors, or other resources.

19.c.–h. A personal health information tool may be used to provide information.

19.e. Special needs may include nutritional/dietary needs.

D. Residential Rehabilitation Program

Description

Residential Rehabilitation Programs are provided for persons who need services designed to achieve predicted outcomes focused on home and community integration and engagement in productive activities. Consistent with the needs of the persons served services foster improvement or stability in functional and social performance and health. These programs occur in residential settings and may be transitional or long term in nature. The residences in which the services are provided may be owned or leased directly by the persons served or the organization.

Applicable Standards

An organization seeking accreditation for a Residential Rehabilitation Program must meet the program description and all standards in this section.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.D. **1. A residential rehabilitation program provides space that:**

a. Meets the needs of the persons served for:

(1) Privacy.

(2) Socialization.

b. Includes outdoor space suitable to meet the needs of the persons served.

c. Is designed to promote the dignity and self-worth of the persons served.

Examples

Persons served have the opportunity to speak on the phone in an area that provides them privacy.

The organization has created areas that encourage persons served to participate in social interactions. The location, the furnishing, and the ambience of these areas invite and encourage people to visit.

The organization has a room set aside for couples who desire to spend time together and in privacy.

3.D. **2. The healthcare and safety needs of the persons served are met in their individual residential environments.**

3.D. **3. Whenever possible, the choice of a private room or roommates is available.**

3.D. **4. Individual possessions and decorations selected by the persons served are evident in their residences.**

3.D. **5. Adaptive devices and related equipment are available to persons with special needs.**

3.D. **6. In order to provide appropriate programming and activities, an adequate number of personnel are available 24 hours a day, 7 days a week.**

Examples

Some programs may allow persons served to go home for a period of time such as a day or weekend. In these instances therapeutic goals are established and discussed in advance and reviewed upon return to the program.

3.D. **7. There are regular meetings between personnel and the persons served to discuss relevant issues concerning the living environment.**

3.D. **8. When the residential rehabilitation program provides food services to persons served, it:**

- **a. Involves the persons served in:**
  - **(1) Meal planning.**
  - **(2) Preparing their food.**
- **b. Promotes access by persons served to:**
  - **(1) At least three nutritious meals a day.**
  - **(2) Snacks, unless contraindicated by the individual service plan, which are consistent with each person's personal choice in relation to:**
    - **(a) Type.**
    - **(b) Timing.**
- **c. Has sufficient capacity to:**
  - **(1) Prepare appropriate food.**
  - **(2) Deliver appropriate food.**
  - **(3) Arrange for appropriate food.**
- **d. Prepares food in a manner that is:**
  - **(1) Sanitary.**
  - **(2) Safe.**
- **e. Presents food:**
  - **(1) In a way that is appetizing.**
  - **(2) At an appropriate temperature.**
- **f. Makes available food that addresses the person's:**
  - **(1) Religious preferences.**
  - **(2) Personal preferences.**
  - **(3) Dietary needs.**

Intent Statements

8.c.(1) When food services are provided through a contractual arrangement and all meals and snacks are prepared off site and delivered to the residence, this standard does not apply.

8.f.(3) In assessing the dietary needs of persons served, it may be necessary in some cases to have an individual with expertise in nutrition plan, review, and supervise special diets. It is always important to recognize that adequate nutrition and intake are key factors in maintaining the health of individuals. Resources to assist in reviewing guidelines are available from the Academy of Nutrition and Dietetics.

Examples

8.f.(2) Personal preferences includes food likes and dislikes and cultural preferences.

3.D. **9. Each residence has an individual responsible for supervising the services provided.**

Intent Statements

Depending on the size and scope of the program, this same individual may be responsible for the administrative and management functions and the residence supervision functions.

3.D. **10. If the main records of the persons served are located separately from the residence, information concerning the persons served that is necessary for safety and program implementation is available to personnel in the residence at all times.**

3.D. **11. As desired by the persons served and their families/support systems, individual plans identify and address:**

- **a. Barriers to community inclusion.**
- **b. Accessing community activities.**
- **c. Opportunities for community participation.**

Intent Statements

The focus of residential rehabilitation programs is to integrate the persons served to the extent possible into day-to-day activities in the residence itself as well as the broader community.

Examples

11.a. Barriers to community inclusion might include the lack of appropriate transportation or the need for specialized equipment or personal assistance.

11.c. Community participation might include activities such as volunteering, attending classes, and attending community events and religious services.

3.D. **12. The program provides the persons served and their families/support systems opportunities to obtain and maintain skills and supports that enhance the quality of their lives.**

3.D. **13. Each person's preference for alternative living arrangements is addressed at least annually or at the request of the person served and/or the family.**

3.D. **14. The persons served use informed choice and personal preference in selecting alternative living arrangements.**

3.D. **15. The persons served are assured that they will receive and are provided ongoing support services as they explore alternative living arrangements.**

3.D. **16. When a residence is provided by the organization, it is designed, constructed, furnished, and maintained in ways similar to others in the neighborhood consistent with the needs and preferences of the persons served.**

3.D. **17. The individual service plan reflects the changing life span issues of the person served.**

3.D. **18. Each person served has the opportunity, as desired, to:**

- **a. Access information on:**
  - **(1) Political issues.**
  - **(2) Civic issues.**
- **b. Actively engage in national and local issues affecting their interests.**
- **c. Vote in all elections in which they are eligible to vote.**

Examples

A group of women in the program have been active in the League of Women Voters. With the upcoming elections, they are involved in educating fellow persons served on the issues and ensuring that all who desire have an opportunity to vote.

Persons served have access to the news: print news, news on television, and on the internet.

A group of concerned persons served plans and implements a recycling campaign in the residence for paper, aluminum, and glass.

The program arranges transportation to the polling place or facilitates obtaining absentee ballots or early voting options.

Resources

Please refer to Appendix D for resources related to accessibility.

3.D. **19. The program:**

- **a. Gives opportunities for expression of final wishes concerning end of life to:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
- **b. Honors wishes concerning end-of-life issues.**
- **c. Initiates related services when appropriate.**
- **d. Provides education if needed regarding end-of-life choices.**

Intent Statements

Persons served and families/support systems have opportunities to talk about end-of-life issues. Persons served and their families/support systems participate in planning their memorial

service and in the creation of end-of-life protocols if they wish.

Examples

Persons served and family members are interviewed about preferences for the dying process (i.e., five wishes, music, people, preparation and notification, comfort items, spiritual needs, funeral arrangements) and individual planning reflects these preferences.

Do-not-resuscitate orders are known and strictly adhered to.

The organization makes known to the persons served upon admission if it does not perform CPR and will only call 911.

3.D. **20. When a person served dies, opportunities are provided:**

- **a. To:**
  - **(1) Other persons served.**
  - **(2) The family/support system.**
  - **(3) Personnel.**
- **b. To express grief and remembrance.**
- **c. To develop and participate in:**
  - **(1) Memorial services.**
  - **(2) Memorial rituals.**
  - **(3) Other forms of grief expression.**

Examples

The program invites persons served and personnel to pay their last respects to a person served after he/she passes away and before the body is removed from the organization.

The person's life is remembered at a memorial service open to all persons served, personnel, and community members.

Personnel are encouraged to attend a community service for a person served with whom they've had a close relationship.

Organizational management contacts any personnel who had a particularly close relationship with a person served to inform him/her of the passing before coming to work.

Memorial gardens are developed outside on facility property in remembrance of those who have passed away.

Memorials that reflect the individual are evident throughout the residence.

E. Vocational Services

Description

Vocational Services provides individualized services to persons to achieve their identified vocational outcomes. The services may include:

- Identification of employment opportunities and resources in the local job market.
- Development of realistic employment goals.
- Establishment of service plans to achieve employment outcomes.
- Identification of resources to achieve and maintain employment.

Vocational Services consider:

- The behavioral, cognitive, and medical, physical, and functional issues of the persons served.
- The vocational goals of the persons served.
- The personnel needs of the employers in the local job market.
- The accessibility and accommodations provided by employers.
- The community resources available.
- The trends and economic considerations in the employment sector.

Applicable Standards

An organization seeking accreditation for Vocational Services must meet the program description and all standards in this section.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A. (Standards 1.–19. only)
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.E. **1. The vocational services provided include career development and training activities that support informed vocational decision making by the person served.**

3.E. **2. The vocational services include:**

- **a. Assisting the person served, prior to job acceptance, to become knowledgeable about:**
  - **(1) Job duties.**
  - **(2) Personnel benefits.**
  - **(3) Rates of pay.**
  - **(4) Employment policies and practices.**
  - **(5) Job site.**
  - **(6) Geographic locations.**
  - **(7) Workforce characteristics.**
  - **(8) Environmental factors.**
- **b. Eliciting information about:**
  - **(1) Job preferences.**
  - **(2) Salary expectations.**
  - **(3) Salary needs.**
  - **(4) Benefits package needs.**
- **c. Assisting the persons served to become knowledgeable about the impact of employment on disability and other benefits, including providing information on the means available to access such benefits.**
- **d. With the permission of the person served, assisting the employer in understanding the effects of the injury, illness, or impairment in terms of:**
  - **(1) Job performance capabilities of the person served.**
  - **(2) Expectations of the person served.**
  - **(3) The need for reasonable accommodations.**
  - **(4) The potential need for an on-site mentor.**

e. With the permission of the person served, assisting coworkers in understanding the effects of the injury, illness, or impairment in terms of:
   (1) Job performance capabilities of the person served.
   (2) Expectations of the person served.
   (3) The need for reasonable accommodations.
f. Assessing, training, or providing guidance to the person served in the development of:
   (1) Work habits.
   (2) Interactions with supervisors.
   (3) Interactions with coworkers.
   (4) Work tolerance and work pace consistent with the abilities and needs of the person served and the requirements of the work place.
   (5) Compensatory strategies to perform daily work tasks.
g. Providing a variety of work opportunities and work tasks to meet the needs of the persons served.

3.E. **3.** Information concerning assistive technology and reasonable accommodations is communicated to:
   a. The persons served.
   b. All team members involved.

3.E. **4.** Assistive technology is used and reasonable accommodations are made in:
   a. The development of services and supports.
   b. The ongoing provision of services.

3.E. **5.** The individual plan for vocational services:
   a. Includes the choices of the person served.
   b. Integrates the results and/or recommendations from all other services.
   c. Specifies the employment objectives of the:
      (1) Person served.
      (2) Individuals providing services.
   d. Specifies the roles and responsibilities of the:
      (1) Person served.
      (2) Individuals providing services.
   e. Includes goals expressed as job possibilities related to existing occupations in the community.
   f. Identifies the nonwork needs of the person served that may impact the achievement and maintenance of vocational outcomes.
   g. Includes a plan for transportation.

Examples

5.f. Nonwork needs may include resolution of problems with a living situation, lack of transportation, health issues, and lack of child care.

3.E. **6.** When the organization provides equipment to be used by the persons served, the equipment:
   a. Replicates the tools and methods required by competitive industry.
   b. Is suitable to the local job opportunities available to the persons served.

3.E. **7.** With the permission of the person served, information related to his or her ability to perform essential job functions is communicated to appropriate individuals in the employment setting.

Intent Statements

While maintaining confidentiality and privacy, it is important that information related to cognitive, behavioral, emotional, psychosocial, and

adjustment issues; functional abilities; etc., is shared with appropriate individuals in the work setting of the person served in order to maximize the effectiveness and the durability of the placement.

3.E. **8. The organization has a policy that addresses:**

- **a. Accepting work from businesses that are being affected by labor strikes.**
- **b. Employing persons in such businesses.**

Examples

The policy addresses topics such as crossing the picket lines to do the work of actively striking workers or accept their work in house.

3.E. **9. The vocational services include work trials and vocational assessments that include input from:**

- **a. The person served.**
- **b. The interdisciplinary team.**
- **c. The work setting.**

Examples

9.c. Input may come from representatives of human resources, supervisors, coworkers, or other employees who interact with the person served in the work setting.

3.E. **10. Protected work trials or situational assessments:**

- **a. Are used on a time-limited basis to obtain information regarding each person's potential abilities and limitations in performing work.**
- **b. Include the active participation of treating personnel.**
- **c. Are part of the total ongoing rehabilitation process.**
- **d. Are timed so that the person served obtains maximum benefit.**
- **e. Are done at the work site or where the program is offered.**

F. Interdisciplinary Pain Rehabilitation Program

Description

An interdisciplinary pain rehabilitation program provides outcomes-focused, coordinated, goal-oriented interdisciplinary team services. The program delivers services that focus on the unique needs of persons who have persistent pain, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.

An interdisciplinary pain rehabilitation program recognizes the individuality, preferences, strengths, and needs of the persons served, their families/support systems, and stakeholders. The program encourages appropriate use of healthcare systems and services by the persons served and their families/support systems and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

An interdisciplinary pain rehabilitation program fosters an integrated system of care that optimizes prevention, recovery, adaptation, inclusion, and participation. The program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in pain research.

Note: *A program seeking accreditation as an interdisciplinary pain rehabilitation program must include in the survey application and the site survey all portions of the program (inpatient, outpatient, etc.) that the organization provides and that meet the program description.*

Applicable Standards

An organization seeking accreditation for an Interdisciplinary Pain Rehabilitation Program must meet the program description and the standards in this section, as follows:

- All programs apply Standards 3.F.1.–34.
- If the program is provided in an inpatient setting, also apply Standards 3.F.35.–38.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents served and not seeking Pediatric Specialty Program accreditation

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.F. **1. When the following services are utilized, the interdisciplinary pain rehabilitation program documents its specific arrangements for:**
- **a. Medical services.**
- **b. Diagnostic services.**
- **c. Laboratory services.**
- **d. Pharmacy services.**
- **e. Including for each:**
  - **(1) Availability on site.**
  - **(2) Capacity.**
  - **(3) Timeliness of response to orders.**
  - **(4) Timeliness of results to the clinician who is making a decision based on those results.**

Intent Statements

If the interdisciplinary pain rehabilitation program utilizes these services it clearly delineates where and how the services are provided, e.g., at the facility where the program is located or through a service agreement with another provider in the community. The timeliness of information received, as well as the mechanism to get information to the appropriate party, is critical for decision making regarding the persons served.

3.F. **2. Written procedures are implemented to:**
- **a. Verify the backgrounds of all personnel prior to the delivery of services to the persons served or to the organization.**
- **b. Respond to the information received.**

Intent Statements

To reduce risk and ensure the safety of the persons served, it is essential that the organization define its process to verify the backgrounds of all personnel, including professional and support personnel, and take action when appropriate.

Examples

The physical therapist and/or support staff such as the receptionist may attend orientation but not provide direct service until background verification is complete.

3.F. **3. The interdisciplinary team includes:**
- **a. The person served.**
- **b. In accordance with the preference of the person served, members of the family/support system.**
- **c. The pain team physician.**
- **d. The pain team psychologist.**
- **e. Dependent on the assessed needs of the person served, one or more healthcare professionals who will assist in the accomplishment of goals related to function, impairment, activity limitations, participation restrictions, environmental factors, and personal factors.**
- **f. Additional healthcare professionals as the needs of the person served change or increase in complexity.**

Intent Statements

3.d. A psychiatrist may fulfill the role of the psychologist on the team if he or she provides the functions of a psychologist.

3.e. The number and types of professionals on the interdisciplinary team in addition to the pain team physician and the pain team psychologist will vary based on the complexity of needs of the persons served.

3.F. **4. The program director for the interdisciplinary pain rehabilitation program has the responsibility and authority to guide and direct:**

- **a. Establishing the program's policies and written procedures.**
- **b. Financial planning and decision making.**
- **c. Resource utilization management.**
- **d. Performance improvement activities.**
- **e. Program development and modification.**
- **f. Strategic planning.**
- **g. Educational activities for the program personnel.**
- **h. Stakeholder relationship management.**
- **i. Advocacy activities.**
- **j. The development of ongoing relationships with the community.**
- **k. Marketing and promoting the program.**

Intent Statements

CARF does not expect to see someone from any particular discipline fulfilling these responsibilities. The organization determines who has responsibility for the areas listed and the job title.

3.F. **5. The medical director for the interdisciplinary pain rehabilitation program is an M.D. or a D.O. who:**

- **a. Maintains an unrestricted license.**
- **b. Has a written agreement with the organization that outlines his or her responsibilities.**
- **c. Actively participates in:**
  - **(1) Ensuring the adequacy of individual treatment prescriptions and programs, including notations of contraindications and precautions, developed with the participation of professional personnel.**
  - **(2) Establishing the program's policies and written procedures.**
  - **(3) Establishing policies and written procedures that identify the functions and responsibilities of the pain team physician.**
  - **(4) Financial planning and decision making.**
  - **(5) Resource utilization management.**
  - **(6) Performance improvement activities.**
  - **(7) Program development and modification.**
  - **(8) Strategic planning.**
  - **(9) Educational activities with the program personnel.**
  - **(10) Stakeholder relationship management.**
  - **(11) Advocacy activities.**
  - **(12) The development of ongoing relationships with the medical community.**
  - **(13) Marketing and promoting the program.**

Intent Statements

5.a. An unrestricted license is a license to practice medicine in the state/province or other jurisdiction of the program that does not have any practice limitations imposed (such as limitations related to prescribing medications, clinical disciplinary actions, or personal behavior).

Examples

Active participation may mean membership by the medical director on a leadership/management team where these areas are reviewed and discussed, participation in feedback groups to develop marketing materials, or the provision

of input on budgetary needs from the medical perspective.

5.c.(10) Stakeholder relationship management includes the development of and participation with stakeholders of the program, such as the medical directors of insurance companies with which the program works and other physicians in the organization who refer to the interdisciplinary pain rehabilitation program or would benefit from education about the program.

3.F. **6. The medical director for the interdisciplinary pain rehabilitation program and each pain team physician:**

- **a. Is certified in his or her specialty area by a nationally recognized board.**
- **b. Demonstrates appropriate experience and training to provide pain physician services through at least one of the following:**
  - **(1) A fellowship for a minimum of one year in interdisciplinary pain medicine or palliative care recognized by a national board.**
  - **(2) A minimum of two years' experience as a collaborative team member providing pain rehabilitation services in an interdisciplinary pain rehabilitation program.**
  - **(3) If he or she has less than the equivalent of two years' experience in an interdisciplinary pain rehabilitation program, participation in a mentorship program that delineates the:**
    - **(a) Intensity of collaboration required with an experienced pain team physician.**
    - **(b) Length of collaboration required with an experienced pain team physician.**
- **c. Maintains his or her:**
  - **(1) Licensure.**
  - **(2) Certification.**
  - **(3) Privileges in the organization, if applicable.**
- **d. Participates in active clinical practice that relates to the population served.**
- **e. Demonstrates currency in medical practice concerning the persons served, including medication management.**
- **f. Demonstrates active learning and involvement in the professional community.**

Intent Statements

6.a. Examples of nationally recognized boards include the member boards of the American Board of Medical Specialties and the National Board of Health and Welfare in Sweden.

6.c.(3) The privileging process authorizes professionals to provide clinical services granted by a governing authority or in accordance with clinical staff bylaws.

6.e. The medical director and pain team physicians could demonstrate currency in medical practice concerning the persons served through their knowledge and use of evidence-based practices. This could also be reflected in the choice of continuing medical education events to attend and pursue and/or participation in research or demonstration projects that would enhance knowledge in certain areas related to their practice in pain management.

6.f. The medical director and pain team physicians could demonstrate active learning and involvement through participation in fellowships, certification in subspecialties, participation in grand rounds in local acute care hospitals, active participation in special interest groups in their physician professional groups, board membership or involvement in consumer advocacy groups, integration of evidence-based practices and medical advances relevant to the population served, and lectures to interdisciplinary pain providers.

3.F. **7. The pain team psychologist:**

- **a. Meets one of the following criteria:**
  - **(1) He or she has the equivalent of one year's full-time experience in an interdisciplinary pain rehabilitation program.**
  - **(2) If he or she has less than the equivalent of one year's full-time experience in an interdisciplinary pain rehabilitation program, the psychologist participates in a mentorship program that delineates the:**
    - **(a) Intensity of collaboration required with an experienced pain team psychologist.**
    - **(b) Length of collaboration required with an experienced pain team psychologist.**
- **b. Maintains his or her:**
  - **(1) Licensure.**
  - **(2) Privileges in the organization, if applicable.**
- **c. Participates in active clinical practice that relates to the population served.**
- **d. Demonstrates currency in psychology practice concerning the persons served.**
- **e. Demonstrates active learning and involvement in the professional community.**
- **f. Has regular, direct individual contact with the person served that is based on the psychological needs of the person served.**

Intent Statements

If a psychiatrist fulfills the role of the psychologist he or she is expected to meet this standard.

7.b.(2) The privileging process authorizes professionals to provide clinical services granted by a governing authority or in accordance with clinical staff bylaws.

Examples

7.d. The pain team psychologist could demonstrate currency in psychological practice concerning the persons served through knowledge and use of evidence-based practices. This could also be reflected in the choice of continuing education events to attend and pursue and/or participation in research or demonstration projects that would enhance knowledge in certain areas that may affect psychology practice.

7.e. The pain team psychologist could demonstrate active learning and involvement through participation in fellowships, certification in subspecialties, active participation in special interest groups in professional associations, board membership or involvement in consumer advocacy groups, integration of evidence-based practices and psychological advances relevant to the population served and lectures to interdisciplinary pain providers.

3.F. **8. If the interdisciplinary pain rehabilitation team includes healthcare professionals under service agreement with external resources:**

- **a. Roles and responsibilities within the organization for negotiating and authorizing service agreements are documented.**
- **b. Services are furnished in accordance with the terms of a written service agreement that specifies:**
  - **(1) The interdisciplinary pain rehabilitation program retains:**
    - **(a) Professional and administrative responsibility for the services.**
    - **(b) Control and supervision of the services.**
  - **(2) The length of the service agreement.**
  - **(3) The manner of service agreement termination or renewal.**
  - **(4) Personnel who furnish the services meet the same qualifications as personnel directly employed by the organization.**

(5) Adequate liability insurance coverage.

(6) Physical space that is conducive to the services provided.

(7) Timeframes for reports to be submitted to the interdisciplinary pain rehabilitation program.

(8) Policies and procedures regarding:

(a) Communication and collaboration throughout the team process.

(b) Availability to interact with:

(i) Persons served.

(ii) Families/support systems.

(iii) The teams of the persons served.

(iv) Other stakeholders.

(9) Information to be gathered for the analysis of performance.

(10) Exchange of information between service providers and the organization.

(11) Requirements to maintain the service agreement.

Intent Statements

All healthcare professionals on the interdisciplinary pain rehabilitation team, including those participating under service agreement, are expected to fulfill the team responsibilities addressed in Standard 2.B.15.

Examples

A written service agreement may also be called a contract, formal arrangement, or letter of agreement.

8.b.(8)(a) Communication and collaboration might include participation in team conferences and family/support system conferences or documentation in the records of persons served.

8.b.(11) Requirements to maintain the service agreement might include frequency requirements; how the provider is expected to stay current with the program's policies, procedures, and practices; timeframes for reports to be submitted to the program; and expectations for participation in conferences or other formal communication related to the persons served.

3.F. **9. The interdisciplinary pain rehabilitation program:**

a. Defines its admissions process.

b. Defines its continuing stay criteria.

c. Identifies the individual who is responsible for admission decisions.

d. Communicates admission decisions to the referral source.

3.F. **10. To ensure that there are no medical or psychological contraindications to entry into the program, prior to initiation of treatment:**

a. The pain team physician, who may use the assistance of an extender:

(1) Obtains a history.

(2) Conducts a physical examination.

(3) Determines the treating diagnosis.

b. The pain team psychologist conducts an assessment.

Intent Statements

10.a. In accordance with relevant internal or external requirements such as state/provincial licensing, legislation governing practice, and the organization's privileging process, the pain team physician may delegate certain aspects of the evaluation to another provider such as a physician assistant or nurse practitioner.

10.b. The psychological assessment could address previous psychological symptoms, diagnoses, and treatment; a review of support systems; the impact of pain on the person's daily functioning; and substance use. Assessment might include the use of standardized tools such as the Minnesota Multiphasic Personality Inventory (MMPI), Millon Behavioral Health Inventory (MBHI), Millon Clinical Multiaxial Inventory (MCMI), Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Oswestry, McGill, or others.

3.F. **11. Initial and ongoing risk assessments for each person served:**

- **a. Address the following areas:**
  - **(1) Aberrant medication-related behavior.**
  - **(2) Addiction.**
  - **(3) Suicide.**
  - **(4) Other maladaptive behavior(s).**
- **b. Are incorporated into:**
  - **(1) The assessment process.**
  - **(2) Individual program planning.**
  - **(3) Discharge/transition planning.**
- **c. Address actions to reduce identified risks.**

Examples

11.a. Initial and ongoing risk assessments might incorporate self-reports from the person served, the use of standardized tools such as the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) (**www.opioidrisk.com/node/1209**), objective measures such as an opioid urine drug screen, or the Substance Abuse and Mental Health Services Administration's TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (**store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA09-4381**).

11.a.(4) Other maladaptive behaviors could include harm to others or to oneself such as not eating, depression, severe anxiety, etc.

3.F. **12. Based on the needs of each person served, a comprehensive assessment addresses, at a minimum:**

- **a. Limiting pain conditions.**
- **b. Comorbidities.**
- **c. Factors that might influence the program, including:**
  - **(1) Cultural.**
  - **(2) Economic.**
  - **(3) Litigation.**
  - **(4) Social.**

Examples

12.b. Arthritis, diabetes, cancer, high blood pressure, sleep disturbance, depression, anxiety, post traumatic stress disorder, and substance use are examples of comorbidities.

12.c.(2) Examples of economic factors that might influence the program include:

- The person served has provided all of the financial support for her extended family and has been unable to return to work due to persistent pain.
- The person served cannot return to full-time employment due to pain, and because the job requires full time the person is out of work.
- Due to the country's economic downturn and the inability to work the person served is having difficulty maintaining her home, car, and loan payments so may frequently miss or cancel appointments.

3.F. **13. The interdisciplinary pain rehabilitation program addresses the needs of the person served in the following health areas:**

- **a. Body functions and structures.**
- **b. Activity.**
- **c. Participation.**
- **d. Environmental factors.**
- **e. Personal factors.**

Examples

CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology.

3.F. **14. In developing the treatment approaches, supports, and/or strategies for the person served the program documents:**

- **a. Methods used to collect findings, including:**
  - **(1) Activities involved.**
  - **(2) Measured results achieved.**
  - **(3) Tools, tests, and instruments that have been determined to be valid.**
- **b. Analysis of findings, including, but not limited to:**
  - **(1) Resolution of conflicting information/opinions, if any.**
  - **(2) Response to referral questions.**

Intent Statements

14.b. The analysis and response to referral questions are substantiated by the findings.

3.F. **15. The predicted outcomes for each person served determine the:**

- **a. Type(s) of services.**
- **b. Duration of services.**
- **c. Frequency of services.**

3.F. **16. Related to the scope and intensity of services recommended for each person served, the program addresses:**

- **a. The willingness of the person served to participate.**
- **b. The ability of the person served to tolerate the services proposed.**
- **c. Medical necessity for the level of services.**
- **d. The potential of the person served to benefit.**

3.F. **17. The interdisciplinary pain rehabilitation program demonstrates:**

- **a. Coordination of services to meet individual needs.**
- **b. Integration of services provided through interaction and feedback:**
  - **(1) Within its own organization.**
  - **(2) With other service providers/ systems.**

3.F. **18. The program communicates with the referral source of each person served at the time of:**

- **a. Admission.**
- **b. Significant changes in the status of the person served.**
- **c. Discharge/transition.**

Intent Statements

Communication with the referral source should be offered. If the referral source indicates that he or she does not want ongoing communication about the person served, e.g., a hospitalist who made the referral but will not be following the person served after discharge/transition from the program, the program notes this in the record of the person served and directs ongoing communication to the primary care physician.

3.F. **19. In response to the preferences of the person served, the interdisciplinary pain rehabilitation program:**

- **a. Assesses the person's use of complementary health approaches.**
- **b. Educates the person served on the efficacy and safety of interventions.**
- **c. Provides information and resources on integrative health, as appropriate.**

Examples

According to the National Institutes of Health National Center for Complementary and Integrative Health (**nccih.nih.gov/health/integrative-health**), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream

approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

Resources

Please refer to Appendix D for resources related to complementary health approaches.

3.F. **20. The pain team physician, who may use the assistance of an extender, has regular, direct individual contact with the person served that is based on the:**

- **a. Medical needs of the person served.**
- **b. Rehabilitation needs of the person served.**

Intent Statements

In accordance with relevant internal or external requirements, including, but not limited to, state/provincial licensing, legislation governing practice, and, if applicable, the organization's privileging process, the pain team physician may delegate certain aspects of physician services to another provider such as a physician assistant or nurse practitioner.

3.F. **21. A physician is available for medical consultation 24 hours a day, 7 days a week.**

Intent Statements

The interdisciplinary pain rehabilitation program makes provisions to ensure that the persons served have access to medical consultation when needed.

Examples

Physician consultation may be provided by the pain team physician, an on-call physician who is familiar with the program and the population served, an urgent care center that has been specifically trained on the needs of persons with persistent pain, etc.

3.F. **22. If pharmacotherapy is used in the program, duration is based on:**

- **a. The needs of each person served.**
- **b. The risk benefit ratio of the medication.**
- **c. Adverse effects of the medication.**

Intent Statements

Please refer to the Glossary for the definition of *pharmacotherapy*.

Pharmacotherapy is based on the needs of the person served, including his or her response to the medication. Factors such as a history of substance use, previous pharmacotherapy, and adverse effects such as medical complications are considered in determining the duration of pharmacotherapy for the person served.

Examples

22.b. Consideration is given to whether the side effects of the medication are manageable by the person served and the ability of the person served to obtain the medication and adhere to the recommended administration.

3.F. **23. The interdisciplinary pain rehabilitation program implements policies and written procedures related to:**

- **a. Medications, including the role of physicians concerning:**
  - **(1) Whether admission to the program is impacted by medication use.**
  - **(2) The prescription of dosages.**
- **b. The responsibility of each person served concerning medication safety issues, including the individual's responsibility to:**
  - **(1) Inform program personnel of changes in medication use.**
  - **(2) Report his or her status as a participant in a pharmacotherapy program to other medical service providers from whom services are received.**

Examples

23.a.(1) Policies and written procedures address medication use that may preclude admission to the program such as intravenous medication that requires ongoing physician monitoring or medication that impedes the ability of the person served to tolerate or safely participate in the program.

23.a.(2) Factors to be considered in determining the dosage include history of medication dependence, current standards of practice, the dosage required for stable functioning, an evaluation of continued unauthorized medication use, and the use of prescribed medications.

23.b.(1) Medication use includes prescription medications, over the counter medications, alcohol, and illicit substances. The person served may be notified of his or her responsibility to inform program personnel of changes in medication use during orientation, individual or group counseling sessions, educational sessions, or information posted in the facility where the program is provided.

3.F. **24. To ensure the safety of the person served, medications prescribed for the person served at the time of discharge/transition by the pain team physician or an external physician are consistent with the available resources:**

- **a. To obtain them.**
- **b. Needed to adhere to recommended administration.**

Examples

Resources that might impact obtaining medications and/or adhering to recommended administration include payment sources, the availability of medication samples, caregiver support, packaging of the medications, and transportation to pick them up at the pharmacy. Similarly, the ability to self-administer medications, language barriers, literacy, or cognitive issues on the part of the person served may pose challenges to adhering to recommended administration.

3.F. **25. If the interdisciplinary pain rehabilitation program provides drug screening, policies and written procedures address drug-screening practices, including:**

- **a. The frequency of drug screening.**
- **b. Provisions for the individualization of drug screening.**
- **c. An interpretation of the results of drug screening.**
- **d. Actions to be taken based on the results of drug screening.**
- **e. Education for:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
  - **(3) Personnel.**

Examples

Policies and written procedures related to drug-screening practices might address the collection and processing of urine samples, continuing education for personnel concerning urinalysis practices, emergency services procedures, and define who has access to and responsibility for maintaining confidentiality for all drug screen results information. The policies and procedures for urine sample collection might define how respect for persons served is maintained while minimizing the potential for falsification during the collection process.

25.a. The policy may require drug screening at the time of admission, when there appears to be a change in behavior, or at the request of the team. It may also specify only a one-time screening.

3.F. **26. To advance the field of pain rehabilitation, leadership supports:**

- **a. The program's participation in research opportunities.**
- **b. The provision of information about available clinical trials, as appropriate, to:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**

Intent Statements

26.a. It is not expected that every program will have its own research center. There are many

opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

26.a. The program provides input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The program participates in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to pain rehabilitation on its research agenda.

The organization participates in associations in which researchers and clinicians interact to influence research in the field of pain rehabilitation.

Resources

Please refer to Appendix D for resources related to clinical trials.

3.F. **27. The interdisciplinary pain rehabilitation program personnel discuss options for pain support groups and resources with:**

- **a. Persons served.**
- **b. Families/support systems.**

Intent Statements

Pain support groups and resources are critical to the ongoing support for the persons served and their families/support systems during participation in the interdisciplinary pain rehabilitation program and after discharge/transition.

Examples

Resources discussed might include the schedule for and topics addressed in support group meetings facilitated by the pain rehabilitation program; contact information and a description of support groups available in the community; recommended reading for members of the family/support system to better understand the impact of persistent pain on their loved ones; and physician, urgent care, or emergency resources that would be appropriate to access if needed during weekend and evening hours.

3.F. **28. There are provisions for contact as appropriate between the persons served and the program after discharge/transition.**

3.F. **29. Pertinent to the roles and responsibilities of their jobs, personnel demonstrate competency in the use of available technology to support operations and effective service delivery.**

Examples

Mechanisms in the electronic medical record documentation system are used by team members to ensure timely exchange of information for modifying the treatment plan.

Personnel are educated and have adequate skills and knowledge to accurately enter data into the electronic billing system to assist in timely billing for services.

Personnel know how to access and use the organization's intranet for mandatory web-based education and training.

Personnel are able to use the internet to search websites for information on evidence-based practice and clinical trials.

3.F. **30. The program provides education and training regarding the nature and value of interdisciplinary pain rehabilitation to:**

- **a. Persons served.**
- **b. External stakeholders.**
- **c. The general public.**

Intent Statements

30.b. Please refer to the Glossary for the definition of *stakeholders*.

Examples

Education might be provided through one-on-one contacts or to groups and include written information, lectures, videos, audio recordings, the provision of information via informational mailings, emails, or the program's website.

30.b. External stakeholders might be payers, other healthcare providers, or referral sources.

3.F. **31. The organization demonstrates:**

- **a. Knowledge of its:**
  - **(1) Case mix.**
  - **(2) Referral patterns.**
  - **(3) Denials.**
  - **(4) Referrals determined to be ineligible for services.**
- **b. A mechanism to appeal denials.**

Intent Statements

The organization is proactive in its knowledge and management of how these areas affect the viability of the interdisciplinary pain rehabilitation program.

Examples

31.a.(3) Denials may be payer denials for admission into the program or for continued services or for a specific intervention or modality.

31.a.(4) Persons referred to the program may be deemed ineligible for services because they do not meet the admission criteria or their needs are outside of the scope of the program.

31.b. The process to appeal denials may identify when an appeal will be made, responsibilities of personnel, and levels of appeal.

3.F. **32. A written analysis of no-shows, cancellations, and dropouts:**

- **a. Is conducted at least annually.**
- **b. Addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) No-shows.**
    - **(b) Cancellations.**
    - **(c) Dropouts.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**

Intent Statements

The program defines no-show, cancellation, and dropout. The consistent use of these definitions increases the accuracy and validity of the information gathered. These three areas are critical to the effectiveness and efficiency of the program. If they are not paid attention, access to services for new persons served may be limited.

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

3.F. **33. The interdisciplinary pain rehabilitation program:**

- **a. Has indicators to measure performance in the following areas:**
  - **(1) Ability of the persons served to manage pain.**
  - **(2) Activity.**
  - **(3) Intensity of subjective pain.**
  - **(4) Participation.**
  - **(5) Satisfaction of the persons served, including satisfaction with:**
    - **(a) Accuracy of information received about the program.**
    - **(b) Clinical practices/behaviors.**
    - **(c) Degree of inclusion of the persons served in their programs.**
    - **(d) Outcomes achieved.**
  - **(6) Use of healthcare services related to pain.**
  - **(7) Use of medication.**

b. At least annually conducts a written analysis that addresses:
- **(1) Performance in relationship to established targets for indicators of:**
  - **(a) Ability of the persons served to manage pain.**
  - **(b) Activity.**
  - **(c) Intensity of subjective pain.**
  - **(d) Participation.**
  - **(e) Satisfaction of the persons served, including satisfaction with:**
    - **(i) Accuracy of information received about the program.**
    - **(ii) Clinical practices/ behaviors.**
    - **(iii) Degree of inclusion of the persons served in their programs.**
    - **(iv) Outcomes achieved.**
  - **(f) Use of healthcare services related to pain.**
  - **(g) Use of medication.**
- **(2) Trends.**
- **(3) Actions for improvement.**
- **(4) Results of performance improvement plans.**
- **(5) Necessary education and training of:**
  - **(a) Persons served.**
  - **(b) Families/support systems.**
  - **(c) Healthcare providers.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

3.F. **34. The organization conducts a written analysis of the services provided:**
- **a. At least annually.**
- **b. That addresses, as evidenced by the records of the persons served:**
  - **(1) Quality of services.**
  - **(2) Appropriateness of services.**
  - **(3) Patterns of service utilization.**
  - **(4) Timeliness of documentation.**
- **c. On a representative sample of:**
  - **(1) Current records.**
  - **(2) Closed records.**
- **d. That is performed by personnel who:**
  - **(1) Are trained and qualified.**
  - **(2) Are not:**
    - **(a) The sole reviewer of the services for which he or she is responsible.**
    - **(b) Solely responsible for the selection of records to be reviewed.**
- **e. That includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Quality of services.**
    - **(b) Appropriateness of services.**
    - **(c) Patterns of service utilization.**
    - **(d) Timeliness of documentation.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of personnel.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

Applicable Standards

If the Interdisciplinary Pain Rehabilitation Program is provided in an inpatient setting, Standards 35.–38. must also be met.

3.F. **35. The admission criteria are written to ensure that the persons admitted require the level of intensity of the services provided by an inpatient interdisciplinary pain rehabilitation program.**

3.F. **36. Nursing services provide for:**

- **a. Nursing coverage 24 hours a day under the supervision of a registered nurse.**
- **b. An intensity of nursing care that corresponds to the needs of the persons served.**

3.F. **37. The inpatient program beds are in an area that is:**

- **a. Designated.**
- **b. Contiguous.**

Intent Statements

Locating the inpatient program beds in a designated area and such that they are contiguous optimizes the effectiveness and efficiency of the team in its delivery of services as well as the opportunities for persons served to interact with each other, and it supports the programmatic approach to interdisciplinary pain rehabilitation versus the provision of individual services by various providers in multiple locations throughout the facility.

3.F. **38. The inpatient interdisciplinary pain rehabilitation program:**

- **a. Gathers information on each person served, including information on:**
  - **(1) Discharges to long-term care.**
  - **(2) Expiration.**
  - **(3) Unplanned transfers to acute medical facilities.**
- **b. At least annually conducts a written analysis that includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Discharges to long-term care.**
    - **(b) Expiration.**
    - **(c) Unplanned transfers to acute medical facilities.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Personnel.**
    - **(b) Payers.**
    - **(c) Regulatory agencies.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

G. Occupational Rehabilitation Program

Description

An Occupational Rehabilitation Program is individualized, focused on return to work, and designed to minimize risk to and optimize the work capability of the persons served. The services provided are integrative in nature, with the capability of addressing the work, health, and rehabilitation needs of those served. Such a program provides for service coordination and management of those persons served with injuries or illnesses. In view of the multiple stakeholders involved in Occupational Rehabilitation Programs, informed consent to obtain or share information about the persons served is provided by the persons served as required.

The program may be provided as a hospital-based program, an outpatient program, or a private or group practice, and/or it may be provided in a work environment (at the job site).

Note: *For Canadian providers of Occupational Rehabilitation Programs, the concept of* occupation *is broader than a person's employment and might include functional roles such as homemaker, student, volunteer, etc.*

Applicable Standards

An organization seeking accreditation for an Occupational Rehabilitation Program must meet the program description and the standards in this section, as follows:

- All programs apply Standards 3.G.1.–14.
- If Occupational Rehabilitation Program—Comprehensive Services accreditation is sought, also apply Standard 3.G.15.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.B. (see guidelines on page 117)
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents are served

3.G. **1. Health and medical contraindications are identified when relevant for each person served prior to the initiation of treatment.**

Examples

Health and medical contraindications could be identified by a recent general history and a physical, the use of a questionnaire such as the Physical Activity Readiness Questionnaire (PAR-Q), or screening questions asked as part of the intake/assessment process regarding chronic health or medical conditions and recent medical events precipitating visits to the emergency room or urgent care that might impact participation in the program.

3.G. **2. At admission the occupational rehabilitation program gathers information on each person served, including information on the:**

- **a. Date of accident/injury/illness.**
- **b. First date of lost time and/or last day of work.**

3.G. **3. The assessment process considers the following factors that affect a person's ability to safely participate in the program:**

- **a. Behavioral status.**
- **b. Cardiovascular status.**
- **c. Cognitive status.**
- **d. Musculoskeletal status.**
- **e. Reasonable accommodation issues.**
- **f. Safety issues.**
- **g. Vocational status.**
- **h. Work capacity.**

Intent Statements

Although the program is expected to address each of these areas in its assessment process for the persons served, it does not have to administer

any specific tests to address them and the extensiveness of the assessment in each of these areas may vary with each individual.

Examples

A recent history and physical, a recent social history, a recent psychological exam, and other screening and information-gathering mechanisms could be used to gather some or all of the information.

3.g. Vocational status could include whether the person served is working full time, part time, or not at all or whether there have been any modifications to his or her work duties.

3.G. **4. The assessment process for each person served identifies and documents the:**

- **a. Presenting problems, diagnoses, or conditions for which the person requires occupational rehabilitation.**
- **b. Other issues that may affect treatment.**
- **c. Questions from the referral source to be answered.**
- **d. Abilities and functional limitations as they relate to the workplace.**
- **e. Original job to return to, a targeted new job, or the availability of transitional work.**
- **f. Functional, work-related goals that would enable the person to return to work.**
- **g. Initial estimated timeframes for goal accomplishment.**
- **h. Services needed.**
- **i. Potential benefits related to the rehabilitation intervention.**
- **j. Discharge plan.**
- **k. Expectations of the:**
  - **(1) Persons served.**
  - **(2) Employer.**
  - **(3) Payer.**

Intent Statements

4.k.(2) Involvement with employers is a keystone of occupational rehabilitation programs. Identifying and documenting the employer's expectations allows the program to plan and treat the person served appropriately.

Examples

4.c. Questions from the referral source may relate to the maximum weight a person may safely lift, the person's ability to sit for extended periods of time to drive or work at a desk, tolerance for keyboarding or other repetitive movement, the person's ability to climb stairs or a ladder, etc.

3.G. **5. Current information on the following is considered in implementing the individual program plan:**

- **a. Job availability.**
- **b. A job description and/or job analysis that addresses essential functions.**
- **c. Availability of modified or alternate duty.**
- **d. The work history of the person served.**
- **e. The person's lifestyle.**
- **f. The person's educational background.**

Intent Statements

Information in each area is gathered as appropriate to the individual's plan and predicted outcomes. For example, if the person served is expected to return to his former job without restriction, information on his educational background may not be necessary. However, if the individual will be prohibited from returning to the job he was doing at the time of injury and vocational retraining will be offered, educational background is relevant.

3.G. **6. The program promotes improvement in:**

- **a. Work cultures.**
- **b. Work environments.**

Intent Statements

Promotion of improvement in work cultures and work environments may positively impact a successful return to work and durability of outcomes and decrease the potential for reinjury. Efforts made on behalf of a person served might also benefit other workers in the setting.

Examples

6.a. Improvement in work cultures could be addressed through education to employers on how to transition injured workers back into the work place and possible ways to accommodate temporary or permanent restrictions. Promoting improvement in work cultures might also be addressed by providing the persons served with strategies to interact and communicate with coworkers, how to work with employee and employer representatives such as union representatives or human resources personnel.

6.b. Improvements in work environments might be accomplished through recommendations that change the way the work is done. This might include the use of adaptive equipment (e.g. anti-stress mats, supportive splints), positioning changes (e.g. addressing body mechanics, height of equipment, height of storage of items), alternating tasks to reduce fatigue, etc.

3.G. **7. On a systematic, organized basis, and based on the needs of the persons served, the program provides or arranges for:**

- **a. Work assessments that include the assessment, through work-site evaluation and/or job analysis, of specific job requirements in relation to program goals.**
- **b. The practice of component work tasks through real or simulated work, along with modification of and instruction in such tasks.**
- **c. The development of the strength and endurance of the person served related to the performance of work tasks.**
- **d. Education on safe work practices.**
- **e. Education of the employer and/or employee representative as to the implications of the present status of the person served.**
- **f. The involvement of family members and/or support systems to promote understanding of the implications of the present status of the person served.**
- **g. A mechanism to promote the responsibility and self-management of the person served.**
- **h. An assessment of the person served in relation to his or her:**
  - **(1) Productivity.**
  - **(2) Safety in the workplace.**
  - **(3) Development of worker behaviors.**
- **i. An identification of the transferable skills of the person served to facilitate his or her return to work.**
- **j. The development of behaviors that will improve the ability of the person served to return to work or to benefit from other rehabilitation.**

Examples

7.e. Employee representatives include legal counsel, union representatives, employee relations representatives, employee health nurses, and case managers.

3.G. **8. Dependent on the needs of the person served, the services provided:**

- **a. Promote optimal function.**
- **b. Address functional, return-to-work goals.**
- **c. Include education about injury prevention.**

3.G. **9. The program addresses, when appropriate, either internally or through referral, adaptations for the:**

- **a. Work environment.**
- **b. Worker.**

Examples

9.a. Adaptations for the work environment might include the use of an ergonomic chair or footrest that can be properly adjusted for the person served, rearranging a work station to reduce the reaching or standing required, installation of a truck seat that reduces vibration when driving, the use of a tilted or heightened work surface to reduce bending, and modifying the sequence of

tasks to be performed to allow more frequent changes of position.

3.G. **10. As the needs of the person served change or increase in complexity, the occupational rehabilitation program provides or makes formal arrangements for the provision of services by additional healthcare professionals.**

3.G. **11. The program:**

- **a. Tracks attendance.**
- **b. Tracks work tolerance.**
- **c. Disseminates this information on an ongoing basis to all relevant stakeholders as requested or required.**

3.G. **12. The discharge summary delineates a person's:**

- **a. Present functional/work status.**
- **b. Potential functional abilities.**
- **c. Functional status related to the targeted jobs or alternative occupations in the competitive labor market.**
- **d. Progressive plan for return to work, if appropriate.**

3.G. **13. The program establishes its timeframe for disseminating discharge summaries to relevant stakeholders.**

3.G. **14. The occupational rehabilitation program:**

- **a. Gathers information on the work capability of each person served at discharge, including information on:**
  - **(1) Fitness to work.**
  - **(2) Ability to return to the same job.**
  - **(3) Ability to return to the same occupation.**
  - **(4) Capacity to begin a new occupation.**
  - **(5) Inability to work.**
- **b. Gathers information from a representative sample of the persons served at a point(s) after discharge, including information on whether they are:**
  - **(1) In the same job as before.**
  - **(2) In the same occupations.**
  - **(3) In new occupations.**
  - **(4) Not working.**
- **c. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Work capability at discharge, including:**
      - **(i) Fitness to work.**
      - **(ii) Ability to return to the same job.**
      - **(iii) Ability to return to the same occupation.**
      - **(iv) Capacity to begin a new occupation.**
      - **(v) Inability to work.**
    - **(b) Work status after discharge, including information on persons:**
      - **(i) In the same job as before.**
      - **(ii) In the same occupations.**
      - **(iii) In new occupations.**
      - **(iv) Not working.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**
    - **(d) Others.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

14.b. Please refer to the Glossary for a definition of *representative sample*.

Occupational Rehabilitation Program—Comprehensive Services

Description

Persons admitted to an Occupational Rehabilitation Program—Comprehensive Services tend to have more complex needs due the nature of their injury, illness, or impairment; length of time they have been off work; home or work circumstances; or other reasons. Through the comprehensive assessment and treatment provided by occupational rehabilitation specialists, Occupational Rehabilitation Program—Comprehensive Services directly provide and coordinate services to address the behavioral, functional, medical, physical, psychological, and vocational components of employability and return to work.

3.G. **15. An occupational rehabilitation program—comprehensive services directly provides services to meet the complex needs of the persons served in the following areas:**

- **a. Behavioral.**
- **b. Functional.**
- **c. Medical.**
- **d. Physical.**
- **e. Psychological.**
- **f. Vocational.**

H. Independent Evaluation Services

Description

Independent Evaluation Services coordinate and facilitate objective, unbiased evaluations based on the following:

- Individualized referral questions.
- Effective and efficient use of resources.
- Regulatory, legislative, and financial implications.
- Relevant communication with stakeholders.

In view of the multiple stakeholders involved, the Independent Evaluation Services support transparency and exchange of information.

Independent evaluations may be completed by a variety of professionals who are not involved in the care of the person served for the purpose of clarifying clinical and case issues. The delivery of Independent Evaluation Services may occur in a variety of settings including, but not limited to, a healthcare environment, a private practice, a community-based setting, or a private or group residence.

Applicable Standards

An organization seeking accreditation for Independent Evaluation Services must meet the program description and the standards in this section, as follows:

- All programs apply Standards 3.H.1.–30.
- If *any* children/adolescents are served, also apply Standards 3.H.31.–35.

Additionally, the standards in Section 1 apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional

Note: *Section 2 standards are **not** applicable to Independent Evaluation Services.*

3.H. **1. The independent evaluation services:**

a. Document the following parameters regarding the scope of their evaluation services:

(1) Geographic area(s) served.
(2) Settings.
(3) Hours of services.
(4) Days of services.
(5) Payer sources.
(6) Fees.
(7) Referral sources.
(8) The specific services offered, including whether the services are provided directly or by service agreement.

b. Document the following parameters regarding the persons served:

(1) Ages.
(2) Activity limitations.
(3) Behavioral status.
(4) Cultural needs.
(5) Impairments.
(6) Medical acuity.
(7) Medical stability.
(8) Participation restrictions.
(9) Psychological status.

c. Share information about their scope with:

(1) Persons served.
(2) Families/support systems, in accordance with the choices of the persons served.
(3) Referral sources.
(4) Payers and funding sources.
(5) Other relevant stakeholders.
(6) The general public.

d. Review their scope at least annually and update it as necessary.

Intent Statements

The scope is defined at the level of the independent evaluation services and provides persons served, families/support systems, referral sources, payers, other relevant stakeholders, and the general public with information that helps them

understand what the evaluation services have to offer and determine whether they will meet the needs of the persons served.

Examples

CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

1.a.(5) and **1.c.(4)** Payers and funding sources could include private payers, such as third party payers; auto insurance companies; HMOs; self-insured employers; or public payers, such as state/provincial or other jurisdictional payers. As part of the identification of primary payer sources, the independent evaluation services might also identify payer requirements that could affect the provision of services.

1.b.(4) Please refer to the Glossary for a definition of *culture*.

1.b.(5) Impairments may include comorbidities.

1.b.(6)–(7) The scope addresses whether the independent evaluation services will accept a referral of someone with an acute and/or unstable medical condition such as a person undergoing chemotherapy or radiation treatment for cancer or a person with a cardiac arrhythmia, chronic obstructive pulmonary disease (COPD), unstable blood pressure, uncontrolled diabetes, or unstable musculoskeletal condition.

1.b.(8) Participation restrictions could include restrictions related to participation in occupational activities, school, homemaking activities, parenting, hobbies, or community events.

1.c.(5) Please refer to the Glossary for a definition of *stakeholders*.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology and to health literacy.

3.H. **2. The organization provides the resources needed to support the overall scope of the independent evaluation services.**

Intent Statements

There is evidence of adequate resources to support and provide the scope of the independent evaluation services defined in Standard 1.

Examples

Resources include, but are not limited to, personnel; finances; leadership; space, materials, equipment, and supplies; and continuing education for personnel.

3.H. **3. An individual is identified by the organization who has the responsibility and authority to direct and maintain the operation of the program.**

Intent Statements

The job description and job title will vary with each organization. The organization identifies the title of this person and his/her responsibilities.

3.H. **4. The program/service demonstrates:**

- **a. Knowledge of the legal decision-making authority of the persons served.**
- **b. When applicable, the provision of information to the persons served regarding resources related to legal decision-making authority.**

Intent Statements

The person served may not have the capacity or be of the age to make decisions in his or her own best interests. An individual may need to be assigned to make decisions regarding healthcare choices, financial decisions, or life care planning. Legal terminology may vary from state to state or province to province; i.e., healthcare power of attorney, power of attorney, and guardianship. The program/service should be able to discuss how it addresses the issue of the legal decision-making authority of the persons served.

4.b. Any limitation on a person's legal decision-making authority should be continued only as long as is appropriate and necessary. The program/service assists the person served and his or her family members/support system to access resources, such as attorneys with expertise in this area, who can assist with facilitating changes, if appropriate, in legal autonomy status.

Examples

4.a. The legal decision-making authority of the persons served may be addressed by someone in the organization who has expertise in competency determination, through a screening process, in team conferences, etc. A provider could demonstrate knowledge of legal decision-making authority through a discussion with the surveyor of legal decision-making authority issues pertinent to existing jurisdictional law, policies that outline levels of legal autonomy, inserviceson issues of legal decision-making authority, and materials for personnel and the persons served that explain legal decision-making authority.

3.H. **5. In accordance with the needs of each person served, the independent evaluation services identify the appropriate:**

- **a. Evaluation services.**
- **b. Evaluation settings.**

Examples

5.a. Evaluation services might include, but are not limited to, functional, medical, psychological, and vocational evaluation services. Depending upon the scope of the referral and the needs of the person referred, evaluations might be conducted by a single evaluator or a team of evaluators.

5.b. Settings might include a healthcare environment, a private practice, a community-based setting, or a private or group residence.

3.H. **6. Prior to an independent evaluation, a risk screening of each person served addresses, as relevant and appropriate, the following areas:**

- **a. Behavioral.**
- **b. Cognitive.**
- **c. Communication.**
- **d. Developmental.**
- **e. Emotional.**
- **f. Environmental.**
- **g. Physical.**
- **h. Capability of the family/support system.**
- **i. Need for observers.**
- **j. Other, as appropriate.**

Intent Statements

Although the independent evaluation services are expected to address each of these areas in the risk screening for the persons served, the extensiveness of the screening in each area may vary with each individual. Conducting the screening prior to evaluation allows for adequate preparation and increases the effectiveness and efficiency of the evaluation process.

Examples

The risk screening might be accomplished by checking with the referral source regarding risks in the various areas or via a phone call with the person served prior to scheduling to determine potential risk areas.

6.c. The screening identifies that the person served has a hearing impairment and uses sign language to communicate. The independent evaluation services arrange for a translator to assist during the evaluation.

6.g. The screening identifies that the person served uses either a cane or a walker to assist with ambulation, depending on where she is going. The independent evaluation services determine that the person should bring both of these to the evaluation.

6.h. The screening identifies that the person's spouse is able to provide transportation only on days she is not working.

3.H. **7. Prior to an independent evaluation, the organization identifies or confirms the evaluation-related needs of the person served in the following areas:**

- **a. Assistive technology.**
- **b. Communication.**
- **c. Equipment.**
- **d. Transportation.**
- **e. Other needs.**

Examples

7.a. Assistive technology may include electronic aids to daily living, environmental controls, or personal emergency response systems.

7.b. The independent evaluation services are notified by the referral source that the person served has a hearing impairment and communicates using sign language. The evaluation service confirms this information and determines that a translator will be needed during the evaluation.

7.e. Additional time to complete an evaluation is an example of other needs that may be identified through the risk screening.

3.H. **8. The organization has information available regarding local resources for:**

- **a. Lodging.**
- **b. Translation services.**
- **c. Transportation.**

Examples

8.a. Information is provided so the person served who is traveling in from out of town can make arrangements for lodging the night before the independent evaluation begins.

3.H. **9. When the needs of a person referred are outside the scope of the independent evaluation services:**

- **a. Relevant stakeholders are informed as to the reasons.**
- **b. Recommendations are made, as appropriate, for alternative evaluation services.**

Examples

The referral source requests that physical and psychological evaluations be completed for the person referred. The independent evaluation services do not have personnel with the competencies to complete a psychological evaluation so they identify another provider that is able to complete the evaluation, and they provide this information to the insurance company that made the referral.

3.H. **10. Prior to an independent evaluation, the organization provides information to the persons served that addresses, at a minimum:**

- **a. Date of evaluation.**
- **b. Time of evaluation.**
- **c. Location of evaluation.**
- **d. Duration of evaluation.**
- **e. Purpose of evaluation.**
- **f. Name and specialty of the evaluator.**
- **g. The organization's policy on observers.**
- **h. The organization's policy on use of recording devices.**
- **i. Responsibilities of the person served.**
- **j. What will occur after evaluation.**
- **k. How to request a copy of the evaluation report.**

Intent Statements

If the independent evaluation requires more than one session, the person served is provided with the date, time, location, duration, and other information for each session.

Examples

10.i. Responsibilities of the person served might address expectations regarding punctuality, provision of maximal effort during the evaluation, safety during evaluations, appropriate clothing, whether to take prescribed medications prior to the evaluation, how to reschedule if necessary, and the consequences of a no-show.

10.k. The person served is provided information on how to request a copy of his or her report from the independent evaluation services or other entity such as the referral source or payer source.

3.H. **11. The independent evaluation occurs in accordance with timeframes established by stakeholder requirements or the independent evaluation services.**

3.H. **12. The independent evaluation services implement communication mechanisms that:**

- **a. Address:**
  - **(1) The needs of:**
    - **(a) The persons served.**
    - **(b) The organization.**
    - **(c) Other stakeholders.**

(2) Emergent issues.
(3) Contingency planning.
(4) Decisions concerning the person served.

b. Ensure the exchange of information regarding the evaluation.

Examples

12.a.(1) Hearing and language issues may pose barriers to communication between the person served and the evaluator. The use of a translator or communication device may be necessary.

12.a.(2) The person served experiences a rise in blood pressure during the evaluation and is concerned about driving herself home. There is a mechanism in place to contact a family member who can drive or accompany the person served home.

The evaluator is delayed returning to the office. A mechanism is in place to convey this information to the person served so he can adjust his arrival time and avoid a lengthy wait.

3.H. **13. When specialized needs or concerns are identified for the persons served, there are conferences or formal communication with the appropriate parties.**

Examples

A person served has multiple evaluations conducted by the independent evaluation services and the evaluators express conflicting opinions. Before the final report is generated the evaluators participate in a conference call to discuss their findings and conclusions.

Conferences and formal communication may take place face to face or via other mechanisms such as conference calls, email, voice-over-internet calling systems, etc.

3.H. **14. The person who coordinates the evaluation process for each person served:**

a. Demonstrates appropriate competencies as defined by the independent evaluation services.
b. Is identified to:
(1) The person served.
(2) The family/support system.
c. Has the authority to coordinate the evaluation.
d. Is knowledgeable about the evaluation being provided to the person served.
e. Is available to interact with:
(1) The person served.
(2) The evaluator(s).
(3) Other stakeholders.
f. Is responsible for ensuring communication with:
(1) External sources.
(2) Internal sources.
g. Ensures that evaluation arrangements are completed.
h. Ensures that evaluation reports are completed.
i. Ensures that evaluation recommendations are communicated to appropriate stakeholders.

Intent Statements

The independent evaluation services determine the individual who will fulfill these responsibilities. CARF does not expect to see someone from any one discipline or any specific number of these individuals. The number will depend on the scope of the independent evaluation services. If these responsibilities are shared by more than one person for a person served, the organization should identify who has ultimate responsibility for the areas that may be delegated and how efforts will be coordinated on behalf of the person served.

The surveyors should be able to ask the persons served and their families/support systems about these individuals and get responses that indicate that they know who is coordinating the evaluation process for the person served.

3.H. **15. Based on the needs of the person served and the scope of the independent evaluation referral, the evaluation team includes:**

- **a. The person served.**
- **b. Personnel with the competencies necessary to evaluate the following areas:**
  - **(1) Behavior.**
  - **(2) Cognition.**
  - **(3) Communication.**
  - **(4) Functional.**
  - **(5) Medical.**
  - **(6) Pain management.**
  - **(7) Physical.**
  - **(8) Psychological.**
  - **(9) Recreation and leisure.**
  - **(10) Social.**
  - **(11) Vocational.**

Examples

15.b.(5) Medical needs might be addressed by a variety of medical subspecialties including, but not limited to, neurology, orthopedics, and physical medicine and rehabilitation.

Medical needs might also include nursing, pharmacy, or nutrition needs in addition to needs that would be addressed by a physician.

3.H. **16. Based on established competencies, the organization determines for members of the team with limited or no prior experience in the specific program area:**

- **a. The intensity of the collaboration required with experienced team members.**
- **b. The length of the collaboration required with experienced team members.**
- **c. The need for discipline-specific collaboration with experienced team members.**

Intent Statements

When healthcare providers who have limited or no experience are added to the evaluation team, the organization outlines a system of mentorship or training through collaboration with an experienced team member(s). The collaboration focuses on activities designed to facilitate the learning of the required competencies.

Examples

The intensity of the collaboration is outlined (e.g., side-by-side collaboration, on-site collaboration, collaboration via telephone). The length of the collaboration is determined (e.g., one week, one month, several months). Finally, it is determined if it is necessary to have the collaboration conducted by an individual of a specific healthcare discipline.

3.H. **17. The responsibilities of the evaluators include:**

- **a. Reviewing relevant materials to facilitate evaluation.**
- **b. Conducting evaluations.**
- **c. Producing evaluation documentation.**
- **d. Communicating with relevant stakeholders.**
- **e. Participating in performance improvement activities.**
- **f. Disclosure of potential conflicts of interest.**

Examples

17.a. Materials include medical records and reports, video recording, audio recording, photography, and imaging.

17.d. Communicating with relevant stakeholders might include responding to questions from the referral source or participating in a case conference with an external case manager.

17.f. An example of a conflict of interest would be if the person served has previously received services from the evaluator or the company for which he or she works.

3.H. **18. Evaluation models and strategies are based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed scientific and health-related publications, clinical practice guidelines, and/or expert professional consensus.**

Intent Statements

The evaluation models and the strategies used are based on accepted practice, including consideration of areas such as information on the efficacy of specific techniques, pertinent research findings, protocols published by various professional groups, or approaches receiving professional recognition for achieving successful outcomes.

Examples

Evidence of conformance to this standard may be demonstrated through minutes of meetings in which these topics were discussed, literature available to the personnel, development of evaluation guidelines and protocols, etc. Resources used in this process might include access to evidence-based practice databases and reviews, journal subscriptions, online access to learning opportunities and reference materials or journals, guest speakers, sponsoring educational events at the organization, inservice programs, journal clubs, collaborative resources, or education efforts with other area providers of services.

3.H. **19. Policies and written procedures are implemented that address:**

- **a. Cancellations.**
- **b. No-shows.**
- **c. Noncompliance.**
- **d. Observers.**
- **e. Use of recording devices.**
- **f. Production of a final report, including:**
  - **(1) Responsibilities.**
  - **(2) Quality review of the content in the report, including:**
    - **(a) Editing.**
    - **(b) Who is responsible for the quality review.**
    - **(c) What information is retained by whom.**
    - **(d) Confirmation that the referral question was answered.**
    - **(e) Final approval of the report by the evaluator(s).**

Examples

19.a.–b. Policies and written procedures might address who should be notified, rescheduling, and fees associated with a cancellation or no-show.

19.e. Recording devices include audio, video, and photography.

19.f.(1) Responsibilities might include who is responsible for each component of producing a final report and the associated timeframes.

3.H. **20. The organization defines:**

- **a. Specific responsibilities of the evaluator.**
- **b. Mechanisms to:**
  - **(1) Monitor the performance of evaluators.**
  - **(2) Address addition, modification, or removal of evaluators.**
  - **(3) Demonstrate current competency relative to the evaluations performed.**
  - **(4) Demonstrate the appropriate use of tools, tests, and instruments prior to their use in an evaluation.**

Examples

20.a. Specific responsibilities might include adherence to the independent evaluation services' policies, procedures, and practices; timeframes for evaluation reports to be generated; and expectations for participation in conferences or other formal communication related to the persons served.

3.H. **21. Evaluators demonstrate:**

- **a. Active learning and involvement in the professional community.**
- **b. Currency in professional practice concerning the persons served.**

Examples

21.a. Evaluators demonstrate active learning and involvement in the professional community through relevant continuing education, active participation in special interest groups of professional association, board membership, or involvement in consumer advocacy groups.

21.b. Evaluators participate in professional practice similar to the services for the persons evaluated and are knowledgeable of current evidence-based practices relevant to the population served.

3.H. **22. Based on the complexity of the needs of persons served, the organization provides or establishes written service agreements for the provision of evaluation services by additional qualified evaluators.**

Examples

A written service agreement might be called a contract, a formal arrangement, or other term used by the independent evaluation services.

3.H. **23. If the independent evaluation services provide evaluation services under service agreement with external resources:**

- **a. Roles and responsibilities within the organization for negotiating and authorizing service agreements are documented.**
- **b. Evaluation services are furnished in accordance with the terms of a written service agreement that specifies:**
  - **(1) The independent evaluation services retain:**
    - **(a) Professional and administrative responsibility for the services.**
    - **(b) Control and supervision of the services.**
  - **(2) The term of the service agreement.**
  - **(3) The manner of service agreement termination or renewal.**
  - **(4) Personnel who furnish the services meet the same qualifications as salaried personnel.**
  - **(5) Adequate liability insurance coverage.**
  - **(6) Physical space that is conducive to the evaluations conducted.**
  - **(7) Timeframes for evaluation reports to be submitted to the independent evaluation services.**
  - **(8) Information to be gathered for the analysis of evaluation service performance.**
  - **(9) Exchange of information between evaluators and the organization.**
  - **(10) Requirements to maintain the service agreement.**

Examples

A written service agreement may also be called a contract, formal arrangement, or letter of agreement.

23.b.(10) Requirements to maintain the service agreement might include frequency requirements; how the evaluator is expected to stay current with the independent evaluation services' policies, procedures, and practices; timeframes for evaluation reports to be submitted to the independent evaluation services; and expectations for participation in conferences or other formal communication related to the persons served.

3.H. **24. The physical plant of the independent evaluation services:**

- **a. Is adequate in:**
  - **(1) Size.**
  - **(2) Design.**
  - **(3) Accessibility.**

(4) **Usability.**

(5) **Flexibility.**

b. **Has equipment available to meet the individual needs of the persons served.**

c. **Facilitates the appropriate use of evaluation equipment.**

d. **Facilitates infection control.**

e. **Is designed to promote effective evaluations.**

f. **Is designed to promote the dignity and self-worth of the persons served.**

Intent Statements

This standard applies to all physical facilities owned, leased, or operated by the independent evaluation services organization.

The physical environment facilitates the accomplishment of evaluations and promotes the dignity, self-worth, and privacy of the persons served. The design of the physical environment, the equipment and supplies needed, and other aspects of the environment vary depending upon the ages of the persons served.

24.a.(4) ISO 9241-11 (1998) Guidance on Usability, issued by the International Organization for Standardization, defines usability as "the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use."

The terms and definitions taken from ISO 9241-11:1998 Ergonomic requirements for office work with visual display terminals (VDTs) - Part 11: guidance on usability, clause 3.1, are reproduced with permission of the International Organization for Standardization, ISO.

Usability ensures that all people will be comfortable, safe, and able to function at their optimal level.

Examples

There is sufficient lighting for those with low vision.

The bathrooms accommodate the use of wheelchairs.

There are private areas for interviews and evaluations.

3.H. **25. The organization maintains a documented preventive maintenance program that includes:**

a. **Calibration of equipment in accordance with manufacturers' recommendations.**

b. **Maintenance of equipment in accordance with manufacturers' recommendations.**

3.H. **26. When crisis management is necessary to handle challenging behaviors, the independent evaluation services demonstrate appropriate use of emergency crisis procedures.**

Intent Statements

In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would deal with challenging behaviors of the persons served.

Examples

Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

3.H. **27. Written communication regarding the evaluation process:**

a. **Is:**

(1) **Accurate.**

(2) **Complete.**

(3) **Accessible.**

b. **Demonstrates avoidance of unnecessary duplication of information.**

Intent Statements

27.a.(3) Written communication regarding the evaluation process is accessible to internal and external stakeholders in accordance with their

needs and responsibilities related to the person served.

27.b. The organization strives to lessen the duplication in written information while at the same time complying with the legal and regulatory requirements to which it is subject.

3.H. **28. The evaluation report documents, at a minimum:**

- **a. Question(s) from the referral source to be answered.**
- **b. Date of the evaluation.**
- **c. Location of the evaluation.**
- **d. Duration of the evaluation.**
- **e. Scope of the evaluation.**
- **f. List of relevant documents reviewed.**
- **g. Interviews conducted.**
- **h. History of accident/injury/illness.**
- **i. Current treatment.**
- **j. Previous treatment.**
- **k. Other issues that may affect the evaluation.**
- **l. Findings in the following areas, as appropriate:**
  - **(1) Behavior.**
  - **(2) Cognition.**
  - **(3) Communication.**
  - **(4) Functional.**
  - **(5) Medical.**
  - **(6) Pain management.**
  - **(7) Physical.**
  - **(8) Psychological.**
  - **(9) Recreation and leisure.**
  - **(10) Social.**
  - **(11) Vocational.**
- **m. Methods used to collect findings, including:**
  - **(1) Activities involved.**
  - **(2) Measured results achieved.**
  - **(3) Validity of tools, tests, and instruments used.**
- **n. Analysis of findings, including, but not limited to:**
  - **(1) Resolution of conflicting information/opinions, if any.**
  - **(2) Response to referral questions.**

Intent Statements

28.n. The analysis and response to referral questions are substantiated by the findings of the evaluation.

3.H. **29. The organization conducts a written analysis of the services provided:**

- **a. At least semiannually.**
- **b. That addresses, as evidenced by the records of the persons served:**
  - **(1) Quality of services.**
  - **(2) Appropriateness of services.**
  - **(3) Patterns of service utilization.**
  - **(4) Timeliness of documentation.**
- **c. On a representative sample of:**
  - **(1) Current records.**
  - **(2) Closed records.**
- **d. That is performed by personnel who:**
  - **(1) Are trained and qualified.**
  - **(2) Are not:**
    - **(a) The sole reviewer of the services for which he or she is responsible.**
    - **(b) Solely responsible for the selection of records to be reviewed.**
- **e. That includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Quality of services.**
    - **(b) Appropriateness of services.**
    - **(c) Patterns of service utilization.**
    - **(d) Timeliness of documentation.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**

(5) **Necessary education and training of personnel.**

3.H. **30. The organization conducts a written analysis of no-shows and cancellations:**

- **a. At least annually.**
- **b. That includes:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) No-shows.**
    - **(b) Cancellations.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of personnel.**

Intent Statements

The organization defines no-show and cancellation. The consistent use of these definitions increases the accuracy and validity of the information gathered.

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

Applicable Standards

Standards 31.–35. apply to organizations that provide Independent Evaluation Services to *any* children/adolescents.

Note: *A person served is defined as a child/adolescent if the individual is under the age at which one is legally recognized as an adult in a given state/province. Refer to the Glossary for a definition of* child/adolescent.

Note: *Emancipated minors are individuals who are under the age at which a state or province would legally recognize them as adults but who have had parental control over them legally terminated. In those states or provinces that recognize emancipated minors, those individuals are considered adults for the purposes of the CARF standards.*

3.H. **31. If the independent evaluation services serve any children/adolescents, information shared with the public, prospective persons served and their families/support systems, and other relevant stakeholders specifies:**

- **a. The age range of the children/adolescents served.**
- **b. The number of children/adolescents served annually by age group.**

Intent Statements

This information is pertinent to the decision-making process related to whether the independent evaluation services are appropriate to meet the needs of a child/adolescent referred.

Examples

Information could be found in brochures, marketing information, outcomes information, or on the organization's website.

3.H. **32. Based on the ages, cognitive levels, interests, concerns, and cultural and developmental needs of the persons served, the independent evaluation services provide:**

- **a. Appropriate evaluations.**
- **b. Equipment.**
- **c. Materials.**
- **d. Schedules that reflect the needs of each child/adolescent served.**

Examples

32.d. Schedules might be adjusted to accommodate school hours, rest times, etc.

3.H. **33. Personnel who serve children/adolescents demonstrate competencies appropriate to the population served.**

Examples

These competencies can be obtained through formal education or continuing education focused on children/adolescents; on-the-job training; mentorship by experienced personnel; ongoing access to books, periodicals, and videos; etc.

3.H. 34. Members of the family/support system are considered and involved as partners in all phases of the evaluation, except where exclusion is justified and appropriate.

Intent Statements

Exclusion may be justified when legal parental rights have been terminated, when there are restrictions on visitation or involvement with the child/adolescent, or when a family member's involvement in the evaluation process is deemed by the professional providing evaluation services to be detrimental to the child/adolescent.

3.H. 35. The tools used to measure satisfaction and feedback are age and developmentally appropriate to elicit input from the children/adolescents served.

Intent Statements

The independent evaluation services strive to capture information that is meaningful to the children/adolescents served and their families/support systems as well as to the service itself for use in performance improvement efforts. Depending on the ages and developmental levels of the children/adolescents served, the independent evaluation services may need to use more than one tool to elicit input on satisfaction and feedback.

I. Case Management

Description

Case Management proactively coordinates, facilitates, and advocates for seamless service delivery for persons with impairments, activity limitations, and participation restrictions based on the following:

- Initial and ongoing assessments.
- Knowledge and awareness of care options and linkages.
- Effective and efficient use of resources.
- Individualized plans based on the needs of the persons served.
- Predicted outcomes.
- Regulatory, legislative, and financial implications.

The delivery of case management may occur in a variety of settings that include, but are not limited to, a healthcare environment, a private practice, in the workplace or in the payer community.

Applicable Standards

An organization seeking accreditation for Case Management must meet the program description and the standards in this section, as follows:

- All programs apply Standards 3.I.1.–31.
- If linked to optional Amputation Specialty Program designation, also apply Standards 3.I.32.–34.
- If linked to optional Brain Injury Specialty Program designation, also apply Standards 3.I.32.–33.
- If linked to optional Spinal Cord Specialty Program designation, also apply Standards 3.I.32.–33. and Standard 35.
- If linked to optional Stroke Specialty Program designation, also apply Standard 3.I.32.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Section 2.D. based on diagnostic categories served (see guidelines on page 157)
- Section 2.E. if *any* children/adolescents are served and not seeking Pediatric Specialty Program accreditation

Note: *Please refer to the table at the beginning of Section 4 for information on the optional specialty program designations that may be added to this program.*

3.I. **1. To meet the needs of the person served, case management:**

a. Identifies:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

b. Coordinates:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

c. Defines its relationships with:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

d. Establishes key communication contacts with:

(1) Appropriate care options and settings.

(2) Specialty programs/services.

(3) Appropriate disciplines/ professions.

3.I. **2. Case management coordinates with:**
- **a. The persons served.**
- **b. Providers of services to the persons served.**
- **c. Payers.**
- **d. Legal entities, as applicable.**

3.I. **3. Case management accesses and utilizes information about:**
- **a. Regulations.**
- **b. Legislation.**
- **c. Financial issues.**
- **d. Service availability.**
- **e. The healthcare delivery system.**

3.I. **4. Case management advocates for:**
- **a. Ethical treatment.**
- **b. Quality-focused, appropriate care.**
- **c. Access to appropriate services.**
- **d. Delivery of care.**
- **e. Efficient use of available resources.**
- **f. Outcomes measurement and management.**
- **g. Development of resources in the community.**
- **h. Services that:**
  - **(1) Are available.**
  - **(2) Are utilized.**
  - **(3) Minimize and/or prevent impairment.**
  - **(4) Reduce activity limitations.**
  - **(5) Lessen participation restrictions.**
  - **(6) Identify environmental barriers.**
- **i. The safety of the persons served.**

3.I. **5. Case management participates in decisions about, but not limited to:**
- **a. Appropriate use of a full continuum of care.**
- **b. Services.**
- **c. Equipment.**
- **d. Supplies.**
- **e. Community resources.**

3.I. **6. Case management facilitates:**
- **a. Communication that:**
  - **(1) Avoids duplication of information.**
  - **(2) Efficiently facilitates necessary services for the persons served.**
- **b. Promotion of health/well-being.**
- **c. Identification of issues concerning benefits.**
- **d. Value-based care.**
- **e. The provision of services to:**
  - **(1) Minimize and/or prevent impairment.**
  - **(2) Reduce activity limitations.**
  - **(3) Lessen participation restrictions.**
  - **(4) Identify environmental barriers.**
- **f. The safety of the persons served.**
- **g. Independent review, as appropriate.**

Intent Statements

6.g. Independent review refers to review by an independent, impartial reviewer of the services provided to the person served.

Examples

6.g. An independent review could take the form of an independent medical examination or a file review by an individual not directly involved in the case.

3.I. **7. The responsibilities of case management include:**
- **a. Reviewing relevant reports to facilitate assessment.**
- **b. Identifying resources.**
- **c. Integrating information on resources into:**
  - **(1) Case management planning.**
  - **(2) Case management implementation.**
- **d. Conducting assessments.**

e. **Predicting outcomes.**
f. **Establishing the case management plan.**
g. **Participating in the establishment of the discharge/transition plan.**
h. **Providing case management services.**
i. **Modifying the case management plan.**
j. **Recommending or ensuring that the individuals on the team change based on the needs of the person served.**
k. **Achieving the predicted outcomes.**
l. **Recommending or ensuring that the persons served are transferred to the most appropriate level of care, based on need.**
m. **Providing education and training.**
n. **Referring the persons served to other services/programs as needed.**
o. **Communicating with relevant stakeholders.**
p. **Participating in performance improvement activities.**

3.I. **8. Either prior to or at the time of entry to case management, case management:**

a. **Gathers input from the persons served about their information needs concerning case management.**
b. **Has a system to respond to the stated information needs of the persons served.**

Intent Statements

The surveyors will need to be able to see how it was determined what consumers want to know about case management.

During the survey, the persons served and their families will be interviewed to obtain their feedback about information shared with them by case management.

Examples

Focus groups, surveys, questionnaires, patient councils, support groups, or other mechanisms might be used to gather input from persons served about their information needs regarding case management.

3.I. **9. In order to inform the persons served about case management either prior to or at the time of initiating services, case management provides information from the performance measurement and outcomes management system to the persons served that addresses, at a minimum:**

a. **The characteristics of the persons served.**
b. **The number of persons served per category of individuals who share similar characteristics within a stated period of time.**
c. **Satisfaction of the persons served with the services received.**

Examples

There are a variety of ways that the information may be shared and which of these ways are used will depend upon the individual needs of the persons served. Some information may be written in different languages, at different reading levels, in larger print size, etc. Some information may be shared orally or through a video presentation.

9.a.–b. The characteristics of the person served may include diagnosis, impairment, activity limitations, level of participation, life role, residential information, age, or gender. Outcomes information may be categorized along one or a combination of these parameters.

3.I. **10. Initial and ongoing assessments completed by case management:**

a. **Are relevant to the needs of the persons served.**
b. **Predict outcomes that include:**
   (1) **Functional status at discharge/transition.**
   (2) **Disposition at discharge/transition.**
   (3) **Duration of services.**
c. **Consider health status.**

d. **Address resource needs and utilization.**
e. **Address discharge/transition planning.**
f. **Address the integration of available resources.**
g. **Identify:**
   (1) **Factors facilitating the achievement of predicted outcomes.**
   (2) **Barriers to the achievement of predicted outcomes.**
h. **Address funding sources.**
i. **Identify expectations of the:**
   (1) **Funding source.**
   (2) **Employer, if appropriate.**

3.I. **11. Whenever possible, case management encourages the persons to be served and/or their family/support system to visit the programs to which they are referred prior to entry to familiarize them with the:**
a. **Programs.**
b. **Personnel.**

3.I. **12. Case management:**
a. **Communicates the behavioral and cognitive needs of the persons served to the programs/services with which they interact.**
b. **Verifies that the programs/services being offered can meet the behavioral and cognitive needs of the persons served.**

3.I. **13. An individual plan based on the needs of each person served addresses the following:**
a. **Minimizing/preventing impairment.**
b. **Reducing activity limitations.**
c. **Lessening participation restrictions.**
d. **Environmental modifications.**
e. **Predicted outcomes of case management.**
f. **Estimated timeframe for case management services.**
g. **Involvement of the persons served in planning.**
h. **Communication with appropriate parties.**
i. **Modification based on the resources of case management.**
j. **A plan for discharge/transition from case management, including mechanisms for interagency coordination.**

3.I. **14. Case management provides each person served with an individualized written disclosure statement that includes sufficient information to address:**
a. **The scope of case management services that will be provided.**
b. **The intensity of case management services that will be provided.**
c. **Insurance coverage and/or payment structure.**
d. **Alternative resources to address additional identified needs.**

Intent Statements

The standard requires that each person be provided with individualized information that is specific to his or her situation. This information does not all have to be in one document. Each person served should have the information presented in such a way that he or she clearly understands what will be provided and for how long, what will not be provided, and what the services will cost him or her, if anything.

Examples

14.c. Examples of information shared regarding insurance coverage may be that the payer will fund only four weeks of case management and then will reassess, a co-pay is required, there is a maximum dollar amount available for case management, etc.

14.d. Examples of alternative resources may be referral to another provider of case management, referral to different funding sources, etc.

3.I. **15. The persons served have the benefit of a consistently assigned case manager.**

Intent Statements

The consistency of staffing provides for continuity of services and prevents confusion of the persons served regarding the identity of their case managers. The concept of consistently assigned personnel does not exclude a system of rotation of assignments. If such a system is used, the persons served are notified before a rotation ends and are introduced to their new case manager.

3.I. **16. To ensure the achievement of predicted outcomes, the case manager for each person served:**

- **a. Demonstrates appropriate competencies as defined by the program.**
- **b. Is identified to:**
  - **(1) The person served.**
  - **(2) The family/support system.**
- **c. Has the authority to coordinate the provision of care.**
- **d. Is knowledgeable about the program and services being provided to the person served.**
- **e. Is available to interact with:**
  - **(1) The person served.**
  - **(2) The team of the person served.**
  - **(3) The family/support system.**
  - **(4) Other stakeholders.**
- **f. Facilitates orientation for the person served that is appropriate to the services and the outcomes predicted.**
- **g. Is responsible for ensuring communication with:**
  - **(1) External sources.**
  - **(2) Internal sources.**
- **h. Brings forward to the team the available financial information to facilitate decision making about the following processes:**
  - **(1) Intake.**
  - **(2) Assessment.**
  - **(3) Service planning.**
  - **(4) Service provision.**
  - **(5) Discharge/transition planning.**
  - **(6) Long-term follow-up.**
- **i. Facilitates the involvement of the person served throughout the service process.**
- **j. Facilitates the gathering of information to assist the organization in follow-up activities for its analysis of program performance.**
- **k. Ensures that discharge/transition arrangements are completed.**
- **l. Ensures that discharge/transition recommendations are communicated to appropriate stakeholders.**
- **m. Facilitates the implementation of discharge/transition recommendations.**

Intent Statements

The surveyors should be able to ask the persons served and their families/support systems about these individuals and get responses that indicate that they know who is coordinating the provision of care for the person served.

Examples

16.h.(1) Financial information that might affect placement decisions for the person served during the intake process is shared with the admitting physician and any team members involved in making recommendations for placement of the person served into the program or referral to a different level of the continuum of services.

3.I. **17. Case management interacts with, facilitates, and communicates with the team providing services which:**

- **a. Is determined by:**
  - **(1) The assessment.**
  - **(2) The individual planning process.**

(3) The predicted outcomes of the person served.

(4) The strategies utilized to achieve the outcomes predicted.

b. Includes:

(1) The person served.

(2) Members of the family/support system, as appropriate.

(3) Personnel with the competencies necessary to evaluate and facilitate the achievement of predicted outcomes in the following areas:

(a) Behavior.

(b) Cognition.

(c) Communication.

(d) Functional.

(e) Medical.

(f) Pain management.

(g) Physical.

(h) Psychological.

(i) Recreation and leisure.

(j) Social.

(k) Spiritual.

(l) Vocational.

c. Provides services that address:

(1) Impairments.

(2) Activity limitations.

(3) Participation restrictions.

(4) Environmental needs.

(5) The personal preferences of the person served.

(6) Identifying the characteristics of the intended discharge/transition environment.

(7) Achievement of predicted outcomes.

Intent Statements

The team composition is determined for each person served through the assessment and individual planning processes. The team is a dynamic group of individuals that may change as the person served progresses through the program. Some professionals may be active team members for the entire length of a person's involvement in the program, while other professionals may become active members of the team as the need for their services is identified.

17.c. CARF uses terminology from the World Health Organization's (WHO's) *International Classification of Functioning, Disability, and Health* (ICF). Refer to Standard 2.B.1. examples for definitions of key terms.

Examples

17.b.(3)(e) Medical needs might include nursing, pharmacy, or nutrition needs in addition to needs that would be addressed by a physician.

17.c. An example of how these concepts interrelate might be a personal chef who sustains a cervical spinal cord injury in a motorcycle accident. Her impairment is paralysis of all four extremities. During rehabilitation she articulates her desire to continue operating her business. Once she returns home, she chooses recipes, instructs personal assistants who perform the manual activities related to preparing, cooking, and delivering the food, and she tastes the foods as they are being prepared. Mirrors are installed in the kitchen so that she can see all food preparation. While she experiences a number of activity limitations related to her role as a personal chef, she has a high level of participation in communicating with customers, preparing the foods, and running her business. The environment of her home provides sufficient space for assistants to work with her in all aspects of her business and her excellent reputation facilitates her continued success with customers.

17.c.(5) Although the occupational therapist has identified dressing skills as an area to be addressed in the individual plan, the person served indicates that his wife will be home with him in the mornings before she goes to work and will assist him with dressing, so he prefers to work on other areas.

The speech-language pathologist is working with the person served on a dysphagia management program and instead of eating meals in the common dining area it is the preference of the person served to eat in her room.

Resources

Please refer to Appendix D for resources related to conceptual framework and terminology.

3.I. **18. Case management facilitates the team's:**

- **a. Ongoing communication regarding the progress of the person served toward his or her predicted outcomes.**
- **b. Collaboration to achieve predicted outcomes.**

3.I. **19. In conjunction with providers of services, case management demonstrates that the persons served make measurable progress toward accomplishment of their predicted outcomes in accordance with predicted timeframes.**

Intent Statements

Predicted outcomes are actively pursued and measured on a regular basis to determine their achievement in the anticipated timeframes and/or the need for modification. If progress toward predicted outcomes is not demonstrated in the anticipated timeframes, the program identifies issues or barriers to outcomes achievement and makes appropriate modifications.

Examples

Conformance may be demonstrated through documentation in the records of the persons served as well as discussion and interviews with personnel, referral sources, payers, and the persons served.

3.I. **20. Information is made available by case management:**

- **a. Regarding local or regional resources for:**
  - **(1) Support.**
  - **(2) Advocacy.**
  - **(3) Civil rights.**
- **b. To:**
  - **(1) The persons served.**
  - **(2) Their families/support systems.**

Examples

Case management provides information to the persons served regarding voting rights and accessibility. This includes resources to obtain and receive assistance in completing voter registration applications, and who to contact with questions about accessibility to cast a ballot.

Case management provides resources to assist parents in understanding the civil rights of their children and the services for which they are eligible.

Case management provides resources to assist the person served and her spouse with information about retirement and disability supports and what their rights are concerning benefits.

Resources

20.a.(3) Please refer to Appendix D for resources related to accessibility.

3.I. **21. As appropriate, case management has information available regarding local options for:**

- **a. Lodging.**
- **b. Transportation.**

3.I. **22. Discharge/transition planning is done in collaboration with:**

- **a. The persons served.**
- **b. Families/support systems.**
- **c. Providers in the continuum of services.**
- **d. Other relevant stakeholders.**

3.I. **23. When there is a change in the discharge/transition plan there is a mechanism for case management to provide as much notice as possible to:**

- **a. The persons served.**
- **b. Their families/support systems.**
- **c. Other relevant stakeholders.**

Examples

23.a.–b. The discharge plan for the person served has been to go home with her family. However, during the training process it becomes evident that the family is not prepared to meet the needs of person served at the time of discharge. The team revises its recommendation to discharge

the person served to a residential program for a period of time. This change, including the rationale, is clearly communicated and explained to the person served and the family.

23.c. Relevant stakeholders could include appropriate personnel, referral sources, payers, etc.

Case management ensures that the vendor who is supplying a walker is contacted to let him know that the person's discharge has been delayed 24 hours until his blood pressure is stable.

Case management contacts the human resources department of the person's employer to recommend return to work part time for the first two weeks instead of resuming full time work immediately upon return.

3.I. **24. The discharge/transition process includes recommendations for services needed to maintain or improve the outcomes achieved.**

3.I. **25. There is a written discharge/transition summary for each person served that is relevant to the services that have been provided by case management.**

3.I. **26. When crisis management is necessary to handle challenging behaviors, case management demonstrates appropriate use of emergency crisis procedures.**

Intent Statements

In the event that behavior escalates to create an unstable, threatening, or dangerous situation, personnel implement the appropriate emergency procedures to protect the immediate health and safety of the person served and any others who may be at risk. The surveyors should be able to determine from interviews with personnel how they would respond to challenging behaviors of the persons served.

Examples

Emergency crisis procedures may be implemented in response to a threat of suicide, verbal aggression or physical violence toward another person or toward property, an emotional outburst, or other behavior deemed by personnel to pose an immediate risk.

3.I. **27. When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that address:**

- **a. Education through modeling of socially and culturally acceptable behaviors for:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
  - **(3) Members of the community with whom the persons served regularly interact.**
- **b. Environmental factors to enhance the socially and culturally acceptable behaviors of the persons served.**
- **c. Environmental modifications.**
- **d. Medication management.**
- **e. Training in the implementation of behavior management programs for:**
  - **(1) Personnel.**
  - **(2) Families/support systems.**

Examples

27.a.(3) Members of the community with whom the person served regularly interacts might include a taxi or transportation driver who regularly drives the persons served to their vocational services location; a hair stylist or barber who regularly provides services to the persons served, or wait staff at the local coffee shop frequented by persons served.

27.c. Environmental modifications might include the use of noise-reducing materials to provide a quiet environment; the installation of flooring or carpeting in neutral solid colors; adjusting the volume of phone ringers and door bells, limiting or controlling where and when people may visit persons served, reducing stimuli such as bright sunlight or odors, and limiting exposure to equipment, appliances, substances, etc. that may pose risk to persons served.

3.I. **28. For services/programs used by case management, it verifies that when there is a need to manage challenging behaviors, personnel, on an ongoing basis:**

- **a. Observe the person served.**
- **b. Describe the behavioral event.**
- **c. Understand the behavioral event:**
  - **(1) From the perspective of the person served.**
  - **(2) From the perspective of the family/support system.**
  - **(3) From the perspective of personnel.**
  - **(4) As communication on the part of the person served.**
- **d. Analyze the potential causes.**
- **e. Determine the approach, treatment, and/or supports necessary.**
- **f. Address the safety of:**
  - **(1) The person served.**
  - **(2) Other persons served.**
  - **(3) Personnel.**
  - **(4) The family/support system.**
  - **(5) Other persons involved with the person served.**
- **g. Implement the appropriate actions.**
- **h. Assess the results.**
- **i. Share the information learned with:**
  - **(1) The person served.**
  - **(2) Other personnel.**
  - **(3) The family/support system, as appropriate.**

3.I. **29. Case management:**

- **a. Gathers information on each person served, including information on:**
  - **(1) Changes in:**
    - **(a) Severity of the conditions.**
    - **(b) Comorbidity.**
  - **(2) Mortality.**
  - **(3) Nonmedical interruptions in the delivery of services.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Changes in:**
      - **(i) Severity of the conditions.**
      - **(ii) Comorbidity.**
    - **(b) Mortality.**
    - **(c) Nonmedical interruptions in the delivery of services.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Personnel.**
    - **(d) Others.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

29.a.(1)(a) Changes in the severity of the conditions refers to the conditions that necessitate services and case management. The information gathered would cover both changes from entry to discharge and from discharge to follow-up.

Examples

29.b.(5)(d) May include payers and/or other service providers.

3.I. **30. The records of the persons served include:**

- **a. Identification data.**
- **b. Assessment information, including information on health status or a health history.**
- **c. The individual plan, with goals stated.**

d. Progress/reassessment documentation.
e. Documentation of critical incidents.
f. Discharge/transition summaries.
g. If appropriate, referral information and medical records, including release forms.

Examples

30.b. In addition to the information generated through the assessment process, the health status/health history information may include information obtained from current and previous service providers and referral sources, along with information gathered from the persons served by self-report.

3.I. **31. An analysis of a representative sample of records of the persons served is conducted:**
a. At least annually.
b. To include:
(1) Documentation completed in accordance with the organization's policies.
(2) Regulatory requirements, if applicable.
(3) CARF documentation requirements.
c. That includes:
(1) Performance in relationship to established targets in each area.
(2) Trends.
(3) Actions for improvement.
(4) Results of performance improvement plans.
(5) Necessary education and training of personnel.

Intent Statements

Please refer to the Glossary for a definition of *representative sample*.

Examples

31.b.(1) Program personnel review and analyze a representative sample of records to determine consistent completion of record content areas, record entries in accordance with established timeframes, and review of discharge recommendations with the persons served and other stakeholders as appropriate.

31.b.(2) The organization identifies its key regulatory agencies and reviews and analyzes a representative sample of records of the persons served to determine if documentation meets identified requirements. Results of the analysis are used in education and training activities to facilitate compliance with regulatory obligations.

Resources

31.b.(3) Refer to Appendix A for identification of CARF required documentation in the records of the persons served.

Applicable Standards

If Case Management is seeking accreditation as an Amputation Specialty Program, Brain Injury Specialty Program, Spinal Cord Specialty Program, or Stroke Specialty Program, Standards 32.–33. must be met.

3.I. **32. To meet the needs of persons served, case management identifies the services/programs with which it links in each of the following areas:**
a. Emergent care.
b. Acute hospitalization.
c. Inpatient rehabilitation program.
d. Long-term care hospital.
e. Skilled nursing care.
f. Home care.
g. Hospice.
h. Day hospital.
i. Outpatient programs.
j. Community-based services.
k. Adult day programs.
l. Residential services.
m. Vocational services.
n. Primary care.
o. Specialty consultants.
p. Long-term care.

Intent Statements

Case management may link with services/programs in a variety of ways. Some case management may have links to full continuum within their own health systems, some link with other providers in the community, and some may link with programs or services outside of their local community such as nationally recognized centers or services for persons served. At a minimum, case management should be knowledgeable about available community resources and either contract with or assist the persons served to access information about the services/programs available in each of the areas listed in the standard.

Examples

Case management might compile a resource guide that addresses each of the programs/services, including contact information.

32.j. Community-based services might include independent living, transportation services, city parks and recreation, home and community-based services, and emergency services for disaster preparedness.

3.I. **33. For all services/programs with which it links, case management:**

- **a. Defines its relationships with the services/programs.**
- **b. Defines responsibilities of the services/programs.**
- **c. Identifies key communication contacts within the services/programs.**
- **d. Acts as a resource in establishing personnel competencies for the services/programs identified related to the specialized needs of the persons served.**

Examples

33.d. Acting as a resource to services/programs in establishing personnel competencies might include providing inservice training and education for providers, articles, case studies, etc.

Applicable Standards

If seeking accreditation for Case Management Amputation Specialty Program, Standard 34. must be met.

3.I. **34. The amputation specialty program identifies the services/programs that it provides directly or with which it links in the following areas:**

- **a. Renal dialysis centers.**
- **b. Prosthetic services.**
- **c. Orthotic services.**
- **d. Pedorthic services.**
- **e. Foot care services.**

Intent Statements

This standard expands upon Standard 3.I.32., which addresses services/programs that the program provides directly or with which it links.

Applicable Standards

If seeking accreditation for a Spinal Cord Specialty Program component, Standard 35. must be met.

3.I. **35. The spinal cord specialty program identifies the programs/services that it provides directly or with which it links in the following areas:**

- **a. Behavioral health.**
- **b. Independent living centers.**
- **c. Clinical research centers.**
- **d. Consumer advocacy organizations.**
- **e. Driver rehabilitation.**

Intent Statements

This standard expands upon Standard 3.I.32., which addresses services/programs that the program provides directly or with which it links.

Examples

35.e. Driver rehabilitation might include assessment, training, and retraining.

Section 4

Specialty Program Designation Standards

Accreditation for the optional specialty program designations included in this section must be sought in conjunction with at least one appropriate program/service in Section 3. The table below identifies how specialty program designations may be linked with programs in Section 3. Refer to Sections 4.A.–4.F. for program descriptions and applicable standards for each specialty program designation. If you need clarification or have any questions, please contact your resource specialist.

	Specialty Program Designations					
	Pediatric Specialty Program (Section 4.A.)*	Amputation Specialty Program (Section 4.B.)	Brain Injury Specialty Program (Section 4.C.)	Cancer Rehabilitation Specialty Program (Section 4.D.)	Spinal Cord Specialty Program (Section 4.E.)	Stroke Specialty Program (Section 4.F.)
May be combined with:						
Comprehensive Integrated Inpatient Rehabilitation Program (Section 3.A.)	✓	✓	✓	✓	✓	✓
Outpatient Medical Rehabilitation Program: Single Discipline and/or Interdisciplinary (Section 3.B.)	✓	✓	✓	✓	✓	✓
Home and Community Services (Section 3.C.)	✓	✓	✓	✓	✓	✓
Residential Rehabilitation Program (Section 3.D.)	✓	✓	✓		✓	✓
Vocational Services (Section 3.E.)		✓	✓		✓	✓
Interdisciplinary Pain Rehabilitation Program (Section 3.F.)	✓					
Case Management (Section 3.I.)	✓	✓	✓		✓	✓
Pediatric Specialty Program may be combined with any other specialty program designation in Section 4.						

A. Pediatric Specialty Program

Description

The essence of a Pediatric Specialty Program is family-centered care. Family-centered care is defined as having eight critical components. They are:

- Recognition that the family/support system is the constant in the child's life, while the service systems and personnel within those systems fluctuate.
- Facilitation of family/support system—professional collaboration at all levels of care.
- Sharing of unbiased and complete information with the family/support system about the child's care on an ongoing basis, in an appropriate and supportive manner.
- Implementation of appropriate policies and programs that are comprehensive and provide emotional and financial support to meet the needs of families/support systems.
- Recognition of family/support system strengths and individuality and respect for different methods of coping.
- Understanding and incorporating the developmental needs of infants, children, and adolescents and their families/support systems into healthcare systems.
- Encouragement of parent-to-parent support.
- Assurance that the design of healthcare delivery systems is flexible, accessible, and responsive to family/support system needs. [Adapted from T.L. Shelton, E.S. Jeppson, and B.H. Johnson, *Family-Centered Care for Children with Special Health Care Needs*. (Washington: Association for the Care of Children's Health, 1987).]

Pediatric Specialty Programs are culturally sensitive, interdisciplinary, coordinated, and focused on outcomes. These programs serve children/adolescents who have significant functional limitations as a result of acquired or congenital impairments. The programs use an individualized, developmental, and age-appropriate approach to rehabilitation that ensures that care focuses on preventing further impairment, reducing activity limitations, and minimizing participation restrictions while maximizing growth and development. The programs encompass care that enhances the life of each child/adolescent served within the family, school, and community. A major focus is on providing developmentally appropriate care that acknowledges each child's/adolescent's need to learn and play.

Note: *An organization seeking accreditation for a Pediatric Specialty Program must also meet the program description and standards for at least one of the programs in Section 3, and may also be combined with any other specialty program designation in Section 4.*

A person served is defined as a child/adolescent if the individual is under the age at which one is legally recognized as an adult in a given state/province. Refer to the Glossary for a definition of child/adolescent.

Emancipated minors are individuals who are under the age at which a state or province would legally recognize them as adults but who have had parental control over them legally terminated. In those states or provinces that recognize emancipated minors, those individuals are considered adults for the purposes of the CARF standards.

Applicable Standards

If an organization chooses to add the optional Pediatric Specialty Program (PSP) designation to one or more appropriate programs/services in Section 3, the program description and standards in this section apply as follows:

- All Pediatric Specialty Programs apply Standards 4.A.1.–23.
- If the PSP is linked to 3.A. Comprehensive Integrated Inpatient Rehabilitation Program, 3.D. Residential Rehabilitation Program, or 3.F. Interdisciplinary Pain Rehabilitation Program (inpatient setting), also apply Standards 4.A.24.–25.
- If the PSP is linked to 3.F. Interdisciplinary Pain Rehabilitation Program, also apply Standard 4.A.26.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which PSP accreditation is sought (see guidelines in Section 2)
- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)

4.A. **1. Using a collaborative partnership approach that emphasizes joint responsibility for decision making and the achievement of established outcomes, the program involves the following, except where exclusion is justified and appropriate, in all phases of the individual program:**

a. The child/adolescent.

b. The family/support system.

Intent Statements

Exclusion may be justified when legal parental rights have been terminated, when there are restrictions on visitation or involvement with the child/adolescent, or when a family member's involvement in the particular phase of the program is deemed by the professional providing services to be detrimental to the child/adolescent.

4.A. **2. The program has policies and written procedures that facilitate collaboration with the child/adolescent served and family/support system in decision making through the following:**

a. Accessible information.

b. Timelines for exchange of information.

c. Identification of their level of understanding of the rehabilitation process.

Intent Statements

To facilitate the decision-making roles of the person served and family/support system they are given information in a way that is understandable and in sufficient time to make informed decisions. Access to information reflects any diversity issues that would impact decision making.

Examples

The pediatric specialty program facilitates the understanding of information by:

- Using simple language and short sentences.
- Avoiding the use of acronyms and technical language.
- Supplementing oral information with printed, audio, or video materials.
- Asking persons served and family members to summarize information they have been provided or do a return demonstration.
- Asking open-ended questions instead of yes/no questions.
- Repeating key points.
- Providing information in the primary language of the person served or family member.
- Offering assistance reviewing and completing forms.
- Using universal symbols in the physical environment.

2.c. The level of understanding of the rehabilitation process may be identified through the assessment process, asking the child/adolescent or family/support system to summarize discussions and decisions made in team conferences, or through verification by the case manager or care coordinator.

4.A. **3. The program facilitates the active involvement of each child/adolescent, as developmentally and age appropriate, in:**

a. Making decisions, both individual and collaborative.

b. Handling developmental transitions.

c. Transitioning to:

(1) Home.

(2) School.

(3) The community.

(4) Adult healthcare services.

d. For older adolescents, identifying:
(1) Supported or transitional living programs.
(2) Supported or transitional work programs.

Examples

3.c.(4) Transitioning to adult healthcare services might include moving from a pediatric program to an adult program, initiating care by an obstetrician/gynecologist, etc.

4.A. **4. The assessments are:**
a. Developmentally appropriate.
b. Culturally sensitive.
c. Age appropriate.

Examples

4.b. A female therapist conducts the assessment of the child served instead of a male therapist in accordance with the cultural preferences of the family.

A nurse who speaks the primary language of the family conducts the assessment to ensure that the child understands the directions given.

4.A. **5. When the child/adolescent served has a primary care physician, he or she is informed of the status of the child/adolescent at the time of:**
a. Initial assessment.
b. Significant changes.
c. Discharge/transition.

Examples

5.b. The primary care physician is notified when there is a change in the anticipated length of stay in the program, a change in medical status, significant improvements in functional abilities, etc.

4.A. **6. The program facilitates appropriate referrals for children/adolescents who do not have a primary care physician.**

Examples

For a child served who lives in a rural community, the program identifies pediatricians, specialists, or family physicians with pediatric/adolescent experience within a reasonable driving distance to facilitate appointments and follow-up.

4.A. **7. Medical consultative services are available to meet the needs of each child/adolescent served.**

Examples

The program provides or arranges for medical consultative services such as dentistry, gynecology, obstetrics, psychiatry, urology, ophthalmology, etc. in accordance with the needs of the children/adolescents served.

4.A. **8. The schedule for each child/adolescent served reflects his or her needs, including:**
a. Behavioral.
b. Cultural/religious.
c. Developmental.
d. Medical.
e. Physical.

Examples

8.d. To address the medical needs of the child/adolescent, the therapy schedule could be designed to include additional rest times or have therapy sessions arranged around scheduled medical tests or procedures.

4.A. **9. In order to provide for effective exchange of information, the program considers:**
a. The ongoing assessment of the family/support system, including:
(1) Strengths.
(2) Limitations.
(3) Knowledge base.
(4) Status of:
(a) Custody.
(b) Medical decision making.
(c) Visitation arrangements.
b. The conservation of funding available to meet the long-term needs of the child/adolescent served.

Intent Statements

This standard expands upon the assessment of the family/support system addressed in Standard 2.B.25.

9.a. The program strives to identify the barriers members of a family/support system bring to the program that would prevent them from being active team members.

4.A. **10. The program provides information to the family/support system about the following, as appropriate:**

- **a. Local, state, provincial, and federal:**
  - **(1) Educational opportunities and services.**
  - **(2) Service systems.**
- **b. Financial resources.**
- **c. Laws and regulations pertaining to:**
  - **(1) Rights.**
  - **(2) Education.**
  - **(3) Environmental accessibility.**
  - **(4) Health.**
  - **(5) Social supports.**
  - **(6) Passenger safety.**

Examples

Information can be shared in a variety of ways. The program may maintain lists of services with names of key contact persons, addresses, phone numbers, and any other pertinent information. The program might have available brochures, videos, or other information about the services it directly provides and community services available. The program may also have outside speakers available on certain topics.

10.a.(2) Service systems may include social services agencies or departments, community programs, support groups, equipment loan closets, and advocacy agencies.

10.c.(4) Laws and regulations on health may include specific services covered by government funding, mandatory immunization, or mandatory health testing for entry into the public school system.

10.c.(5) Social supports may include school aftercare for children with disabilities, social service for in-home support for parents to assist with child care, or transportation to and from school or other activities.

10.c.(6) Laws and regulations pertaining to passenger safety might address the use of car seats and wheelchair tie downs.

4.A. **11. The program provides or arranges for support, as needed, including, but not limited to:**

- **a. Parent-to-parent.**
- **b. Family/support system-to-family/support system.**
- **c. Sibling-to-sibling.**
- **d. Peer-to-peer.**

4.A. **12. With the consent of the family/support system and the permission of the child/adolescent served, information about activity limitations and participation restrictions is provided to the:**

- **a. Siblings of the children/adolescents served.**
- **b. Peers of the children/adolescents served.**

Examples

Information on activity limitations may be provided to siblings who will be assisting the child/adolescent served with dressing or feeding activities. Information may be given to peers who will assist the child/adolescent served by being a companion in the classroom or pushing the child's wheelchair at recess so he or she can participate in games and activities.

4.A. **13. The education and training program for the child/adolescent served addresses, as developmentally and age appropriate, and based on need:**

- **a. Knowledge of and capacity to describe and discuss in an age-appropriate fashion:**
  - **(1) Abilities.**
  - **(2) Activity.**
  - **(3) Participation.**

- **b. Coping techniques, including but not limited to:**
  - **(1) Assertiveness training, including:**
    - **(a) Appropriate expression of needs.**
    - **(b) Negotiation of conflicting needs.**
    - **(c) Adaptive resolution of conflict.**
  - **(2) Anger management.**
  - **(3) Stress management.**
- **c. Advocacy training.**
- **d. Preparation for adolescence/ adulthood.**
- **e. Consequences of decisions.**
- **f. Community resources for leisure activities.**
- **g. Prevention.**
- **h. Relationships with peers and siblings.**
- **i. Training in the use of assistive technology and adaptive devices and toys.**
- **j. Sexuality, including:**
  - **(1) Normal development.**
  - **(2) After the onset of injury, illness, or impairment.**
- **k. Parenting skills.**

Examples

The education program could be provided using a variety of methods such as one-on-one teaching, formal groups, and lectures; videos or audio recordings; written information; and computerized programs.

13.a.(1) Describing and discussing abilities in an age-appropriate fashion might include how the child could explain to classmates that he or she is able to carry school books but not to get books down from a library shelf, open a door using a remote button control, etc.

13.b.(1) Assertiveness skills allow a child/adolescent to intervene appropriately when his or her needs are not being met or rights are being violated. Assertive behaviors occur in a three step process: 1) the identification and appropriate expression of internal state or needs, 2) Listening to the other party and building a mutual understanding of each other's needs, 3) Mutual problem-solving to resolve the conflicting needs of each party involved. This necessitates that a child has the ability, appropriate to his or her developmental and functional level, to identify his or her internal state (e.g., happy, mad, sad, hungry, in pain), differentiate wants from needs, and express themselves in a manner which respects others but advocates for their rights. Once needs are identified and expressed, a child/adolescent also needs skills of listening and comprehending the other person's point of view and appreciating the other person's needs before being able to problem-solve to a solution that resolves conflicts between points of views and conflicting needs.

13.d. This might include pre-vocational training, performing higher level activities of daily living (ADLs) such as food preparation, managing money and/or bank accounts, and making appointments.

13.g. Education on prevention might address smoking, drug and alcohol use, and using birth control.

13.j. Education on sexuality might address appropriate versus inappropriate sexual exploration and expression for the child/adolescent's age/functional level, e.g., body image, flirting, and relationships; sexual development and functioning after injury, illness or impairment; and identification of situations that constitute abuse and means by which to elicit support/intervention from other adults.

4.A. **14. Based on need, the education and training program for the family/ support system addresses:**

- **a. Knowledge of and capacity to describe and discuss:**
  - **(1) Ability.**
  - **(2) Activity.**
  - **(3) Participation.**
- **b. Transition to:**
  - **(1) Home.**
  - **(2) School.**
  - **(3) The community.**

c. Normal growth and development, including age-appropriate:
- **(1) Social skills.**
- **(2) Behaviors.**

d. Accessing emergency care if necessary.

e. Specific healthcare procedures and techniques.

f. Sexuality, including:
- **(1) Normal development.**
- **(2) After the onset of injury, illness, or impairment.**

g. Therapeutic home programs.

h. Prognoses.

i. Realistic goals.

j. Safety issues related to:
- **(1) Delivery of care.**
- **(2) The service delivery site.**

k. Information about:
- **(1) Allergies.**
- **(2) Precautions.**

l. Information on respite care.

m. Training in the use of assistive technology and adaptive devices and toys.

n. Passenger safety, including:
- **(1) Laws.**
- **(2) Appropriate use of equipment.**

o. The medical condition and anticipated long-term issues of the child/adolescent.

Examples

The education program could be provided using a variety of methods such as one-on-one teaching, formal groups, and lectures; videos or audio recordings; written information; and computerized programs.

14.d. Education on emergency care might address knowing when the child/adolescent needs emergency care versus when contacting the primary care physician or nurses advice line is more appropriate, when other children in the family need emergency care, or how to dial 911.

14.f. Education for the family/support system might address normal sexual exploration and expression across the developmental span, e.g., body image, flirting, and relationships; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

14.j.(1) Education on safety issues related to the delivery of care might address the importance of hand washing and maintaining a sterile field for dressing changes, or properly disposing of needles and syringes used in insulin injections.

14.j.(2) Education on safety issues related to the service delivery site might be instructing an adolescent to stay in a given spot when waiting for his parents to pick him up after outpatient therapy, or what to do if the sidewalks between the group home and the recreation building are covered with snow or ice.

14.k. Education on allergies might address allergies to latex, food, and the environment; signs and symptoms that would indicate an allergic reaction; information on precautions that could address where to buy products that will be needed; or new ideas for preparing special diets.

4.A. **15. Information is exchanged to facilitate collaboration between the program and school systems.**

Examples

The program strives to establish collaborative working relationships with community schools and systems. The exchange of information allows the program and the schools to be aware of rehabilitation and education resources available such as assistive technology, adaptive equipment, pediatric specialists, speakers' bureaus, as well as the process to access those resources.

4.A. **16. To facilitate communication and transition of the child/adolescent served to the community school, information is exchanged between the program and the school system:**

- **a. At critical decision-making points during the rehabilitation process of the child/adolescent.**
- **b. Including, but not limited to:**
  - **(1) Preonset school and/or work records.**
  - **(2) Preparation of the school for transition of the child/adolescent from the program to school.**
  - **(3) Assessment of modifications and adaptations of the environment.**
  - **(4) Preparation for transition from school to work and/or vocational training.**
  - **(5) Involvement in planning for transitional or supported living programs.**

Examples

16.a. Critical decision-making points might include the time of initial assessment to help determine premorbid skills, at development of the plan to support a return to the classroom, or at the time of significant changes that might require a change in the availability of classroom support.

4.A. **17. To facilitate transition to the community, an individualized plan is established for each child/adolescent that includes:**

- **a. As appropriate, identification of other resources in the community that are or will be involved with the child/adolescent served.**
- **b. A plan for transition from the program, including mechanisms for interagency coordination.**

Examples

17.b. The plan for transition of the child/adolescent to the community might address coordination with agencies such as city parks and recreation, girl scouts and boy scouts, boys and girls clubs, youth groups, church groups, and group sports.

4.A. **18. Ongoing medical input to the program is provided by a rehabilitation physician who:**

- **a. Is qualified as at least one of the following:**
  - **(1) A pediatric physiatrist.**
  - **(2) A pediatrician with a completed fellowship in behavior, development, or rehabilitation.**
  - **(3) A pediatrician with two years' experience in pediatric rehabilitation/habilitation.**
  - **(4) A physician with comparable training and experience.**
- **b. Participates in active clinical practice that relates to the population served.**
- **c. Demonstrates currency in medical practice concerning children/adolescents.**
- **d. Demonstrates active learning and involvement in the professional community.**

Examples

18.c. The rehabilitation physician demonstrates knowledge and use of evidence-based practice to ensure currency in medical practice in the pediatric field. This is also reflected in the choice of continuing medical education events to attend and pursue. This could also be evidenced through participation in research or demonstration projects that would enhance knowledge in certain areas that may affect the physician's practice.

18.d. The physician demonstrates active learning and involvement through participation in fellowships, certification in subspecialties, participation in grand rounds in local acute hospitals, active participation in special interest groups in his or her physician professional group, board membership or involvement in consumer advocacy groups, integration of evidence-based practices and medical advances relevant to the population served.

4.A. **19. For pediatric specialty programs that are part of a larger entity, the leadership supports the provision of the program through the development of:**

- **a. A budget that supports the stated scope of the pediatric specialty program.**
- **b. Pediatric rehabilitation competencies for all personnel who provide services to the children/adolescents served.**
- **c. Facilities that meet the unique needs of children/adolescents.**
- **d. Policies and written procedures that address:**
  - **(1) The unique needs of children/adolescents.**
  - **(2) Integration of the pediatric specialty program into the larger organization.**

Intent Statements

Pediatric specialty programs may be part of larger entities that have variable focus on pediatric rehabilitation, e.g., a children's medical center, a rehabilitation hospital that serves adults and children, an acute care hospital or outpatient clinic that serves people with a variety of impairments, etc. It is critical to the provision of the pediatric specialty program that the leadership of the larger entity understands that the rehabilitation needs of the children/adolescents served differ from their medical needs and/or the needs of any adults served.

19.b. To optimize the delivery of services the leadership supports the need for providers who are not routinely assigned to the pediatric specialty program or float personnel working in the program to gain an understanding of the family-centered approach and training in pediatric competencies.

19.c. The facilities may have to serve multiple purposes when a pediatric specialty program is integrated into a larger entity. Delineating how space, materials, equipment, and other aspects of the environment of care will be used, including negotiating a solution to competing needs when necessary, will facilitate the delivery of care and the ability of the programs to meet the diverse needs of all persons served.

Examples

19.c. Part of a common area on the inpatient rehabilitation unit is used as a play area for pediatric persons served and their siblings. Rules are established for what play behaviors are tolerated, what level of supervision is to be maintained, and when it is appropriate to ask that children not use this resource if it is agitating or distracting adult persons served or visitors.

In order to maximize participation while at the same time respecting privacy needs, the outpatient clinic establishes guidelines for the use of private treatment areas versus open areas for the delivery of therapy services and family education.

19.d. Policies and written procedures assist both personnel who routinely work in the program and those intermittently or temporarily assigned to ensure the delivery of quality services as well as the continuity of daily operations. For example, delineation of who can provide what services and the required level of training and education to do so facilitate the delivery of appropriate, competent services to the children/adolescents served and their families/support systems. Delineation of how the outcomes and performance improvement activities of the program are integrated into or separate from those of the larger entity facilitates the ability of the pediatric specialty program to monitor and improve its performance.

4.A. **20. Personnel who serve children/adolescents demonstrate competencies in pediatric rehabilitation, including, but not limited to:**

- **a. Normal growth and development.**
- **b. Family-centered care, including:**
  - **(1) Communication with families/support systems.**
  - **(2) Facilitating active involvement of the family/support system in the rehabilitation process.**
- **c. Behavior management.**

d. Sexuality, including:
- **(1) Normal development.**
- **(2) After the onset of injury, illness, or impairment.**

e. Knowledge of the education system and resources.

f. Recognition and reporting of suspected abuse and neglect.

g. Setting boundaries.

h. The use of play to facilitate therapeutic interventions.

Examples

These competencies can be obtained through formal education or continuing education focused on children/adolescents; on-the-job training; mentorship by experienced personnel; and ongoing access to books, periodicals, videos, and audio recordings.

20.d. Personnel competencies might address normal sexual exploration and expression across the developmental span, e.g., body image, flirting, and relationships; normal physical sexual development and functioning; physical sexual development and functioning after injury, illness or impairment; vulnerability of children/adolescents with injury, illness, or impairment to abuse; physical and behavioral signs of abuse; and means by which families/support systems can support appropriate sexual exploration and expression.

20.g. The therapeutic relationship requires the establishment of rapport as well as appropriate limits on behaviors. Education might include topics such as refraining from establishing a degree of friendship with a child/adolescent served such that the provider's role as an adult and/or the parents' authority is compromised, recognizing that even though providers and family members may disagree about what is best for the child the parent is the final authority regarding the child, and the adaptive balance of emotional engagement and distance in a child and family's care so that providers are invested in the persons served but their roles as professionals are not compromised.

4.A. **21. The tools used to measure satisfaction and feedback are age and developmentally appropriate to elicit input from the children/adolescents served.**

Intent Statements

The program strives to capture information that is meaningful to the children/adolescents served and their families/support systems as well as to the program itself for use in performance improvement efforts. Depending upon the ages and developmental levels of the children/adolescents served, the program may need to use more than one tool to elicit input on satisfaction and feedback.

4.A. **22. The program includes in its data collection system indicators to measure as age and developmentally appropriate the feedback of the children/adolescents served, including satisfaction with:**

a. Activity level.

b. Participation level.

c. Inclusion and active involvement of the child/adolescent in the team process.

d. Inclusion and active involvement of the family/support system in the team process.

e. The relevance of the information provided.

f. Clinical practices/behaviors.

Examples

22.a. Satisfaction with activity level might address the ability of the child to perform self-care activities such as getting dressed, brushing teeth, and getting ready for school.

22.b. Satisfaction with participation level might address the transition of the child/adolescent to home, school, or community activities such as play groups, student council, school sports teams, and Boy Scouts/Girl Scouts.

22.f. Satisfaction with clinical practices/behaviors might address satisfaction with how the child/adolescent was treated by team members, the results of the therapy sessions, appropriateness of interventions utilized, etc.

4.A. **23. Emergency plans take into consideration the unique needs of the children/adolescents served.**

Examples

Emergency plans address abduction, the need for supervision during an evacuation, etc.

Applicable Standards

Refer to the applicable standards guidelines on page 246 for applicability of Standards 24.–26.

4.A. **24. Individual possessions and decorations selected by the children/adolescents served are permitted in the personal space used by them.**

4.A. **25. The organization has policies and written procedures that address the opportunity for families/support systems to remain with the children/adolescents served 24 hours a day if desired by both the families/support systems and the children/adolescents and deemed appropriate by the program.**

4.A. **26. The team serving children/adolescents includes a psychologist experienced in pediatric pain management.**

B. Amputation Specialty Program

Description

A person-centered Amputation Specialty Program utilizes a continuum of care with a holistic interdisciplinary team approach. Interventions address the needs and desires of the person served and family/support systems and include, but are not limited to medical, rehabilitation, behavioral, psychosocial, vocational, avocational, and educational needs; prosthetic, orthotic, and pedorthic services; equipment; self-management of healthcare; preventive strategies; identification and use of peer support; and techniques to facilitate empowerment. The program supports and establishes connections to the local and national community that enhance the quality of the person's everyday life. The person served actively participates as a member of the interdisciplinary team to develop and understand the services provided and the impact on his or her functional abilities.

The Amputation Specialty Program focuses on strategies of collaboration to impact perioperative care, prevention, minimizing impairment, maximizing independent function, and maximizing the quality of life of the person served. Through the use of performance indicators, the program measures the effectiveness of services provided across the continuum offered.

An Amputation Specialty Program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, community-based programs, and residential or long-term residential services.

Applicable Standards

If an organization chooses to add the optional Amputation Specialty Program (ASP) designation to one or more appropriate programs/services in Section 3, the program description and all standards in this section are applicable.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which ASP accreditation is sought (see guidelines in Section 2)
- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)
- Section 2.E. if the program serves *any* children/adolescents and is not seeking accreditation as a Pediatric Specialty Program. (Not applicable for Home and Community Services ASP; see guidelines in Section 2)

4.B. **1. The amputation specialty program defines its interventions in the following areas:**

- **a. Preventing, recognizing, assessing, and treating conditions related to limb loss and its complications.**
- **b. Identifying and reducing the risk factors for further amputation.**
- **c. Facilitating functional independence and performance.**
- **d. Identifying and meeting the need for prosthetic care.**
- **e. Facilitating psychological and social coping and adaptation skills.**
- **f. Facilitating community integration and participation in life roles.**
- **g. Providing services for families/support systems.**

Intent Statements

The amputation specialty program defines its interventions so that persons served and other stakeholders can understand the scope of services provided and make informed decisions about whether participation in the program will meet their current needs.

Examples

1.a. Conditions related to limb loss and its complications may include congenital limb anomaly, contracture, phantom pain, deconditioning, degenerative joint disease, depression, diabetes mellitus, exercise intolerance, falls and injuries, fatigue, malnutrition, medications, obesity, peripheral vascular disease, pressure ulcers, skin irritations, and spasticity or abnormal muscle tone.

1.b. Risk factors for further limb loss may include diabetes mellitus, infection, obesity, smoking, peripheral vascular disease, and improper fit of prosthesis.

1.c. Interventions to facilitate functional independence could include training for transfer skills, activities of daily living (ADL), use of transportation, and application of and confidence in skills of using a prosthesis.

1.d. Prosthetic care includes assessment, services, and maintenance.

1.e. Interventions might include counseling, support groups, or individual approaches to specific situations.

1.f. Interventions to address community integration and participation in life roles might include arranging for transportation for the person served to attend services at his or her usual place of worship or training to return to cycling, swimming, golfing, or fishing. Another example is the therapeutic recreation specialist and/or physical therapist going into the community with the person served and working with him or her to board public transportation.

1.g. The family and support system are integral to assisting the person served to attain maximal function and quality of life. Services for families and support systems might include support groups and group or individual education sessions.

4.B. **2. The interdisciplinary team of the amputation specialty program collaborates with acute care providers to facilitate effective and efficient movement through the continuum of care.**

Intent Statements

Information on how collaboration between the acute care providers and the amputation specialty program interdisciplinary team occurs should be available for the survey team.

Examples

Collaboration in effectively and efficiently moving the person served through the continuum of care could include evidence of affiliations and referral arrangements, preadmission assessments, and methods for timely exchange of relevant information.

4.B. **3. The physician with amputation specialty program expertise demonstrates efforts to impact perioperative decision making to improve outcomes for the person served, including, but not limited to:**

- **a. Collaboration with surgeons performing amputations.**
- **b. Exchange of information on factors facilitating achievement of optimal functional outcomes postsurgery.**
- **c. Exchange of information on barriers to the achievement of optimal functional outcomes postsurgery.**
- **d. Education.**
- **e. Research, if applicable.**
- **f. Participation as a team member with the surgeon, as feasible.**
- **g. Collaboration with prosthetists on timing of prosthetic interventions.**

Intent Statements

The program demonstrates that the rehabilitation physician with amputation specialty program expertise is involved as early as possible with the persons served, their surgeons, and other health professionals to facilitate achievement of optimal rehabilitation outcomes and function.

Examples

3.a. The physician with amputation specialty program expertise collaborates with the surgeon regarding level of amputation for the most effective rehabilitation outcomes.

3.b.–c. Information exchanged could include comorbidities, preoperative strength, cardiovascular fitness, emotional and psychological status, social support, and goals and expectations of the persons served.

3.d. Education to impact perioperative decision making might be specific to individuals or through formal education sessions. Education could include exchange of information on evidence-based practice, factors impacting rehabilitation outcomes, sharing of articles and resources, presentation in educational rounds, or case studies.

4.B. **4. A prosthetist is a member of the interdisciplinary team in a comprehensive integrated inpatient rehabilitation amputation specialty program or an outpatient medical rehabilitation amputation specialty program.**

Intent Statements

The prosthetist is an integral member of the interdisciplinary team to identify prosthetic options; provide appropriate prosthesis if indicated to meet the needs of the person served; and facilitate and educate the person served in the care, maintenance, and use of the prosthesis to assist the person served to achieve predicted outcomes.

4.B. **5. Information regarding available funding to meet the ongoing needs of the persons served is incorporated into the following processes:**

- **a. Intake.**
- **b. Assessment.**
- **c. Service planning.**
- **d. Service provision.**
- **e. Discharge/transition planning.**
- **f. Life-long follow-up.**

Intent Statements

Persons who have limb loss often have ongoing needs that may continue beyond the portion of the continuum addressed by the amputation specialty program. It is important for the amputation specialty program to identify each person's potential needs and incorporate the available and potential funding resources into the above processes.

Examples

Considerations for available funding may include equipment needs, prosthetic needs, and insurance and funding caps for prosthesis.

For example:

- The person served has a limited amount of funding per calendar year for equipment, so only the equipment that is most necessary for safety and independence is obtained during the first year.
- The person served has limited funds for a prosthesis, so alternative funding sources or options for therapy are explored.

4.B. **6. For each person served, based on need, the program demonstrates knowledge of:**

- **a. The etiology of the limb loss.**
- **b. Medical history.**
- **c. Social history.**
- **d. Comorbidities.**
- **e. Risk factors.**
- **f. Pain issues.**
- **g. Cognition.**
- **h. Mood disturbances.**
- **i. Medications.**
- **j. Foot care.**
- **k. Limb care.**
- **l. Prosthetic use and care, including, but not limited to:**
  - **(1) How to apply and adjust the fit of the prosthesis.**
  - **(2) Limb and prosthetic hygiene.**
  - **(3) Individual utilization.**
  - **(4) Training.**
  - **(5) Maintenance.**
- **m. The results of previous prosthetic interventions.**
- **n. Contact information for the individual's prosthetist.**

Intent Statements

To ensure the safety of the persons served and determine the most appropriate and beneficial interventions, knowledge of the etiology of the limb loss, health and medical status and history, and results of previous interventions are important. The knowledge will allow the program to minimize unnecessary interventions, establish an accurate baseline of health and functional status, set realistic goals, and optimize results.

Examples

6.d. Comorbidities might include diabetes, cardiovascular disease, renal disease, or pulmonary disease.

6.e. Risk factors might include that the person continues to smoke, is overweight, exhibits symptoms of skin breakdown and infections, or expresses the potential to harm himself/herself or others.

6.h. Mood disturbances might include depression, anxiety, or panic related to post-traumatic stress disorder.

6.i. Knowledge of medications includes the medication and dosage prescribed, why the medication was prescribed, and any medication sensitivities.

6.l.(3) Individual utilization could include the number of hours that the prosthesis is worn each day, situations when the person served chooses to wear or not wear the prosthesis, and activities that are performed with or without the prosthesis.

6.l.(4) Training is crucial and could range from a handout to individualized occupational and/or physical therapy. Training could involve the prosthetist and include sock management as well as use and care of the prosthesis.

6.l.(5) Prosthetic maintenance could include identification of malfunction or deterioration of the prosthesis such as cracking or chipping.

4.B. **7. The amputation specialty program provides or arranges for the following services as needed:**

- **a. Limb loss education regarding self-management, including, but not limited to:**
  - **(1) Management of secondary complications.**
  - **(2) Skin care.**
  - **(3) Prosthetic options.**
  - **(4) Fit of the prosthesis.**
  - **(5) Accuracy of information received regarding prosthetic issues.**
- **b. Family/support system support.**
- **c. Prosthetic services.**
- **d. Orthotic services.**
- **e. Pedorthic services.**
- **f. Environmental modification.**
- **g. The provision of durable medical equipment.**
- **h. Training in the use of durable medical equipment.**
- **i. Adaptive equipment.**
- **j. Assistive technology.**
- **k. Psychological services.**
- **l. Sexual counseling.**
- **m. Specialty consultants.**
- **n. Substance use counseling and treatment.**
- **o. Strategies that address health and medical conditions, including, but not limited to:**
  - **(1) Diabetes management.**
  - **(2) Pain management.**
  - **(3) Regular preventive:**
    - **(a) Foot care.**
    - **(b) Limb care.**
  - **(4) Cardiovascular management.**
  - **(5) Risk reduction.**
  - **(6) Wound care.**
  - **(7) Skin care/integrity.**
  - **(8) Fitness and exercise promotion.**
- **p. Smoking cessation.**
- **q. Body weight control.**
- **r. Nutrition counseling.**
- **s. Adaptive recreation.**
- **t. Assessment of footwear adequacy, including insoles.**
- **u. Driver training.**
- **v. Vocational rehabilitation.**
- **w. Attention to spiritual needs.**

Examples

7.a.(3) Information provided might include whether or not a prosthesis is appropriate or indicated and prosthetic options best suited to the individual's lifestyle.

7.a.(4) Information provided might include what to expect in a comfortable prosthetic fit, impact on gait, and management of the residual limb.

7.a.(5) Persons served could be educated in how to determine the accuracy of information obtained from sources such as internet websites.

7.f. Environmental modification could include home or workplace modifications, bathrooms, ramps, appliances, clothing, or automobile adaptations.

7.m. Specialty consultants could include vascular surgeons, plastic or reconstructive surgeons, endocrinologists and diabetes specialists.

7.o.(8) Recreational activity in an area of interest such as walking or swimming can contribute to fitness of the person served.

7.s. Adaptive recreation might include consideration of options for specialty prostheses.

4.B. **8. The amputation specialty program provides or arranges for peer support services that:**

- **a. Reflect the characteristics of the persons served.**
- **b. Address the preferences of the persons served.**
- **c. Address the needs of the persons served.**

Intent Statements

The program may directly provide peer support services or partner with another resource to provide these services.

Examples

8.a. Peer supporters assigned reflect the ages, characteristics, interests, and life roles of the persons served to facilitate effective guidance.

8.b.–c. Peer support might facilitate successful life transitions, adjustment to disability, and awareness of and access to community resources, advocacy groups, and activities.

4.B. **9. There is documented evidence of training of peer supporters on current practices in peer support services, including at a minimum:**

- **a. Role of peer supporters.**
- **b. Boundaries.**
- **c. Communication skills.**

Intent Statements

If the program arranges for peer support services, the evidence of training of peer supporters may be from the entity providing the services.

Examples

9.b. The peer relationship requires the establishment of rapport as well as awareness of appropriate limits on behaviors. Training may address boundaries relative to peer supporters socializing, social media connections, and/or communication with persons served outside of their role as a peer supporter; recommending specific service providers or equipment to persons served.

Resources

Please refer to Appendix D for resources related to peer support services and training for peer supporters.

4.B. **10. The program provides or arranges for:**

- **a. Health assessments that address, at a minimum:**
  - **(1) Cardiovascular status.**
  - **(2) Cognitive function.**
  - **(3) Comorbidities.**
  - **(4) Hearing.**
  - **(5) Hydration.**
  - **(6) Mood disturbances.**
  - **(7) Motor function.**
  - **(8) Nutrition.**
  - **(9) Skin integrity.**
  - **(10) Skin sensation.**
  - **(11) Visual deficits.**
  - **(12) Wound care.**
  - **(13) Neuromusculoskeletal status.**
  - **(14) Pain.**
  - **(15) Pulmonary function.**
  - **(16) Body weight.**
  - **(17) Deep vein thrombosis (DVT) prophylaxis.**
  - **(18) Serum glucose.**
  - **(19) Renal function.**
  - **(20) Prosthesis functioning.**
- **b. Health promotion.**
- **c. Services that prevent illness.**
- **d. Health screenings.**

Intent Statements

10.a. Health assessments may be provided directly or arranged through other providers depending on the scope and resources of the program. The amputation specialty program should be aware of all factors necessary to determine the most appropriate and beneficial interventions for the person served.

Examples

10.a.(3) Comorbidities could include other medical conditions that are not directly related to the limb loss, such as hypertension, stroke, or arthritis.

10.a.(5) Assessment of hydration could include monitoring for signs of dehydration or maintaining intake and output records. Issues with hydration could impact residual limb volume and fit of the prosthesis.

10.a.(6) Mood disturbances might include depression, change in self-esteem, and post-traumatic stress disorder.

10.a.(7) Motor assessment could include performance of activities of daily living (ADL), ambulation, balance, range of motion, strength, and endurance.

10.a.(8) Assessment of nutrition could include monitoring for signs of

malnutrition, maintaining intake records, and noting balance of foods eaten.

10.a.(9) Assessment of skin integrity could include regular skin checks and routine inspection of skin when applying, removing, or adjusting the prosthesis.

10.a.(10) Skin sensation could include hypersensitivity or reduced sensitivity of the residual and contralateral limb or foot.

10.a.(11) Visual deficits could include visual acuity and deficits such as hemianopsia or diplopia. Visual deficits could impact safety or need for additional equipment or alternatives in self-monitoring of skin integrity.

10.a.(14) Assessment of pain could include radiographs to verify or exclude sources of residual limb pain following traumatic amputation, as well as assessment of the effectiveness of pharmacologic and coping strategies.

10.b. Health promotion could include arranging for a speaker from national or local amputee associations with expertise to address amputation, prosthetics, adaptive recreation, nutrition, exercise, or other areas identified by the persons served. It could also include encouraging or facilitating participation in wellness programs.

10.c. Providing or arranging for vaccinations is an example of services that prevent illness.

10.d. Health screening could include breast cancer, colon cancer, oral cancer, or blood pressure screenings.

4.B. **11. The amputation specialty program includes strategies that address, but are not limited to:**

- **a. Cardiovascular health.**
- **b. Depression.**
- **c. Diabetes management.**
- **d. Identification and utilization of specialized:**
  - **(1) Equipment.**
  - **(2) Technology.**
- **e. Infection prevention and control.**
- **f. Life role functioning.**
- **g. Lifestyle.**
- **h. Nutrition counseling.**
- **i. Pain management.**
- **j. Preventive:**
  - **(1) Foot care.**
  - **(2) Limb care.**
- **k. Pulmonary capacity.**
- **l. Recreation/leisure and other activities.**
- **m. Residual limb management.**
- **n. Skin integrity.**
- **o. Smoking cessation.**
- **p. Vocational choice.**
- **q. Weight control.**
- **r. Wellness.**
- **s. Adjustment to limb loss.**

Examples

11.b. The emotional well-being of the person served includes addressing depression due to loss of self-esteem related to alteration in body image and activity limitations.

11.d.(1) Specialized equipment might include contracture prevention devices, temporary and permanent prostheses, pain management devices such as transcutaneous electrical nerve stimulation (TENS) units, ADL adaptive devices, or durable medical equipment (DME).

11.f. Life roles may include the individual's role in the family/support system or larger community: e.g., employee, student, or volunteer. Interventions could include discussion and counseling in identifying ability or required modification to return to previous life role function or to a new role.

11.g. Lifestyle includes the way of life and activity patterns of the individual. For example, the person served may be sedentary or routinely physically active.

11.i. Persons served may experience phantom pain as well as skin, muscular, nerve, or bone pain. Examples of approaches to pain management include cognitive strategies, pharmacologic intervention, and modalities such as TENS units.

11.k. Pulmonary capacity includes pulmonary reserve to meet increased system demands associated with use of a prosthesis.

11.m. Residual limb management could include wound healing, shaping and shrinking,

desensitization, promotion of range of motion and strengthening of proximal joints and muscles, and protection from external trauma.

11.r. Wellness could encompass areas such as nutrition, exercise, psychological well-being, and recreation.

11.s. Adjustment to limb loss includes physical and emotional adjustments and takes into account life roles and vocational needs.

4.B. **12. The amputation specialty program addresses prevention of:**

- **a. Further limb loss.**
- **b. Limb complications.**
- **c. Onset or progression of comorbidities.**
- **d. Cardiovascular complications.**
- **e. Musculoskeletal deformities.**
- **f. Infections.**
- **g. Mood disturbances.**
- **h. Pain.**
- **i. Injury.**
- **j. Falls.**
- **k. Chronic disability.**
- **l. Substance use.**
- **m. Complications related to:**
  - **(1) Disability.**
  - **(2) Aging.**
  - **(3) Lack of appropriate follow-up.**
- **n. Skin injury.**

Intent Statements

The program addresses prevention/minimization of conditions and complications related to limb loss through ongoing monitoring of the status of the person served, education of the person served and the family/support system, and training in self-management of health.

Examples

12.a. Further limb loss could involve the residual limb, the contralateral limb, foot, or other extremities.

12.b. Limb complications might include infections, skin breakdown, swelling, muscle atrophy, and contractures.

12.c. Interventions could include education in recognition of subtle changes that might indicate the onset or progression of comorbidities.

12.d. Prevention of cardiovascular complications could be addressed through diet, nutrition, exercise, weight control, and adherence to medication regimens.

12.e. Musculoskeletal deformities might include contractures, Charcot foot deformity, and bone or joint deformity.

12.f. Prevention of infections could include appropriate skin care and education on signs of infection.

12.g. Mood disturbances might include depression, emotional lability, or post-traumatic stress disorder.

12.h. Pain includes residual limb pain, phantom pain involving the amputated limb, positional pressure; prosthesis-related pain; and muscle, nerve, or bone pain.

12.j. Prevention of falls might include dynamic balance training and environmental assessment for fall risks.

12.n. Skin injury includes cuts, bruises, abrasions, burns, and decubiti.

4.B. **13. Education:**

- **a. Facilitates self-management.**
- **b. Is appropriate to the needs of:**
  - **(1) The persons served.**
  - **(2) The families/support systems.**
- **c. Provides for but is not limited to education regarding:**
  - **(1) Accessing emergency care if necessary.**
  - **(2) Adaptation to limb loss.**
  - **(3) Adaptive equipment.**
  - **(4) Assistive devices.**
  - **(5) Mobility, including:**
    - **(a) Bed mobility.**
    - **(b) Wheelchair mobility.**
    - **(c) Ambulation.**
    - **(d) Transfer skills.**
  - **(6) Caregiver support.**

(7) Communication with other care providers.

(8) Decision making on care options, including, but not limited to:

- **(a) Obtaining a prosthesis.**
- **(b) Using a prosthesis.**
- **(c) Impact of cardiovascular status.**
- **(d) Risk factors in use of a prosthesis.**

(9) Energy conservation and expenditure.

(10) Fall prevention and management.

(11) Health risks.

(12) Home modifications.

(13) Home safety.

(14) Hydration.

(15) Importance of appropriate follow-up to prevent complications.

(16) Information about consumer groups, including how to access them.

(17) Information on lifetime health and wellness resources.

(18) Information about local, regional, provincial, or national community resources, including how to access them.

(19) Intimacy.

(20) Management of:

- **(a) Perioperative pain.**
- **(b) Postsurgical pain.**
- **(c) Residual limb pain.**
- **(d) Phantom limb sensation.**
- **(e) Phantom limb pain.**
- **(f) Secondary pain.**

(21) Musculoskeletal deformities, including:

- **(a) Prevention.**
- **(b) Management strategies when deformities are present.**

(22) Nonprosthetic:

- **(a) Mobility.**
- **(b) Function.**

(23) Nutrition.

(24) Residual limb care.

(25) Risk factors for further limb loss.

(26) Self-advocacy.

(27) Sequencing and education on the rehabilitation process, including, but not limited to:

- **(a) Importance of regular clinical follow-up.**
- **(b) Identification of system for follow-up.**
- **(c) Responsibilities concerning follow-up.**

(28) Specific healthcare procedures and techniques, including, but not limited to:

- **(a) Limb volume fluctuation.**
- **(b) Skin inspections.**

(29) Peer support.

(30) Use and care of the prosthesis, including, but not limited to:

- **(a) How to apply and adjust the fit of the prosthesis.**
- **(b) Limb and prosthetic hygiene.**
- **(c) Individual utilization.**
- **(d) Training.**

(31) Weight management.

Intent Statements

This standard expands upon the education addressed in Standards 2.B.30.–31. and Standard 2.C.21.

13.a. The concept of self-management recognizes that assistance, supports and external resources may be necessary for successful management of one's own health. Education should be provided based on the stated needs of the persons served.

Examples

Resources for education include the Amputee Coalition of America and the National Limb Loss Information Center.

13.c.(2) Adjustment to limb loss could include education for the persons served and families/support systems on adjustment to disability, resuming sexual activity, and personal acceptance.

13.c.(6) Education might include information on resources available such as respite and community groups.

13.c.(7) Strategies for communicating with other care providers could include teaching the persons served and families to plan for conversations with providers, preparing questions, being organized, and taking their personal health information to appointments.

13.c.(11) Prevention education to avoid health risks could address obesity, nutritional disorders, smoking cessation, management of hypertension, signs and symptoms of myocardial infarction, hip or other fractures, osteoporosis, DVT, osteoarthritis, pressure ulcers, and joint pain.

13.c.(19) Intimacy might include sexuality, self-image, and self-esteem.

13.c.(23) The maintenance of good nutrition contributes to stable health, maintaining skin integrity, and weight control.

13.c.(30)(a)–(b) Limb hygiene includes identification of pressure areas or altered fit of the prosthesis due to fluctuation in residual limb volume and how to adjust the residual limb cover to result in the best fit of the prosthesis.

13.c.(31) Education includes the importance of weight management as it impacts on the fit of the prosthesis, potential comorbidities, and activity of the person served.

4.B. **14. With consideration of the life-long needs of the person served, written recommendations are provided by the day of discharge/transition that address:**

- **a. Age-specific considerations.**
- **b. Self-management.**
- **c. Local, regional, provincial, or national consumer organizations.**
- **d. Orthotic services.**
- **e. Pedorthic services.**
- **f. Foot care services.**
- **g. Follow-up.**

Intent Statements

This standard expands upon the written recommendations addressed in Standard 2.B.36. To maximize safety and facilitate continuity of care, it is important that discharge/transition recommendations be provided to the person served and his or her family/support system to allow sufficient time to ensure that the recommendations are understood and will be implemented.

4.B. **15. The amputation specialty program:**

- **a. Offers follow-up care for those persons who remain in its service area.**
- **b. Arranges for follow-up care for persons who leave the system's geographic service area.**
- **c. Establishes a plan of follow-up for each person served.**

4.B. **16. The amputation specialty program designates the individual(s) who will be responsible for coordination of the follow-up plan of each person served.**

Examples

The individual designated could be the person served, a member of the person's family or support system, a caregiver at another setting to which the person is being discharged, or a community-based case manager.

4.B. **17. The amputation specialty program:**

- **a. Gathers information on each person served, including information on:**
  - **(1) The number of persons served with:**
    - **(a) Upper limb loss.**
    - **(b) Lower limb loss.**

(2) The number of persons who experience additional amputation from admission to discharge in the amputation specialty program, involving:

(a) The residual limb.

(b) The contralateral limb.

(3) The number of persons who developed new foot ulcers from admission to discharge in the amputation specialty program, if applicable.

b. Gathers information on each person served at follow up, including information on:

(1) The use of the prosthesis after discharge.

(2) The number of persons who experience additional amputation after discharge from the amputation specialty program, involving:

(a) The residual limb.

(b) The contralateral limb.

(3) The number of persons who developed new foot ulcers after discharge from the amputation specialty program, if applicable.

c. At least annually conducts a written analysis that includes:

(1) Performance in relationship to established targets for:

(a) The number of persons served with:

(i) Upper limb loss.

(ii) Lower limb loss.

(b) The number of persons who experience additional amputation after admission to the amputation specialty program, involving:

(i) The residual limb.

(ii) The contralateral limb.

(c) The number of persons who developed new foot ulcers after admission to the amputation specialty program, if applicable.

(d) The use of the prosthesis after discharge.

(2) Trends.

(3) Actions for improvement.

(4) Results of performance improvement plans.

(5) Necessary education and training of:

(a) Persons served.

(b) Families/support systems.

(c) Personnel.

Intent Statements

Information collected, when analyzed and included in performance improvement efforts, could allow the program to continually refine and improve the quality of services provided. Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

17.a.(2)–(3) Information is gathered on numbers of persons who experience additional amputations or new foot ulcers, if applicable, while receiving services in the Amputation Specialty Program.

C. Brain Injury Specialty Program

Description

A Brain Injury Specialty Program delivers services that focus on the unique medical, physical, cognitive, communication, psychosocial, behavioral, vocational, educational, accessibility, and leisure/recreational needs of persons with acquired brain injury. The program integrates services to:

- Minimize the impact of impairments and secondary complications.
- Reduce activity limitations.
- Maximize participation, including wellness, quality of life, and inclusion in the community.
- Decrease environmental barriers.
- Promote self-advocacy.

A Brain Injury Specialty Program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. It provides access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons with acquired brain injury. A Brain Injury Specialty Program utilizes current research and evidence to provide effective rehabilitation and supports future improvements by advocating for or participating in brain injury research.

A Brain Injury Specialty Program partners with the persons served, families/support systems, and providers from emergency through community-based services to foster an integrated system of services that optimizes recovery, adjustment, inclusion, participation, and prevention. A Brain Injury Specialty Program engages and partners with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a brain injury to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large.

Note: *A program seeking accreditation as a Brain Injury Specialty Program must include in the survey application and the site survey all portions of the program (Comprehensive Integrated Inpatient Rehabilitation Program, Outpatient Medical Rehabilitation Program, Home and Community Services, Residential Rehabilitation Program, and Vocational Services) that the organization provides and that meet the program descriptions.*

Note: *Please refer to the Glossary for the definition of* acquired brain injury.

Applicable Standards

If an organization chooses to add the optional Brain Injury Specialty Program (BISP) designation to one or more appropriate programs/services in Section 3, the program description and all standards in this section are applicable.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which BISP accreditation is sought (see guidelines in Section 2)
- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)
- Section 2.E. if the program serves *any* children/adolescents and is not seeking accreditation as a Pediatric Specialty Program. (Not applicable for Home and Community Services BISP; see guidelines in Section 2)

4.C. **1. The brain injury specialty program defines its interventions in the following areas:**

- **a. Preventing brain injury.**
- **b. Recognizing, assessing, and treating conditions related to brain injury and preventing complications and comorbidities.**
- **c. Identifying and reducing the risk factors for recurrent brain injury.**
- **d. Facilitating functional independence and performance.**
- **e. Facilitating psychological well-being and social coping and adjustment.**
- **f. Facilitating community inclusion and participation in life roles.**
- **g. Assistive technology.**
- **h. Services for families/support systems.**

Examples

1.a. Preventing brain injury might be addressed through community outreach and education such as speaking to high school groups about high risk behaviors, educating sports leagues about the signs and symptoms of concussion, and participating in local campaigns to wear helmets when riding bicycles.

1.c. Throughout the continuum of services the program addresses with the person served activities and behaviors that may contribute to another brain injury. Strategies and techniques would be addressed, taught, reviewed and/or supported by the program. Examples might be involvement in counseling and support groups for substance use or addressing a balance disorder that increases the risk of falling.

1.d. Interventions to address functional independence and performance could address cognition, memory, communication, behavior, balance, self-care and other activities of daily living, and/or motor function.

1.e. Interventions may include counseling, support groups, or individual approaches to specific situations. For example, a social coping and adjustment skill may be practicing how to ask others to speak more slowly or repeat instructions to allow the person who has a brain injury increased time to process information.

1.f. Interventions to address community inclusion and participation in life roles might include training in self-advocacy for the person served, arranging for transportation for the person served to attend services at his or her usual place of worship, or facilitating volunteer opportunities for the person served. Another example is the therapeutic recreation specialist going into the community with the person served and working with him or her to order food that fits in the person's dietary parameters at a restaurant.

1.h. The family and support system are integral to assisting the person served to attain maximal function and quality of life. Services for families and support systems might include support groups, group or individual education sessions, assistance with respite, and/or home modifications.

4.C. **2. The program facilitates collaboration with the person served and family/support system in decision making through the following:**

- **a. Accessible information.**
- **b. Timing for exchange of information.**
- **c. Identification of their level of:**
  - **(1) Understanding of the rehabilitation process.**
  - **(2) Health literacy.**

Intent Statements

To facilitate the decision-making roles of the person served and family/support system they are given information in a way that is understandable and in sufficient time to make informed decisions. Access to information reflects any diversity issues that would impact decision making.

Examples

2.c.(1) The level of understanding of the rehabilitation process may be identified through the preadmission assessment or assessment processes, asking the person served or family/support system to summarize discussions and decisions made in team conferences, or verification by the case manager or care coordinator.

2.c.(2) The U.S. Department of Health and Human Services Health Resources and Services Administration defines health literacy as the

degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.

The brain injury specialty program facilitates the understanding of information by:

- Using simple language and short sentences.
- Avoiding the use of acronyms and technical language.
- Supplementing oral information with printed, audio, or video materials.
- Asking persons served and family members to summarize information they have been provided or do a return demonstration.
- Asking open-ended questions instead of yes/no questions.
- Repeating key points.
- Providing information in the primary language of the person served or family member.
- Offering assistance reviewing and completing forms.
- Using universal symbols in the physical environment.

Resources

Please refer to Appendix D for resources related to health literacy.

4.C. **3. The program demonstrates knowledge and application of clinical research to treatment practices.**

Examples

Professional associations and consolidated information databases are frequently used resources for information on evidence-based practices, clinical practice guidelines, accepted practices in the field, and peer-reviewed publications.

Resources

Please refer to Appendix D for resources related to evidence-based practice and research.

4.C. **4. The program demonstrates knowledge of and coordination with local, regional, provincial, national, or international networks or agreements to facilitate:**

- **a. Specialized brain injury services.**
- **b. Use of appropriate subspecialties.**
- **c. Advocacy.**

4.C. **5. Initial and ongoing assessments of each person served document information about:**

- **a. History.**
- **b. Status in the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Cultural.**
  - **(5) Decision-making capacity.**
  - **(6) Dual diagnosis.**
  - **(7) Educational.**
  - **(8) Functional.**
  - **(9) Leisure/recreational activities.**
  - **(10) Medical.**
  - **(11) Physical.**
  - **(12) Psychological.**
  - **(13) Sexual.**
  - **(14) Social.**
  - **(15) Spiritual.**
  - **(16) Vocational.**
- **c. Important events and life experiences.**
- **d. Life routines.**
- **e. Usability of the living environment.**

Intent Statements

Although the program is expected to address each of these areas, it does not have to administer any specific tests to address them. The extensiveness of the assessment in each of these areas may vary according to the unique needs of each person served.

Examples

5.b.(5) An assessment addresses the person's capacity to make decisions in his or her own best

interests including decisions about healthcare choices, financial decisions, or life care planning.

5.b.(6) Dual diagnosis refers to other health conditions, comorbidities, or diagnoses that the person served may have in addition to brain injury, e.g., spinal cord injury, diabetes, high blood pressure, arthritis, depression, anxiety, post traumatic stress disorder, an addiction, or other mental health diagnoses.

5.b.(10) Medical status might address nutrition, vital signs, sleep patterns, or other active or chronic medical conditions to see if interventions are needed.

5.b.(11) Physical status might include limitations related to ambulation, endurance, diabetic neuropathy, obesity, or arthritis.

5.b.(13) An assessment might address the person's interest in discussing sexual issues, sexual issues unrelated to brain injury, sexual issues related to brain injury, increase or decrease in sexual desire, erections, lubrication, capability of orgasm and/or ejaculation, painful intercourse, fertility, and birth control options.

5.c. As part of the initial assessment the persons served are asked what important events throughout the year they typically celebrate.

Families and friends are invited and participate in birthdays, anniversaries, and other special events for each person served.

Milestone events in the lives of persons served are planned for and celebrated with the personnel and persons served.

5.d. Information on life routines may address bathing, dressing, grooming, eating, or sleeping habits; work routines; routine activities such as cooking, exercise, gardening, child care, pet care, or hobbies; social interaction; and spiritual/religious activities.

5.e. Initial and ongoing assessments address the usability of the environments in which the individual lives, works, and plays. The usability of the environment may be impacted by numerous factors. For example:

- Square footage may be adequate but patterns on floors or carpets, lighting, the arrangement of furniture, the height of counters and sinks, etc., may diminish the usability of the space.
- Outside areas have benches and tables but no protection from the sun or elements.
- A person served who exhibits self-injurious behavior or has been identified as at risk for suicide lives in a high-rise apartment with a balcony.

Usability ensures that all people will be comfortable, safe, and able to function at their optimal level.

4.C. **6. Initial and ongoing risk assessments for each person served:**

- **a. Address the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Developmental.**
  - **(5) Emotional.**
  - **(6) Environmental.**
  - **(7) Medical.**
  - **(8) Physical.**
  - **(9) Vocational.**
  - **(10) Capability of the family/support system.**
  - **(11) Financial resources.**
  - **(12) Legal.**
  - **(13) Other, as appropriate.**
- **b. Are incorporated into:**
  - **(1) The assessment process.**
  - **(2) Individual program planning.**
  - **(3) Discharge/transition planning.**

Intent Statements

Initial and ongoing risk assessments allow the team to address the changing needs of the person served throughout the program and in its planning for discharge or transition to the next level of care.

Examples

Risk assessments may be incorporated into individual assessments by team members or addressed by the team at meetings about the person served.

6.a.(1) Behavioral risks could include the risk of a person served attempting to elope from an inpatient or residential program or leave home

without supervision, or a person who expresses the potential to harm himself/herself or others.

6.a.(6) Environmental risks may include safety risks in the home such as stairs, throw rugs, a lack of grab bars in the shower, or balconies without proper barriers.

6.a.(7) An example of a medical risk might be lack of sleep or nutrition compromise related to swallowing problems, the person's inability to safely prepare meals when home alone, lack of money or transportation to shop for food, and/or lack of appetite.

6.a.(8) A person served with obesity may be at a higher risk for falling or causing injury to a caregiver.

6.a.(9) An example of a vocational risk may be that the person served worked as a painter and this would now pose safety issues due to current balance deficits.

6.a.(11) Addressing risks related to financial resources might include education on conserving or managing financial resources to ensure the most effective use of resources to meet ongoing needs.

6.a.(12) Legal risks may include a person's history of driving under the influence of alcohol, as a sex offender, or the need to address legal status related to decision making.

Note: *A Brain Injury Specialty Program does not have to meet Standard 8. in Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program.*

4.C. **7. To meet the needs of the persons served, the program provides or arranges for diagnostic services to screen for and assess the status of:**

- **a. Bladder function.**
- **b. Bowel function.**
- **c. Cardiac function.**
- **d. Cognitive function.**
- **e. Mental health.**
- **f. Metabolic function.**
- **g. Musculoskeletal function.**
- **h. Neurologic function.**
- **i. Obstetric and gynecological health.**
- **j. Pulmonary function.**
- **k. Sensory function.**
- **l. Skin integrity.**
- **m. Swallowing.**
- **n. Thromboembolic disease.**
- **o. Other common secondary conditions.**

Examples

7.e. Diagnostic services for mental health may assess for depression, anxiety, substance use, or post traumatic stress disorder.

7.k. Sensory screenings might address vision, hearing, vestibular function, and/or the person's ability to regulate his/her body temperature.

7.n. Thromboembolic disease could include DVT.

7.o. Hypertrophic ossification and sleep issues are examples of other common secondary conditions.

4.C. **8. Prior to the implementation of specific treatments, personnel:**

- **a. Provide the rationale for those treatments to the:**
  - **(1) Person served.**
  - **(2) Family/support system.**
- **b. Provide options, as appropriate, based on the feedback received.**

Intent Statements

To increase understanding and engagement in the rehabilitation process, the persons served and families/support systems are provided with the rationale for specific treatments, including options if appropriate, before those treatments are implemented. This may range from explanations for various disciplines' interventions to specific tasks to be undertaken at a given session.

If members of the family/support system are not available prior to implementation of a specific treatment, personnel provide the information to them at the earliest possible opportunity. Likewise, in accordance with the preference of the person served, if members of the family/support system do not participate on the team they are not part of these discussions.

Note: *A Brain Injury Specialty Program does not have to meet Standard 7. in Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program.*

4.C. **9. Dependent on the needs of the persons served and their stated goals, the program provides or arranges for:**

- **a. Assistive technology.**
- **b. Audiology services.**
- **c. Chaplaincy services.**
- **d. Dialysis.**
- **e. Driver rehabilitation.**
- **f. Durable medical equipment.**
- **g. Dysphagia management.**
- **h. Environmental modification.**
- **i. Medical consultative services.**
- **j. Medical nutrition therapy.**
- **k. Neurobehavioral services.**
- **l. Neuropsychological services.**
- **m. Orthotic services.**
- **n. Ostomy/wound care.**
- **o. Peer support.**
- **p. Prosthetic services.**
- **q. Psychiatric services.**
- **r. Psychological services.**
- **s. Rehabilitation engineering.**
- **t. Respiratory therapy.**
- **u. Sexual education.**
- **v. Spasticity management.**
- **w. Substance use counseling and treatment.**
- **x. Total parenteral nutrition.**
- **y. Vestibular assessment.**
- **z. Visual assessment.**
- **aa. Vocational rehabilitation.**

Examples

If the program does not directly provide the service, arranging for the service may include bringing the service into the program while the person served is participating in the program, arranging for an appointment off site while the person served is participating in the program, or providing potential resources for the service after the person served is discharged/transitions from the program.

9.e. Driver rehabilitation might include assessment, training, retraining, or exploration of adaptations for vehicles.

9.h. Environmental modifications might include installing a ramp, widening doorways, or lowering counters for someone who will use a wheelchair upon return home; installing grab bars or materials that provide traction in the shower or tub; voice activated environmental control units to turn lights, televisions, or computers on and off or open curtains; and rearranging rugs and furniture to increase accessibility, usability, and reduce the risk of falling.

9.i. The program provides or arranges for medical consultative services such as dentistry, gynecology, obstetrics, urology, ophthalmology, endocrinology, etc., in accordance with the needs of the persons served.

9.o. Peer support might facilitate successful life transitions; adjustment to disability; and awareness of and access to community resources, advocacy groups, and activities.

9.r. Psychological services might address grief counseling, relationship counseling, adjustment, and behavioral issues.

9.s. Rehabilitation engineering services might be provided by a clinician such as an occupational therapist, speech-language pathologist, or physical therapist or by someone with a background in a science or technology field such as computer science, mechanical engineering, or electrical engineering. Although it is not required, RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America (**www.resna.org**) offers certifications including Assistive Technology Professional (ATP), Seating and Mobility Specialist (SMS), and Rehabilitation Engineering Technologist (RET) that reflect specialized expertise in those areas.

9.u. Sexual education might address how sexual desire and functioning are affected by brain injury, the impact of brain injury on relationships, how medications related to brain injury may affect sexual functioning and desire, fertility, and birth control. Education for the spouse/partner/significant other of the person served might address sexual functioning after brain

injury including how brain injury and cognitive functioning may impact the expression of sexual desires and behaviors. Issues to address might include medications, fatigue, distractibility, communication, hormones, or problems with positioning. Education may also include how the spouse/partner/significant other may assist the person served in expressing sexual desires and behaviors in a manner, time, and place that are safe, private, legal, and appropriate.

4.C. **10. Based on the individual needs of the persons served, the brain injury specialty program provides or arranges for resources, services, supports, and/or interventions:**

- **a. In the following areas:**
  - **(1) Community access, including:**
    - **(a) Driving.**
    - **(b) Mobility.**
    - **(c) Transportation needs.**
  - **(2) Life roles, including:**
    - **(a) Basic life skills.**
    - **(b) Life-long learning.**
    - **(c) Parenting skills.**
    - **(d) Spousal/significant other relations.**
    - **(e) Work re-entry.**
  - **(3) Adjustment to disability, including:**
    - **(a) Aging with a disability.**
    - **(b) Insight.**
    - **(c) Peer support.**
    - **(d) Supervision needs.**
  - **(4) Medical, including:**
    - **(a) Comorbid conditions.**
    - **(b) Falls.**
    - **(c) Medication.**
    - **(d) Nutrition.**
    - **(e) Secondary complications.**
    - **(f) Seizures.**
  - **(5) Community participation, including:**
    - **(a) Advocacy.**
    - **(b) Fitness.**
    - **(c) Leisure/recreation.**
    - **(d) Socialization.**
    - **(e) Volunteerism.**
    - **(f) Wellness.**
  - **(6) Mental health.**
- **b. At each of the following times:**
  - **(1) Beginning of services.**
  - **(2) Appropriate intervals.**
  - **(3) Discharge/transition.**

Intent Statements

While not every person served will have needs in all areas, an assessment is performed at points in time to ensure that all relevant needs are identified and addressed. The extensiveness of the assessment in each of these areas may vary according to the unique needs of each person served.

Examples

10.a.(1)(c) and **10.a.(5)(b)** To facilitate getting to the fitness center on weekdays the person served will need to use public transportation. The program provides contact numbers and scheduling information for several options in the community.

10.a.(2) Life roles could address the role of the person served in his or her family, e.g., as a spouse, significant other, parent, and/or sibling; as a worker; as a volunteer; or any other role relating to the person's participation in life situations.

10.a.(2)(b) Life-long learning may involve returning to school, community college, a university setting, vocational training, specialized training, or enrichment classes. For children and adolescents the program may provide education on site or collaborate with the community school on accommodations that will allow the child to return. For an adult a vocational specialist may assist with recommendations on appropriate programs to pursue based on the person's vocational skills and interests.

10.a.(2)(d) Spousal/significant other relations might include issues related to sexuality and changes in roles within the family.

10.a.(3)(b) An assessment of the insight of the person served might consider whether the

person is able to identify cognitive, functional, and/or physical limitations and areas of preservation that are consistent with what members of the team, including members of the family/support system, identify. The assessment might also consider whether the person served is able to self-manage identified limitations, seeking assistance and/or resources as needed.

10.a.(4)(e) Examples of secondary complications include endocrine issues, infectious diseases, seizures, sleep issues, and urinary tract infections.

10.a.(6) Counseling services are incorporated into the individual plan to address a person's history of depression, anxiety, post traumatic stress disorder, or substance use.

Resources

Please refer to Appendix D for resources related to peer support services and training for peer supporters.

4.C. **11. On an ongoing basis, the program addresses for each person served the impact of behavior, cognition, communication, medical, and sensory deficits on the following areas:**

- **a. Physical function.**
- **b. Psychological function.**
- **c. Social function.**
- **d. Vocational function.**
- **e. Education.**
- **f. Family dynamics.**
- **g. Participation.**

Examples

Sensory deficits might include visual, auditory, or vestibular deficits or the inability to regulate one's body temperature.

11.e. Education might involve determining how to provide education to the person served while he or she is in the brain injury specialty program. It might also involve identifying and making recommendations to community schools regarding the best way to provide information or special accommodations to be made if the person served will be returning to school, college, or vocational training.

11.f. Family dynamics might address changes in roles and relationships within the family.

11.g. Participation might include the person's ability to return to school or work, play with grandchildren, participate in a poker or bridge group, volunteer in the community, eat out with friends, attend worship services, etc.

4.C. **12. On an ongoing basis, the program addresses the impact of brain injury on the family/support system of the person with brain injury, including, but not limited to the person's:**

- **a. Children.**
- **b. Siblings.**
- **c. Spouse/significant other.**
- **d. Parents.**
- **e. Other members of the support system.**

Intent Statements

Please refer to the Glossary for a definition of *family/support system*.

The impact on various members of the person's family/support system may include anger, depression, denial, financial hardship, embarrassment, fear, abandonment, separation and/or divorce.

4.C. **13. The brain injury specialty program minimizes complications related to:**

- **a. Family/support system dynamics.**
- **b. Discharge/transition planning.**
- **c. Follow-up.**

Examples

13.b.–c. For the person served to make a successful transition to the next level of services or home, potential complications are anticipated and addressed. For example, if the discharge plan involves the person going home it is important to ensure that members of the family/support system are available and prepared to address the needs of the person served in the home environment. Or, if home adaptations are necessary they are identified and planned in advance so they can be completed by the time of discharge or soon thereafter.

Follow-up plans are clearly communicated to all parties and appointments, arrangements, and expectations are specified and followed through. If transportation is not available, community resources to assist with transportation to appointments are provided.

4.C. **14. The brain injury specialty program addresses prevention of:**

- **a. Onset or progression of comorbidities.**
- **b. Substance use.**
- **c. Injury.**
- **d. Falls.**
- **e. Abuse.**
- **f. Complications related to:**
  - **(1) Disability.**
  - **(2) Aging.**

4.C. **15. Wellness for the persons served is promoted through activities that:**

- **a. Are based on input from the persons served.**
- **b. Consider input from families/ support systems.**
- **c. Provide for daily structured and unstructured activities.**
- **d. Promote healthy behavior.**
- **e. Reflect their choices.**
- **f. Align with their cognitive capabilities.**
- **g. Align with their communication capabilities.**
- **h. Promote their personal growth.**
- **i. Promote self-responsibility.**
- **j. Enhance their self-image.**
- **k. Improve or maintain their functional levels.**
- **l. Allow for social interaction.**
- **m. Allow for autonomy.**
- **n. Include opportunities for community inclusion.**
- **o. Are documented in the individual plan for each person served.**

Examples

Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

15.c. Examples of unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large print books/audio books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
- Websites and literature on volunteer opportunities in the community are available.
- Brochures and pamphlets listing activities offered at local community centers are available in the outpatient waiting room.

Resources

Please refer to Appendix D for resources related to wellness.

4.C. **16. The brain injury specialty program creates an environment that supports appropriate relationships between personnel and the persons served.**

Intent Statements

In accordance with the organization's ethical codes of conduct, personnel maintain professional relationships and appropriate boundaries with persons served.

Examples

Persons served are referred to by their preferred form of address rather than other informal terms or names.

Personnel socialize with persons served in the context of therapeutic activities provided by the program but do not involve persons served in personal relationships or activities.

The therapist providing services in the community does not ask the person served who is a mechanic to do her a favor and work on her car.

The director of the residential program does not ask the person served who is an electrician to do repairs on the residence in order to save on expenses.

The residential aide who works overnight wears appropriate clothing rather than pajamas.

4.C. **17. Based on the needs and preferences of the persons served, the program addresses:**

- **a. Self-awareness.**
- **b. Social awareness.**
- **c. Peer relationships.**
- **d. Relationship issues.**
- **e. Sexuality.**
- **f. Reproductive issues.**

Examples

17.a. Self-awareness may include issues related to body image, self-esteem, coping abilities, or self-monitoring.

17.b. Social awareness may include coaching the person served on appropriate communication with friends and acquaintances using email, text messaging, and/or social media.

17.e. The program may address sexuality through arranging for specialty medical consultations and therapy, couples or marital counseling, or arranging for private and discrete areas for the person served and his or her sexual partner.

4.C. **18. Consistent with their personal preferences, the program supports persons served in developing, maintaining, and/or increasing their social contacts and relationships:**

- **a. With:**
  - **(1) Families/support systems.**
  - **(2) Friends.**
  - **(3) Significant others.**
- **b. Within the program.**
- **c. External to the program.**

Intent Statements

In addition to creating an environment that supports appropriate relationships between personnel and persons served, the program also supports persons served in developing, maintaining, and/or increasing their social contacts and relationships with families/support systems, friends, and significant others both within and external to the organization. Boundaries are established as appropriate for personal relationships between persons served and between persons served and personnel.

Examples

Families are invited to share meals with the persons served.

Persons served are encouraged to invite friends to visit and share a cup of coffee and a snack.

Persons served have access to a telephone in a private area for maintaining contact with friends and family members.

Persons served desiring to do so send and receive emails from friends and family members.

4.C. **19. The program identifies and supports the preferences of the persons served around:**

- **a. Lifecycle events.**
- **b. Community events.**
- **c. Cultural events.**
- **d. Spiritual events.**

Examples

19.a. Lifecycle events might include birthdays, anniversaries, family reunions, births, and other milestones.

19.b. Community events may be local festivals, fundraisers, and other activities in which the person served has participated in the past and views as important. Community events may also include civic events such as voting or serving on a board in which the person served may want to participate.

19.c. Depending upon the interests of the individual, he or she may desire to participate in festivities such as Cinco de Mayo, Greek festivals, St. Patrick's Day parades, etc.

19.d. Depending on the background of the person served there may be spiritual events such as Ash Wednesday, Yom Kippur, or Ramadan that are important for the individual to observe. This may mean adaptations in diet, meal times, or therapy times during those events to better meet the needs and support the preferences of the person served.

4.C. **20. Consistent with their personal preferences, the persons served are provided with opportunities to:**

- **a. Share their talents and skills.**
- **b. Mentor.**
- **c. Teach.**

Intent Statements

The program creates formal and informal opportunities for the persons served to find meaning and purpose through the sharing of their expertise and talents with other persons served and personnel.

Examples

Persons served may be involved in activities that provide them with opportunities to share their talents commensurate with their abilities, such as:

- Tutoring a student.
- Teaching a class in an area of expertise, such as cooking, crocheting, current events, political science, anthropology, or geography.
- Providing companionship to another person served.
- A group of former teachers getting together to assist local schools.
- Providing leadership or participating in a resident/participant council or similar committees.
- Showcasing artwork, photography, or collections in a public display.
- Assisting in production of a residential newsletter.

4.C. **21. The program provides an organized education program about brain injury that:**

- **a. Is appropriate to the needs of:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **b. Provides for, but is not limited to, education regarding:**
  - **(1) Neuroanatomy.**
  - **(2) Etiology and epidemiology of acquired brain injury.**
  - **(3) Communication with providers.**
  - **(4) Active involvement in the service delivery process.**
  - **(5) Behavioral supports.**
  - **(6) Cognitive interventions.**
  - **(7) Communication interventions.**
  - **(8) Developmental/life transitions.**
  - **(9) Community resources.**
  - **(10) Recognition and reporting of suspected abuse and neglect.**
  - **(11) Boundaries.**
  - **(12) Medical complications.**
  - **(13) Risks associated with brain injury.**
  - **(14) Self-advocacy.**
  - **(15) Psychological issues following brain injury.**

Intent Statements

This standard expands upon the education addressed in Standards 2.B.30.–31. and Standard 2.C.21.

Examples

21.b.(3) Education on communication with providers could include teaching the persons served and families to plan for conversations with providers, preparing questions, being organized, and taking their portable healthcare profile to appointments.

21.b.(10) This might include identification of what should be considered in the areas of abuse and neglect such as verbal abuse, physical abuse, attendant care habitually late, leaving person unattended, etc.

21.b.(11) Education regarding boundaries might address appropriate interactions with strangers, other persons served, and professionals.

21.b.(13) Information and education is provided to the family/support system as to the possible dangers and risks involved should the person served have difficulty controlling and/or inhibiting sexual expression or engage in risky behaviors due to cognitive, judgment, or impulse-related issues. Other risks may include substance use, anger management, or increased vulnerability.

4.C. **22. The program:**

- **a. Educates the persons served and families/support systems on respite care.**
- **b. Provides, arranges for, or assists with arrangements for respite care.**
- **c. If it provides respite care, requires the person served to bring the following with him or her, if applicable:**
  - **(1) Adaptive equipment.**
  - **(2) Assistive technology.**
  - **(3) Emergency contact information.**
  - **(4) Information on everyday routines.**
  - **(5) Information/instructions regarding any special needs.**
  - **(6) Instructions for specific healthcare procedures.**
  - **(7) Medications.**
  - **(8) Pertinent health/medical history.**

Examples

Respite care may be provided a variety of ways including, but not limited to, by extended family members or neighbors in their homes or the home of the person served, participation in an adult day program, external caregivers coming to the home of the person served, or referral to community resources so that the family has an opportunity for respite.

22.a. Education on respite care might address the need for respite care, benefits of respite care, how to obtain respite care, and the options available to meet the needs of the person served and family/support system.

4.C. **23. The program serves as a resource for information:**

- **a. For:**
  - **(1) Persons with acquired brain injury.**
  - **(2) Families/support systems.**
  - **(3) The community.**
- **b. Including, but not limited to:**
  - **(1) Advocacy opportunities.**
  - **(2) Consumer organizations.**
  - **(3) Disaster planning.**
  - **(4) Peer opportunities.**
  - **(5) Respite care.**
  - **(6) Specialists in brain injury services.**
  - **(7) Support groups.**

Examples

23.b.(3) If the person lives in a rural or isolated area there may be discussion about preparing his or her home for a disaster, including proper back-up generators, food, how to get to a shelter, who to communicate with, etc.

23.b.(4) The program provides information on volunteering in the community after discharge from the program or training as a peer mentor for other persons with brain injury, speaking at schools, and/or facilitating and accompanying a person with brain injury to community activities and groups.

4.C. **24. For persons served longer than one year, or upon request, the program offers comprehensive annual reviews:**

- **a. For:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **b. That address:**
  - **(1) Academic education needs.**
  - **(2) Behavior status.**

(3) **Cognitive status.**
(4) **Communication status.**
(5) **Education needs.**
(6) **Equipment.**
(7) **Financial resources.**
(8) **Function.**
(9) **Housing.**
(10) **Leisure/recreational activities.**
(11) **Life-long planning.**
(12) **Medical status.**
(13) **Psychological needs.**
(14) **Relationship resiliency.**
(15) **Respite.**
(16) **Substance use.**
(17) **Technology status.**
(18) **Transportation.**
(19) **Vocational status.**

c. **That include the provision of findings and recommendations to:**
(1) **The person served.**
(2) **Other relevant stakeholders.**

Intent Statements

Annual reviews are offered to persons participating in the program longer than a year and to persons who have been discharged and would benefit from such a review.

Examples

The brain injury specialty program offers an annual review of status through teleconference, follow-up appointment, or calls involving the person served and members of the family/support system.

24.b.(11) Life-long planning might include issues related to aging with a disability, housing options, and employment options.

24.b.(12) A review of medical status might include current medications the person served is taking, recent medical procedures, and the status of comorbid health conditions.

24.b.(17) Technology status might address what assistive technology, electronic aids to daily living, or environmental controls the person served is using; whether the technology is functioning properly and achieving the intended purpose; and whether the person served needs additional training or resources for preventive maintenance, adjustment, repair, or replacement.

4.C. **25. To promote seamless service delivery for the persons served:**

a. **The brain injury specialty program proactively coordinates, facilitates, and advocates for appropriate transitions.**
b. **Discharge/transition planning addresses:**
(1) **Life routines.**
(2) **The level of understanding of the family/support system regarding the current status of the person served.**
(3) **Expectations of the:**
(a) **Person served.**
(b) **Family/support system.**
(4) **Contingency plans.**
(5) **The environment of the next component of the continuum of services or discharge location, including:**
(a) **Facilitating factors.**
(b) **Barriers.**
(6) **Self-advocacy.**
(7) **Capability of the family/support system.**
(8) **Financial resources.**
(9) **Access to healthcare.**
(10) **Transportation.**
(11) **Identification of resources in the community that are or will be involved with the person served.**
(12) **Mechanisms for coordination with other resources.**
(13) **A follow-up plan for each person served.**
(14) **Follow-up services, including services for persons who leave the program's geographic service area.**

(15) Designation of the individual(s) who will be responsible for coordination of the follow-up plan of the person served.

Intent Statements

25.b. Planning may address discharge/transition to another level of services within the continuum offered by the brain injury specialty program or to another setting including home and/or another organization and may be geared toward maintenance and/or improvement depending upon the needs and status of the person served.

25.b.(1) Discharge/transition planning encompasses more than recommendations to meet ongoing medical and rehabilitation needs. It also incorporates those daily routines and activities that are meaningful to the person served.

Examples

25.a. The brain injury specialty program demonstrates coordination among all components of its continuum of services and those with which it links that includes interaction and feedback such as formal meetings related to discharge/transition planning for individual persons served, the sharing of treatment techniques and strategies between program teams, written communications, teleconferences, faxes, and the timely transmission of records.

25.b.(1) Discharge/transition planning addressing life routines might include structuring activities to facilitate taking medications; planning activities that require higher attention and executive function early in the day to reduce impact of fatigue on performance; and use of external supports such as day planners or smart phone applications for reminders. Life routines may address bathing, dressing, grooming, eating, or sleeping habits; work routines; routine activities such as cooking, exercise, gardening, child care, pet care, or hobbies; social interaction; and spiritual/religious activities.

25.b.(2) and **25.b.(3)(b)** For discharge/transition to be successful for the person served, it is critical for the family/support system to be realistic in its expectations. For example, it may be important for the family/support system to anticipate a temporary decline in the person's functioning when he or she first comes home. It may also be important to realistically understand the supervision needs of the person served so that family members can properly plan for assistance at home while they are at work during the day.

25.b.(8) The program addresses conservation of funding to meet long-term needs and eligibility for additional funding for services.

25.b.(15) Depending upon the person's needs, follow-up plans might be coordinated by someone from the brain injury specialty program, an external case manager, or a member of the person's family/support system.

4.C. **26. There are provisions for contact as appropriate between the person served and/or the family/support system and the program after discharge/transition.**

Examples

Contact between the persons served and the program may be made to:

- Address questions about discharge recommendations, follow-up plans, or changes in the status of the person served.
- Schedule a comprehensive annual review.
- Explore opportunities for peer mentoring persons currently served by the program.
- Request information on resources for home adaptations/modifications such as ramps or environmental control systems, fitness programs in the community that can accommodate people who use a wheelchair, support groups, or specialty physicians.

4.C. **27. Within its scope of practice and expertise, the brain injury specialty program acts as a resource to providers from emergency through community-based services.**

Examples

The program acts a resource to other providers who may encounter or provide services to persons with brain injury. It may provide educational sessions or materials, consultation, or training to providers on topics such as recognizing the signs and symptoms of mild brain injury; the development of treatment practices,

service models, and programs for persons served throughout the brain injury continuum of services; respite care; peer counseling and mentoring; advocacy activities; understanding dual diagnosis; cognition and behavior; aging with acquired brain injury; appropriate service referrals; factors facilitating and barriers to achievement of optimal outcomes; and collaboration with providers on the timing of brain injury interventions.

4.C. **28. The program works with community leaders in emergency preparedness concerning the unique needs of persons with brain injury to address:**

- **a. Emergency preparedness.**
- **b. Evacuation.**
- **c. Shelter.**
- **d. Recovery.**

Intent Statements

The program works with community leaders in emergency preparedness, e.g., civil defense, homeland security, Red Cross, to educate them about the unique needs of persons with brain injury and how to ensure that those needs can be met in the event of an emergency.

28.d. Recovery after a disaster means the return of the person served to his or her home or community setting.

Examples

28.d. Recovery might include transportation from the recovery center; home repairs due to damage from fire, water, wind, etc.; utility recovery; or public health assessment for safe/healthy living conditions.

Resources

Please refer to Appendix D for resources related to emergency preparedness education for persons served and other stakeholders.

4.C. **29. The program demonstrates efforts to educate the community about:**

- **a. Prevention of traumatic brain injury.**
- **b. Impact of acquired brain injury.**
- **c. The need for brain injury rehabilitation.**
- **d. Accessibility and reasonable accommodation.**
- **e. Inclusion.**

Examples

The program's efforts to build awareness and understanding in the community of the needs and interests of persons who have sustained a brain injury might include:

- Providing educational workshops to community members.
- Participating in community events and initiatives, e.g., festivals and charity events such as walks/runs for a cause.
- Entering collaborations with local governments and community-based groups to enhance services.
- Promoting integrated/inclusive community events, e.g., integrated arts such as theatre and dance and community meals.
- Speaking to philanthropic/foundation organizations about the need and funding for respite care options.

Topics addressed might include recognizing signs and symptoms of a concussion in school athletes, the importance of wearing helmets when riding bicycles and skateboards for prevention of brain injury; and the impact of brain injury on a person's family/support system, activities, and life roles.

4.C. **30. To facilitate advocacy for persons served, the brain injury specialty program demonstrates knowledge of:**

- **a. Regulations.**
- **b. Legislation.**
- **c. Financial issues.**
- **d. Funding availability.**
- **e. Service availability.**
- **f. Protection and advocacy resources.**
- **g. The healthcare delivery system.**
- **h. Resources and services related to aging.**

Examples

30.a. The program stays abreast of current regulations and potential changes to regulations.

The program encourages personnel, as appropriate, to respond to requests for public comment when regulatory changes are proposed. Part of the program's corporate citizenship may be to testify during regulatory reviews or development of new or revised regulations. Examples of regulations may be those that address residential programs, staffing patterns, and services offered.

30.b. Many pieces of legislation are proposed in the arena of brain injury. Being active with national or state/provincial trade associations that stay current with legislative proposals is integral to a brain injury specialty program. Not all legislation may impact the portion of the continuum the program offers, but the field of brain injury benefits from the input and support of all experts in the field. Examples include funding for family members to be paid caregivers and preassessments for cognitive abilities prior to beginning sports or resuming military service.

30.c. The program provides the person served resources to assist in developing a trust. The program assists the person served with information on who to contact at the local utility companies about bills that may be late.

30.d. The program is knowledgeable about brain injury Medicaid waivers.

30.f. The program is knowledgeable about the resources and opportunities available through disability rights organizations and networks.

Resources

Please refer to Appendix D for resources related to protection and advocacy.

4.C. **31. To advance the field of brain injury rehabilitation, leadership supports:**

- **a. The program's participation in research opportunities.**
- **b. The provision of information:**
  - **(1) To persons served.**
  - **(2) To families/support systems.**
  - **(3) About available:**
    - **(a) Research opportunities.**
    - **(b) Clinical trials.**

Intent Statements

31.a. It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

31.a. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the rehabilitation program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to brain injury rehabilitation on its research agenda.

The organization participates in associations in which researchers and clinicians interact to influence research in the field of brain injury, e.g., American Congress of Rehabilitation Medicine (**www.acrm.org**), International Brain Injury Association (**www.internationalbrain.org**), North American Brain Injury Society (**www.nabis.org**), and European Brain Injury Society (**www.ebissociety.org**).

Resources

Please refer to Appendix D for resources related to clinical trials.

4.C. **32. Education for personnel that addresses the unique needs of persons with brain injury:**

- **a. Is provided at:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. Includes, but is not limited to:**
  - **(1) Neuroanatomy.**
  - **(2) Etiology and epidemiology of acquired brain injury.**
  - **(3) Communication with persons served and their families/support systems.**

(4) Communication with other providers serving the persons served.
(5) Facilitating active involvement of the persons served and families/support systems in the service delivery process.
(6) Facilitating behavioral supports.
(7) Facilitating cognitive interventions.
(8) Facilitating communication interventions.
(9) Handling developmental/life transitions.
(10) Knowledge of community resources.
(11) Recognition and reporting of suspected abuse and neglect.
(12) Setting and maintaining professional boundaries.
(13) Medical complications.
(14) Special populations.
(15) Risks associated with brain injury.
(16) Psychological issues following brain injury.

Intent Statements

Education is provided to both clinical and nonclinical personnel who have regular contact with persons served and their families/support systems.

Examples

32.b.(14) Special populations might include persons who are aging, incarcerated, in the military, or who have dual diagnoses such as spinal cord injury or substance use.

4.C. **33. The brain injury specialty program:**
a. Gathers information on satisfaction:
(1) Including satisfaction with:
(a) Clinical practices/behaviors.
(b) The degree of inclusion of the persons served in their programs.
(c) Outcomes achieved.
(d) Information received about the program, including:
(i) Accuracy of information.
(ii) Usefulness of information.
(2) From:
(a) Persons served.
(b) Families/support systems.
(c) Other relevant stakeholders.
b. At least annually conducts a written analysis that addresses:
(1) Performance in relationship to established targets:
(a) For satisfaction with:
(i) Clinical practices/behaviors.
(ii) The degree of inclusion of the persons served in their programs.
(iii) Outcomes achieved.
(iv) Accuracy of information received about the program.
(v) Usefulness of information received about the program.
(b) From:
(i) Persons served.
(ii) Families/support systems.
(iii) Other relevant stakeholders.
(2) Trends.
(3) Actions for improvement.
(4) Results of performance improvement plans.
(5) Necessary education and training of:
(a) Persons served.
(b) Families/support systems.
(c) Healthcare providers.
(d) Personnel.

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is

considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

Examples

33.a.(1)(d) The organization may choose to gather satisfaction feedback from stakeholders on topics such as their perception of the accuracy of information furnished on the scope and intensity of services to be provided to the person served, the program's scope of services statement, and/or their expectations of the program.

D. Cancer Rehabilitation Specialty Program

Description

A person-centered cancer rehabilitation specialty program utilizes a holistic interdisciplinary team approach to address the unique rehabilitation needs of persons who have been diagnosed with cancer. A cancer rehabilitation specialty program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, or community-based programs. Personnel demonstrate competencies and the application of evidence-based practices to deliver services that address the preventive, restorative, supportive, and palliative rehabilitation needs of the persons served.

Cancer rehabilitation is an integral component of quality cancer care. The cancer rehabilitation specialty program focuses on strategies to optimize outcomes from the time of diagnosis through the trajectory of cancer in an effort to prevent or minimize the impact of impairments, reduce activity limitations, and maximize participation for the persons served. The program communicates and collaborates with healthcare providers to deliver coordinated care and promote seamless transitions in care.

The program is guided by the individual preferences, strengths, and needs of the persons served and their families/support systems. A cancer rehabilitation specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons who have been diagnosed with cancer. Through the use of performance indicators the program measures

the effectiveness of services across the continuum offered. A cancer rehabilitation specialty program advocates on behalf of persons who have been diagnosed with cancer to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A cancer rehabilitation specialty program translates current research evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in cancer research.

Applicable Standards

If an organization chooses to add the optional Cancer Rehabilitation Specialty Program (CRSP) designation to one or more appropriate programs/services in Section 3, the program description and all standards in this section are applicable.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which CRSP accreditation is sought (see guidelines in Section 2)
- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)
- Section 2.E. if the program serves *any* children/adolescents and is not seeking accreditation as a Pediatric Specialty Program. (Not applicable for Home and Community Services CRSP; see guidelines in Section 2)

4.D. **1. The cancer rehabilitation specialty program defines its interventions in the areas of preventive, restorative, supportive, and palliative rehabilitation, including:**

- **a. Prevention, recognition, assessment, and treatment of conditions related to the effects of cancer and its treatment.**
- **b. Promotion of healthy lifestyles.**
- **c. Optimization of function.**
- **d. Psychological and social coping and adaptation skills.**
- **e. Community integration and participation in life roles.**
- **f. Services and education for families/support systems.**

Examples

1.a. The effects of cancer and its treatment, which vary based on the type of cancer and the response of each person to treatment, may include, but are not limited to, fatigue, pain, lymphedema, balance dysfunction, joint pain, neuropathy, osteoporosis, sexual dysfunction, swallowing difficulties, lack or appetite, weight gain or loss, shortness of breath, upper extremity dysfunction, weakness, depression, anxiety, grief, fear, and anger.

1.b. Promotion of healthy lifestyles might address physical activity; nutrition, healthful eating, and weight management; protection from the sun; smoking cessation; alcohol use; vaccines; cancer screenings; as well as measures individuals may take to reduce the risk of cancer developing or recurring.

1.c. Optimization of function could address cognition, memory, communication, balance, self-care and other activities of daily living, motor function, and/or pacing and energy conservation techniques to help manage fatigue.

1.d. Interventions might include counseling, support groups, spiritual or religious approaches, complementary medicine, or individual approaches to specific situations.

1.e. Interventions to address community integration and participation in life roles might include training in self-advocacy for the person served, arranging for transportation for the person served to attend services at his or her usual place of worship or an exercise class, engagement in work activities, facilitating volunteer opportunities for the person served, or pursuing alternative leisure pursuits.

1.f. The family and support system are integral to assisting the person served to attain optimal function and quality of life. Services for families and support systems might include support

groups and counseling as well as group or individual education sessions.

Resources

Please refer to Appendix D for resources related to cancer rehabilitation.

4.D. **2. The program facilitates collaboration with the person served and family/support system in decision making through the following:**

a. Accessible information.

b. Timing for provision and exchange of information.

c. Identification of their understanding of the rehabilitation process.

Intent Statements

To facilitate the decision-making roles of the person served and family/support system they are given information in a way that is understandable and in sufficient time to make informed decisions. Access to information reflects any diversity issues that would impact decision making.

Examples

The U.S. Department of Health and Human Services Health Resources and Services Administration defines health literacy as the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness.

The cancer rehabilitation specialty program facilitates the understanding of information by:

- Using simple language and short sentences.
- Avoiding the use of acronyms and technical language.
- Supplementing oral information with printed, audio, or video materials.
- Asking persons served and family members to summarize information they have been provided or do a return demonstration.
- Asking open-ended questions instead of yes/no questions.
- Repeating key points.
- Providing information in the primary language of the person served or family member.
- Offering assistance reviewing and completing forms.
- Using universal symbols in the physical environment.

2.c. Understanding of the rehabilitation process may be identified through the assessment process, asking the person served or family/support system to summarize discussions and decisions made in team conferences, or verification by the case manager or care coordinator.

Resources

Please refer to Appendix D for resources related to health literacy.

4.D. **3. The program demonstrates knowledge and application of evidence-based practices in the field of cancer rehabilitation.**

Examples

Professional associations are frequently used resources for information on evidence-based practices, clinical practice guidelines, accepted practices in the field, and peer-reviewed publications.

Personnel from the program participate on a multidisciplinary tumor board in which experts of various disciplines review and discuss the conditions of and treatment options for persons with cancer.

Team members seek specialty certifications or participate in special interest sections through their professional associations such as the Oncology Section of the American Physical Therapy Association (**www.oncologypt.org)** or the American Speech, Language and Hearing Association's Voice and Voice Disorders Special Interest Group (**www.asha.org/SIG/03**).

Resources

Please refer to Appendix D for resources related to evidence-based practice and research and to cancer rehabilitation.

4.D. **4. The program demonstrates knowledge of and coordination with local, regional, provincial, national, or international resources to facilitate:**

- **a. Specialized cancer services.**
- **b. Use of appropriate subspecialties.**
- **c. Advocacy.**
- **d. Access to community support and education resources.**

4.D. **5. The program demonstrates efforts to:**

- **a. Influence outcomes for the persons served, including, but not limited to:**
  - **(1) Collaboration with acute and/or palliative services.**
  - **(2) Exchange of information on factors facilitating the achievement of optimal outcomes.**
  - **(3) Exchange of information on barriers to the achievement of optimal outcomes.**
  - **(4) Participating in and supporting evidence-based practice.**
  - **(5) Participation in research, if applicable.**
  - **(6) Participation as a team member with the acute providers, as feasible.**
  - **(7) Collaboration with physicians on the selection and timing of medical interventions.**
- **b. Collaborate with primary care, palliative care, and specialty physicians after discharge.**

Intent Statements

Rehabilitation professionals are involved as early as possible with the persons served, their physicians, and other health professionals to facilitate early referral to rehabilitation and achievement of optimal rehabilitation outcomes and function.

Examples

5.a.(2)–(3) Information exchanged could include comorbidities, emotional and psychological status, preoperative strength and cardiovascular fitness, social support, and goals and expectations of the persons served.

5.b. Specialty physicians might include an oncologist or reconstructive surgeon.

4.D. **6. For each person served, the cancer rehabilitation specialty program identifies:**

- **a. The physician(s) who is providing medical management for the person served.**
- **b. The rehabilitation professional who is providing rehabilitation management for the person served.**
- **c. Mechanisms for coordination, communication, and collaboration when these are not the same individuals.**

Intent Statements

6.a. The physician(s) who is providing medical management includes physicians who are treating the person served for comorbid conditions.

Examples

6.b. A physical medicine and rehabilitation physician (physiatrist) or a physician (neurologist, orthopedist, pediatrician, etc.) who is qualified by virtue of specialized training and experience in rehabilitation provides rehabilitation management for the persons served in the inpatient cancer rehabilitation specialty program.

In an outpatient lymphedema program a physical therapist might be responsible for rehabilitation management for the persons served.

In a head and neck cancer program the speech-language pathologist collaborates with each person's physician to manage his or her individual rehabilitation plan.

6.c. The person who coordinates the provision of care for the person served, who may be a case manager, primary therapist, navigator, etc., facilitates coordination, communication, and collaboration among the physicians and rehabilitation professionals involved with the person served.

4.D. **7. Initial and ongoing assessments of each person served document information about:**

- **a. Cancer-related history.**
- **b. Relevant medical history.**
- **c. Status in the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Comorbid conditions.**
  - **(5) Cultural.**
  - **(6) Decision-making capacity.**
  - **(7) Developmental.**
  - **(8) Educational.**
  - **(9) Functional.**
  - **(10) Leisure/recreational activities.**
  - **(11) Medical management.**
  - **(12) Physical.**
  - **(13) Psychological.**
  - **(14) Sexual.**
  - **(15) Social.**
  - **(16) Spiritual.**
  - **(17) Vocational.**
- **d. Important events and life experiences.**
- **e. Life routines.**
- **f. Usability of the living environment.**
- **g. Understanding of the person served and the family/support system regarding:**
  - **(1) The status of the person served.**
  - **(2) The expectations of the person served.**

Intent Statements

Although the program is expected to address each of these areas, it does not have to administer any specific tests or assessments to address them. The extensiveness of the assessment in each of these areas may vary according to the unique needs of each person served.

Examples

7.c.(4) Diabetes, high blood pressure, arthritis, and cardiovascular disease are examples of comorbid conditions that the person served may have in addition to a diagnosis of cancer.

7.c.(5) The program is aware that different cultures view cancer differently. How it is viewed by a person served may impact his or her recovery and acceptance, participation in treatment, and return to prior life roles.

7.c.(6) An assessment addresses the person's capacity to make decisions in his or her own best interests including decisions about healthcare choices, financial decisions, life care planning, and/or end-of-life choices.

7.c.(11) Vital signs, nutrition, sleep patterns, and/or other active or chronic medical conditions are assessed to see if medical management is needed.

7.c.(12) Physical status might address fatigue, pain, lymphedema, neuropathy, obesity, endurance, mobility, etc.

7.c.(13) An assessment of psychological status might screen for depression, anxiety, post traumatic stress disorder, substance use, and/or other mental health diagnoses.

7.c.(14) An assessment might address the person's interest in discussing sexual issues, increase or decrease in sexual desire, sexual dysfunction, fertility, and birth control options.

7.d. The persons served are asked what important events throughout the year they typically celebrate. The assessment may identify a lack of desire to participate in these activities due to pain, fatigue, disfigurement, depression, or embarrassment.

7.e. Information on life routines may address bathing, dressing, grooming, eating, or sleeping habits; work routines; routine activities such as cooking, exercise, gardening, child care, pet care, or hobbies; social interaction; and spiritual/religious activities.

7.f. Initial and ongoing assessments address the usability of the environments in which the individual lives, works, and plays. The usability of the environment may be impacted by numerous factors. For example:

- Square footage may be adequate but patterns on floors or carpets, lighting, the arrangement

of furniture, the height of counters and sinks, etc., may diminish the usability of the space.

- Outside areas have benches and tables but no protection from the sun or elements.
- A person served may prefer a private area to eat meals at work due to swallowing difficulties after throat cancer. However, there is only a large cafeteria and no accommodations have been made for a more private area.

Usability ensures that all people will be comfortable, safe, and able to function at their optimal level.

Resources

Please refer to Appendix D for information related to cancer rehabilitation resources.

4.D. **8. The program addresses the reduction of risks for each person served through:**

- **a. Initial and ongoing risk assessments that:**
  - **(1) Address the following areas:**
    - **(a) Behavioral.**
    - **(b) Cognitive.**
    - **(c) Communication.**
    - **(d) Developmental.**
    - **(e) Emotional.**
    - **(f) Environmental.**
    - **(g) Medical management.**
    - **(h) Physical.**
    - **(i) Vocational.**
    - **(j) Capability of the family/support system.**
    - **(k) Financial resources.**
    - **(l) Legal.**
    - **(m) Other, as appropriate.**
  - **(2) Are incorporated into:**
    - **(a) The assessment process.**
    - **(b) Individual program planning.**
    - **(c) Discharge/transition planning.**
- **b. Actions to mitigate identified risks.**

Intent Statements

Initial and ongoing risk assessments allow the team to address the changing needs of the person served throughout the program and in its planning for discharge or transition to the next level of care.

Examples

Risk assessments may be incorporated into individual assessments by team members or addressed by the team at meetings about the person served.

A person served who is experiencing a high level of anxiety is unable to cope with her role as a supervisor in the work place and begins avoiding interactions with colleagues and calling in sick.

Because of chemo brain a young mother is having difficulty remembering to pick up her children at school and assisting them with homework; a college student is having difficulty concentrating in class and staying on top of his school work.

A person's perception of her abilities and limitations is not consistent with what members of the team and her family/support system identify, leaving her at risk when she cooks or bathes while she is home alone.

A person who lives alone is having increasing difficulty operating the speech generating device she has been using, leaving her at risk to communicate clearly with family when they call to check on her or in the event of an emergency.

Examples of emotional risks may include a person who feels so devastated he is unable to remember appointments, follow through on instructions that have been given, or focus on driving safely; a person served who feels overwhelmed by changes in body image or guilty about changes in family roles and is starting to withdraw from family members and friends.

Environmental risks may include safety risks in the home—stairs, throw rugs, a lack of grab bars in the shower, balconies without proper barriers—or a job that involves extended periods of time outdoors and in the sun.

Example of medical risks include lack of sleep, nutrition compromise related to swallowing problems, low blood pressure causing fainting, low blood cell counts leaving the person at risk for infection, or osteoporosis putting the person at risk for fractures.

A person served with obesity or balance issues may be at a higher risk for falling or causing injury to a caregiver. Fatigue may lead to inactivity, muscle weakness, deconditioning, or balance issues.

An example of a vocational risk may be that the person served worked as a painter and this would now pose safety issues due to current balance deficits.

Addressing risks related to financial resources might include that the person has been unable to work and needs assistance with paying bills, buying groceries, or obtaining medications. It might also address the need for education on conserving or managing financial resources to ensure the most effective use of resources to meet ongoing needs.

Legal risks may include the need to address legal status related to decision making, write a will, create a trust, etc.

Other risks might include a person who expresses the potential to harm himself/herself or others, a conflict between the medical treatment recommended and the person's religious beliefs that prohibit such treatment, or when a person served believes illness is punishment for something she did.

4.D. **9. In accordance with the preference of the person served, the person's primary care physician, oncologist, and/or specialty physician is informed of the status of the person served at the time of:**

- **a. Initial assessment.**
- **b. Significant changes.**
- **c. Discharge/transition.**

Intent Statements

Communication with primary care physicians, oncologists, and specialty physicians is offered. If the expressed preference of a person served is not to communicate with a particular physician or a physician indicates he or she does not want ongoing communication, the program would note this in the record of the person served.

Examples

9.b. Examples of significant changes in the status of the person served include inability to participate in the rehabilitation program due to fatigue from cancer treatment, an acute illness that precipitates transfer to another level of care, a fall that results in significant injury, etc.

4.D. **10. Prior to the implementation of specific rehabilitation treatments, personnel:**

- **a. Provide the rationale for those treatments to the:**
  - **(1) Person served.**
  - **(2) Family/support system.**
- **b. Provide options, as appropriate, based on the feedback received.**

Intent Statements

To increase understanding and engagement in the rehabilitation process, the persons served and families/support systems are provided with the rationale for specific treatments, including options if appropriate, before those treatments are implemented. This may range from explanations for various disciplines' interventions to specific tasks to be undertaken at a given session.

If members of the family/support system are not available prior to implementation of a specific treatment, personnel provide the information to them at the earliest possible opportunity. Likewise, in accordance with the preference of the person served, if members of the family/support system do not participate on the team they are not part of these discussions.

4.D. **11. The schedule for each person served reflects his or her:**

- **a. Preferences.**
- **b. Needs.**
- **c. Feedback.**
- **d. Choice to participate in personally meaningful activities.**

Examples

11.a. The children of a person served in the inpatient program typically visit after school so the schedule for therapy sessions ends by mid-afternoon.

Given several options to obtain outpatient medical rehabilitation, an individual seeks services at a location close to his place of work so that appointments can be scheduled during lunch

or immediately before or after work, minimizing time away from the work place.

11.b. To accommodate the transportation resources she has available, the person served is scheduled in the afternoon so her daughter, who works in the morning, can provide her transportation to therapy sessions.

A person served reports he is experiencing increasing fatigue throughout the day so therapy sessions are scheduled in the morning when he has more energy.

11.c. A person served provides feedback that he would like to modify his schedule for home visits to ensure that his wife, who works, can be home during the sessions.

A person served provides feedback that she no longer needs a break between therapy sessions and would like to revise the schedule to have back-to-back sessions.

11.d. The person served has received nutritional counseling to optimize her diet, but fatigue and pain are making it difficult to prepare meals at home. She states it would be meaningful to be able to practice these skills in the rehabilitation program. The occupational therapist incorporates meal preparation into the individual plan and schedules these sessions around lunch time.

4.D. **12. Based on the individual needs of the persons served, the program provides or arranges for:**

- **a. Services to address identified needs in the following areas:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Comorbid conditions.**
  - **(5) Cultural.**
  - **(6) Decision-making capacity.**
  - **(7) Developmental.**
  - **(8) Educational.**
  - **(9) Functional.**
  - **(10) Leisure/recreational activities.**
  - **(11) Medical management.**
  - **(12) Physical.**
  - **(13) Psychological.**
  - **(14) Sexual.**
  - **(15) Social.**
  - **(16) Spiritual.**
  - **(17) Vocational.**
- **b. Health promotion.**
- **c. Services that prevent illness.**

Examples

If the program does not directly provide the service, arranging for the service may include bringing the service into the program while the person served is participating in the program, arranging for an appointment off site while the person served is participating in the program, or providing potential resources for the service after the person served is discharged/transitions from the program.

12.a.(13) Psychological services might address grief counseling, relationship counseling, individual counseling for depression or anxiety, and adjustment issues.

12.a.(14) Services might address education on the impact of cancer on relationships, sexual desire and functioning, fertility, and birth control.

12.a.(16) The program may have access to a variety of spiritual leaders from the community to visit and work with the persons served. A variety of weekly religious services may be offered.

12.a.(17) For a person served preparing to return to work the program might communicate with the employer regarding the person's functional abilities and how they relate to the job demands, adaptations to the environment that might be needed, a flexible schedule that allows extra time for breaks or a graduated return to work schedule, etc.

A person served with swallowing problems due to cancer may be hesitant to return to work because of fear of choking or aspiration. Services might focus on increasing compensatory techniques to allow the person to return to work with less anxiety.

12.b. Health promotion services may address blood pressure checks, nutritional support and counseling, or fitness classes.

12.c. Services that prevent illness might include cancer screenings and tests such as mammogram, Prostate-Specific Antigen (PSA) Test, Pap and HPV testing; and vaccinations.

4.D. **13. Based on the individual needs of the persons served, the cancer rehabilitation specialty program provides or arranges for resources, services, supports, and/or interventions:**

- **a. In the following areas:**
  - **(1) Advocacy.**
  - **(2) Communication.**
  - **(3) Driving.**
  - **(4) Falls.**
  - **(5) Insight of the person served.**
  - **(6) Leisure.**
  - **(7) Life roles.**
  - **(8) Nutrition.**
  - **(9) Parenting skills.**
  - **(10) Peer support.**
  - **(11) Physical activity.**
  - **(12) School continuance or re-entry.**
  - **(13) Socialization.**
  - **(14) Spouse/significant other relations.**
  - **(15) Supervision needs.**
  - **(16) Transportation needs.**
  - **(17) Volunteerism.**
  - **(18) Wellness.**
  - **(19) Work continuance or re-entry.**
- **b. At each of the following times:**
  - **(1) Beginning of services.**
  - **(2) Appropriate intervals.**
  - **(3) Discharge/transition.**

Examples

13.a.(3) Interventions related to driving may include the need for an adaptive driving evaluation and/or training or adaptive driving equipment such as hand controls, pedal extensions, enlarged mirrors, wheelchair lifts, or safety systems.

13.a.(4) Interventions may include participation in a fall prevention program or an in-home assessment to identify and remove potential fall risks.

13.a.(7) Life roles could address the role of the person served in his or her family, e.g., as a spouse, significant other, parent, and/or sibling; caring for an adult parent; as a worker; as a volunteer; or any other role relating to the person's participation in life situations.

13.a.(9) Resources are offered to address needs for assistance with childcare or homework after school or counseling for children to understand a parent's illness.

13.a.(12) School continuance or re-entry may involve returning to school, community college, a university setting, vocational training, specialized training, or enrichment classes. For children and adolescents the program may provide education on site or collaborate with the community school on accommodations that will allow the child to return. For an adult a vocational specialist may assist with recommendations on appropriate programs to pursue based on the person's vocational skills and interests.

Resources might include tutors to help catch up on missed classes and homework or assistance in the classroom to take notes. Interventions might include working with instructors on schedule changes to accommodate appointments or physical tolerance to attend class.

13.a.(14) Spousal/significant other relations might include issues related to sexuality and changes in roles within the family.

13.a.(15) Supervision needs may be addressed with the family of the person served in terms of safety concerns related to cooking, using stairs, installing grab bars or a shower chair for bathing.

13.a.(16) To facilitate getting to the fitness center on weekdays the person served may need to use public transportation. The program provides contact numbers and scheduling information for several options in the community.

13.a.(17) There may be a need to adapt the schedule or responsibilities of volunteer work done by the person served, e.g., perhaps certain tasks could be done at home instead of in person. Volunteer work may be used to improve endurance prior to returning to work.

13.a.(18) Resources on wellness might include information on group exercise classes at local fitness centers; walking and hiking groups in the community; cooking classes that focus on nutrition and cancer.

4.D. **14. In response to the preferences of the person served, the cancer rehabilitation specialty program:**

- **a. Assesses the person's use of complementary health approaches.**
- **b. Educates the person served on the efficacy and safety of interventions.**
- **c. Provides information and resources on integrative health, as appropriate.**

Examples

According to the National Institutes of Health National Center for Complementary and Integrative Health (**nccih.nih.gov/health/integrative-health**), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

Resources

Please refer to Appendix D for resources related to complementary health approaches.

4.D. **15. On an ongoing basis, the program addresses for each person served, the impact of behavior, cognition, communication, medical, and sensory deficits on the following areas:**

- **a. Physical function.**
- **b. Psychological function.**
- **c. Social function.**
- **d. Vocational function.**
- **e. Ability to learn.**
- **f. Family dynamics.**
- **g. Participation.**

Examples

Sensory deficits might include visual, auditory, or vestibular deficits or the inability to regulate one's body temperature.

Examples of how behavior, cognition, communication, medical, or sensory deficits may impact the person served include:

- Due to fatigue the person is not able to climb the stairs to her apartment on the third floor or tolerate being on her feet for several hours as a docent at the museum.
- Due to communication issues the person is not able to ask for assistance getting on and off public transportation or finding items at the grocery store.
- Low blood cell counts result in dizziness or weakness that cause the person to fall.
- The anxiety of the person escalates when she is unable to recall the directions she was given to get to her doctor's appointment.
- Depression about changes in body image or headaches triggered by too much noise in public places leads the person to isolate herself from friends and family.
- Because of physical changes, fatigue, difficulty concentrating, communication issues, etc., the person no longer wants to participate in the book club, poker night, choir, or other group activities in which she previously engaged.
- Due to chemo brain the person wants to resign from his volunteer position on the board.

- The person is self-conscious about completing medical procedures away from home.
- The side effects of treatment limit the student's tolerance to attend classes, track and complete assignments, finish tests, etc.
- Depression or anger due to cancer and its treatment cause the person to be short-tempered with coworkers or family members.
- Confusion, fatigue, and/or pain limit the person's ability to follow directions, remember routine tasks, or learn new tasks at work such as using a computer program.
- Due to fatigue and/or pain the person is not able to play ball with his son or ride bikes with the family.
- The person's young children are frightened by the scarring or physical disfigurement from their parent's surgery. For the same reasons the person's teenage children do not want their parent attending their sporting or theater events.

4.D. **16. On an ongoing basis, the program addresses the impact of cancer on the family/support system of the person served, including, but not limited to his or her:**

a. Children.
b. Siblings.
c. Spouse/significant other.
d. Parents.
e. Other members of the support system.

Intent Statements

Please refer to the Glossary for a definition of *family/support system*.

Examples

The impact on various members of the person's family/support system may include abandonment, anger, denial, depression, divorce, separation, embarrassment, fear, and/or financial hardship.

16.a. Children may be embarrassed to have parent with a disfigurement attend parent-teacher conferences or their sports events.

16.b. A young child may not understand why her older sister with cancer cannot play with her as much as she used to.

16.c. The spouse of the person served finds he is resentful of the additional responsibilities he has to take on related to child care and household upkeep when his wife is unable to participate in her usual routine.

16.d. Parents are trying to balance the needs of their child with cancer and the needs of their other children and family members.

16.e. Other members of the support system might include friends and colleagues, who are concerned but limit conversation about the person served in order to maintain her privacy.

4.D. **17. The cancer rehabilitation specialty program minimizes complications related to:**

a. Family/support system dynamics.
b. Discharge/transition planning.
c. Follow-up.

Examples

17.b.–c. For the person served to make a successful transition to the next level of services or home, potential complications are anticipated and addressed. For example, if the discharge plan involves the person going home it is important to ensure that members of the family/support system are available and prepared to address the needs of the person served in the home environment. Or, if home adaptations are necessary, they are identified and planned in advance so they can be completed by the time of discharge or soon thereafter.

Follow-up plans are clearly communicated to all parties and appointments, arrangements, and expectations are specified and followed through. If transportation is not available, community resources to assist with transportation to appointments are provided.

4.D. **18. Wellness for the persons served is promoted through activities that:**

- **a. Are based on input from the persons served.**
- **b. Consider input from families/ support systems.**
- **c. Consider prior level of fitness of the persons served.**
- **d. Provide for daily structured and unstructured activities.**
- **e. Promote healthy behavior.**
- **f. Reflect their choices.**
- **g. Align with their cognitive capabilities.**
- **h. Align with their communication capabilities.**
- **i. Align with their physical capabilities.**
- **j. Promote their personal growth.**
- **k. Promote self-responsibility.**
- **l. Enhance their self-image.**
- **m. Improve or maintain their functional levels.**
- **n. Allow for social interaction.**
- **o. Allow for autonomy.**
- **p. Include opportunities for community inclusion.**
- **q. Are documented in the individual plan for each person served.**

Examples

Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

18.d. Examples of unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.
- Large print books/audio books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
- Websites and literature on volunteer opportunities in the community are available.
- Brochures and pamphlets listing activities offered at local community centers are available in the outpatient waiting room.

Resources

Please refer to Appendix D for resources related to wellness.

4.D. **19. The program:**

- **a. Gives opportunities for expression of final wishes concerning end of life to:**
  - **(1) The persons served.**
  - **(2) Families/support systems.**
- **b. Honors wishes concerning end-of-life issues.**
- **c. Provides education, if needed, regarding end-of-life choices.**
- **d. Facilitates access to related services, as appropriate.**

Intent Statements

Persons served and families/support systems are offered opportunities to talk about end-of-life issues.

Examples

Upon their request persons served and family members are interviewed about preferences for the dying process (i.e., five wishes, music, people, preparation and notification, comfort items, spiritual needs, funeral arrangements), and individual planning reflects these preferences.

Persons served and their families/support systems participate in planning their memorial service and in the creation of end-of-life protocols if they wish.

Do-not-resuscitate orders are known and strictly adhered to.

The organization makes known to the persons served upon admission if it does not perform CPR and will only call 911.

Information is provided on advanced care planning, palliative care, and hospice as requested. The team determines with the person served and family/support system how much information will be provided and when.

4.D. **20. When a person served dies, opportunities are provided:**

- **a. To:**
  - **(1) Other persons served.**
  - **(2) The family/support system.**
  - **(3) Personnel.**
- **b. To express grief and remembrance.**
- **c. To develop and participate in:**
  - **(1) Memorial services.**
  - **(2) Memorial rituals.**
  - **(3) Other forms of grief expression.**

Examples

The program invites persons served and personnel to pay their last respects to a person served after he/she passes away.

The person's life is remembered at a memorial service open to all persons served, personnel, and community members.

Personnel are allowed to attend a community service for a person served with whom they've had a close relationship.

Organizational management contacts any personnel who had a particularly close relationship with a person served to inform him/her of the passing before coming to work.

Memorial gardens are developed outside on facility property in remembrance of those who have passed away.

4.D. **21. The cancer rehabilitation specialty program demonstrates how education for the persons served and families/support systems:**

- **a. Is coordinated.**
- **b. Is reinforced:**
  - **(1) Throughout the rehabilitation process.**
  - **(2) Among members of the interdisciplinary team.**
- **c. Is age appropriate.**
- **d. Is culturally appropriate.**
- **e. Fosters self-management.**
- **f. Addresses, as appropriate to the needs of each person served and family/support system:**
  - **(1) Physical effects of cancer and its treatment.**
  - **(2) Psychological/emotional effects of cancer and its treatment.**
  - **(3) Social effects of cancer and its treatment.**
  - **(4) Utilization of equipment.**
  - **(5) Health behaviors.**

Intent Statements

This standard expands upon the education addressed in Standards 2.B.30.–31. and Standard 2.C.21.

21.c. Age-appropriate education is tailored to the age, developmental level, and cognitive level of the person receiving it. Content and presentation are modified to meet the needs of a young child compared to a teenager, adult, or older adult.

21.e. The concept of self-management recognizes that assistance, supports, and external resources may be necessary for successful management of one's own health.

Examples

21.f. Examples of specific topics that may be addressed include, but are not limited to:

- Autonomic dysfunction, bowel and bladder management, bone health, cardiotoxicity, deconditioning, fatigue, hormonal changes, pain, peripheral neuropathy, radiation fibrosis syndrome, sleep disturbances, and weight changes.
- Anxiety, depression, fear of recurring cancer, grief, and chemo brain.
- Caregiver support, family dynamics, end-of-life issues, self-advocacy, and respite.
- Assistive devices, communication devices, lymphedema supplies, orthotics and prosthetics, oxygen, and wound care supplies.
- Nutrition, physical activity, prevention of new cancer, smoking, substance use, sun exposure, weight management, wellness, and utilization of healthcare resources.

Resources

Please refer to Appendix D for resources related to education for persons served, families/support systems, and caregivers.

4.D. **22. The program provides information, including contact information, to the persons served and families/support systems about the following, as appropriate:**

- **a. Financial resources.**
- **b. Healthcare benefits, including insurance.**
- **c. Service options available in the community.**
- **d. Support services.**

Examples

22.a. Financial resources might include resources available if the person served is not able to return to work, social security benefits, etc.

22.c. Service options in the community might include transportation, in-home support services, and meals on wheels.

22.d. Information on support groups, including where and when they meet, is available to persons served and their families/support systems.

4.D. **23. To promote seamless service delivery for the persons served:**

- **a. The cancer rehabilitation specialty program proactively coordinates, facilitates, and advocates for appropriate transitions.**
- **b. Discharge/transition planning addresses:**
  - **(1) Expectations of the:**
    - **(a) Person served.**
    - **(b) Family/support system.**
    - **(c) Relevant stakeholders.**
  - **(2) The environment of the next component of the continuum of services or discharge location, including:**
    - **(a) Facilitating factors.**
    - **(b) Barriers.**
  - **(3) The understanding of the family/support system regarding the current status of the person served.**
  - **(4) Aging with disability.**
  - **(5) Life routines and participation.**
  - **(6) Contingency plans.**
  - **(7) Self-advocacy.**
  - **(8) Capability of the family/support system.**
  - **(9) Financial resources.**
  - **(10) Access to healthcare.**
  - **(11) Transportation.**
  - **(12) Emergency preparedness.**
  - **(13) Identification of resources in the community that are or will be involved with the person served.**
  - **(14) Mechanisms for coordination with other resources.**
  - **(15) A follow-up plan for each person served.**
  - **(16) Follow-up services, including services for persons who leave the program's geographic service area.**
  - **(17) Designation of the individual(s) who will be responsible for coordination of the follow-up plan of the person served.**

Intent Statements

23.b. Planning may address discharge/transition to another level of services or to another setting including home and/or another organization and may be geared toward maintenance and/or improvement depending upon the needs and status of the person served.

Examples

23.a. The cancer rehabilitation specialty program demonstrates coordination among all components of its continuum of services and those with which it links that includes interaction and feedback such as formal meetings related to discharge/transition planning for individual persons served, the sharing of treatment techniques and strategies between program teams,

written communications, teleconferences, faxes, and the timely transmission of records.

23.b.(1)(b) and **23.b.(3)** For discharge/transition to be successful for the person served, it is critical for the family/support system to be realistic in its expectations. For example, it may be important for the family/support system to anticipate a temporary decline in the person's functioning when he or she first comes home. It may also be important to realistically understand the supervision needs of the person served so that family members can properly plan for assistance at home while they are at work during the day.

23.b.(2)(a) Facilitating factors might include a home that does not require any adaptations for the person served, a supportive and engaged family/support system, and an employer who is willing to allow a flexible work schedule to accommodate appointments and health needs.

23.b.(2)(b) Barriers might include a lack of family support or availability; lack of transportation; the need for accessible housing; and factors such as fatigue, pain, or cognitive issues that are interfering with the person's daily activities.

23.b.(5) Discharge/transition planning addressing life routines might include structuring activities to facilitate taking medications, planning activities that require higher attention and executive function early in the day to reduce impact of fatigue on performance, and use of external supports such as day planners or smart phone applications for reminders. Life routines may address bathing, dressing, grooming, eating, or sleeping habits; work routines; routine activities such as cooking, exercise, gardening, child care, pet care, or hobbies; social interaction; and spiritual/religious activities.

23.b.(9) The program addresses conservation of funding to meet long-term needs and eligibility for additional funding for services.

23.b.(13) Resources in the community might include wellness programs, fitness programs, support groups, and on-line communities.

23.b.(17) Depending upon the person's needs, follow-up plans might be coordinated by someone from the cancer rehabilitation specialty program, a member of the person's family/support system, or an external case manager.

4.D. **24. To ensure the safety of the person served, medications prescribed for the person served at time of discharge/transition are consistent with the available resources:**

- **a. To obtain them.**
- **b. Needed to adhere to recommended administration.**

Examples

Resources that might impact obtaining medications and/or adhering to recommended administration include payment sources, the availability of medication samples, caregiver support, packaging of the medications, and transportation to pick them up at the pharmacy. Similarly, language barriers, literacy, or cognitive issues on the part of the person served or caregivers may pose challenges to adhering to recommended administration.

4.D. **25. There are provisions for contact as appropriate between the person served and/or the family/support system and the program after discharge/transition.**

Examples

Contact between the persons served and the program may be made to:

- Address questions about discharge recommendations, follow-up plans, or changes in the status of the person served.
- Request information on resources for home adaptations/modifications, fitness programs in the community designed for people who have been diagnosed with cancer, support groups, or specialty physicians.

4.D. **26. The program provides education and training regarding the nature and value of cancer rehabilitation to:**

- **a. Persons served.**
- **b. External stakeholders.**
- **c. The general public.**

Intent Statements

26.b. Please refer to the Glossary for the definition of *stakeholders*.

Examples

Education might be provided through one-on-one contacts or to groups and include written information, lectures, videos, audio recordings, the provision of information via informational mailings, emails, or the program's website.

26.b. External stakeholders might be payers, other healthcare providers, or referral sources.

4.D. **27. Within its scope of practice and expertise, the cancer rehabilitation specialty program acts as a resource to providers from acute through community-based services regarding:**

- **a. Evidence-based practice.**
- **b. Development of service models and programs for persons served.**
- **c. Outreach and support.**
- **d. Training of personnel in cancer rehabilitation.**

Examples

The program acts a resource to other providers who may encounter or provide services to persons who have been diagnosed with cancer. It may provide educational sessions or materials, consultation, or training to other providers; the development of service models and programs for persons served throughout the cancer rehabilitation continuum of services; respite care; advocacy activities; appropriate service referrals; factors facilitating and barriers to achievement of optimal outcomes; and collaboration with providers on the timing of rehabilitation interventions.

4.D. **28. The cancer rehabilitation specialty program identifies and addresses gaps in service delivery.**

Intent Statements

Gaps in service delivery are addressed at both the level of the person served and the level of the program.

Examples

Gaps in service delivery for a person served may be addressed by referring the person to another program/service in the local community or contracting with an external provider to engage with the team of the person served. For example, a therapist working with a person served observes that the person is no longer able to do household chores because of fatigue and pain, and as a result, there are now concerns about the safety and cleanliness of the home. The therapist could refer the person back to his or her physician for medical evaluation and a potential referral for homemaker services.

The cancer specialty rehabilitation program may explore developing a new service, partnering with another provider in the community to provide or develop additional services, or advocating with a payer to cover services that are not currently covered.

4.D. **29. To advance the field of cancer rehabilitation, leadership supports:**

- **a. Outreach and education initiatives promoting integration of cancer rehabilitation services.**
- **b. The program's participation in research opportunities.**
- **c. The provision of information:**
  - **(1) To persons served.**
  - **(2) To families/support systems.**
  - **(3) About available:**
    - **(a) Research opportunities.**
    - **(b) Clinical trials.**

Intent Statements

29.b. It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

29.b. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the rehabilitation program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to cancer rehabilitation on its research agenda.

The organization participates in associations in which researchers and clinicians interact to influence research in the field of cancer rehabilitation.

Resources

Please refer to Appendix D for resources related to clinical trials and to cancer rehabilitation.

4.D. **30. Documented, competency-based education for personnel that addresses the unique needs of persons who have been diagnosed with cancer:**

- **a. Is provided at:**
  - **(1) Orientation.**
  - **(2) Regular intervals.**
- **b. Includes, but is not limited to:**
  - **(1) Etiology and epidemiology of cancer.**
  - **(2) Cancer treatment and its effects.**
  - **(3) Communication with persons served and their families/support systems.**
  - **(4) Communication with other providers serving the persons served.**
  - **(5) Facilitating active involvement of the persons served and families/support systems in the service delivery process.**
  - **(6) Facilitating behavioral supports.**
  - **(7) Facilitating cognitive interventions.**
  - **(8) Facilitating communication interventions.**
  - **(9) Handling developmental/life transitions.**
  - **(10) Knowledge of community resources.**
  - **(11) Recognition and reporting of suspected abuse and neglect.**
  - **(12) Setting and maintaining professional boundaries.**
  - **(13) Medical complications.**
  - **(14) Special populations.**
  - **(15) Risks associated with cancer.**
  - **(16) Late effects and risk for late effects of treatment.**
  - **(17) Psychological issues across the cancer trajectory.**

Intent Statements

Education is provided to both clinical and nonclinical personnel who have regular contact with persons served and their families/support systems.

Examples

30.b.(2) Education might address the importance of infection control techniques for persons served who are at risk of infection, precautions related to weight bearing, etc.

30.b.(13) Medical complications might be related to comorbid conditions of the persons served, response to cancer treatments, oncological emergencies, etc.

30.b.(14) Special populations might include adult survivors of pediatric cancer or persons with dual diagnoses such as depression, anxiety, or other mental health issues.

30.b.(16) Late effects of treatment—side effects of cancer treatment that become apparent after treatment has ended—may include, but are not limited to, fatigue, pain, lymphedema, early menopause, heart problems, reduced lung capacity, kidney and urinary problems, neuropathy, bone and joint problems, muscle weakness, secondary cancers, cataracts, dry mouth, permanent hair loss, problems with thyroid or adrenal glands, slowed or halted bone growth in children, decreased range of motion in the treated area, skin sensitivity to sun exposure, scarring at the surgical site, problems fighting infection, nutritional problems, cognitive problems such as trouble focusing or memory loss, changes in sexual function or fertility, and difficulty with speech or swallowing.

30.b.(17) Psychological issues include anger, anxiety, adjustment, concerns about body image, confusion, depression, distress, fear of recurrence, feelings of loss of control, grief, guilt, and sadness.

4.D. **31. The cancer rehabilitation specialty program:**

- **a. Gathers follow-up information on a representative sample of the persons served, including information on:**
  - **(1) Quality of life.**
  - **(2) Satisfaction of the persons served, including satisfaction with:**
    - **(a) Accuracy of information received about the program.**
    - **(b) Clinical practices/behaviors.**
    - **(c) Degree of inclusion of the persons served in their programs.**
    - **(d) Outcomes achieved.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Quality of life.**
    - **(b) Satisfaction of the persons served, including satisfaction with:**
      - **(i) Accuracy of information received about the program.**
      - **(ii) Clinical practices/behaviors.**
      - **(iii) Degree of inclusion of the persons served in their programs.**
      - **(iv) Outcomes achieved.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Healthcare providers.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

Examples

31.a.(2)(a) The organization may choose to gather satisfaction feedback from persons served on topics such as their perception of the accuracy of information furnished on the scope and intensity of services to be provided to the person served, the program's scope of services statement, and/or their expectations of the program.

E. Spinal Cord Specialty Program

Description

A person-centered spinal cord specialty program utilizes a holistic, culturally aware, interdisciplinary team approach to address the unique rehabilitation needs of persons who have been diagnosed with spinal cord dysfunction, whether due to trauma or disease. A spinal cord specialty program may be provided in a variety of settings, including inpatient, outpatient, home and community, residential, and vocational settings. Personnel demonstrate competencies and the application of evidence-based practices to deliver services that address the preventive, restorative, supportive, and lifelong rehabilitation needs of the persons served.

The spinal cord specialty program focuses on strategies to optimize outcomes in an effort to prevent impairments or minimize the impact thereof, reduce activity limitations, and maximize participation for the persons served. The program communicates and collaborates with all appropriate healthcare providers and other relevant stakeholders to deliver coordinated care and promote appropriate transitions in the continuum of care.

The program is guided by the individual preferences, strengths, and needs of the persons served and their families/support systems. Throughout the program the person's perception of and adjustment to his or her disability is considered and addressed. A spinal cord specialty program assists the persons served to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available and encompasses care that advocates for full inclusion to enhance the lives of the persons served within their families/support systems, communities, and life roles.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized spinal cord program. The spinal cord specialty program formally links with key components of care that address the lifelong needs of the persons served. A spinal cord specialty program advocates on behalf of persons served to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A spinal cord specialty program translates current research evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in spinal cord research.

Note: *Spinal cord dysfunction could be caused by trauma, cancer involving the spinal cord, inflammatory conditions such as multiple sclerosis, and nontraumatic etiologies such as myelopathies, vascular events, or infections.*

Note: *A program seeking accreditation as a spinal cord specialty program must include in the survey application and the site survey all portions of the program (comprehensive integrated inpatient rehabilitation program, outpatient medical rehabilitation program, home and community services, residential rehabilitation, and vocational services) that the organization provides and that meet the program descriptions.*

Applicable Standards

If an organization chooses to add the optional Spinal Cord Specialty Program (SCSP) designation to one or more appropriate programs/services in Section 3, the program description and all standards in this section are applicable.

Note: *SCSP accreditation must include any portion of the continuum of services addressed in Sections 3.A.–3.E. providing specialized spinal cord services that meet both the SCSP program description and the program description for that portion of the continuum.*

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which SCSP accreditation is sought (see guidelines in Section 2)

- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)
- Section 2.E. if the program serves *any* children/adolescents and is not seeking accreditation as a Pediatric Specialty Program. (Not applicable for Home and Community Services SCSP; see guidelines in Section 2)

4.E. **1. The documented scope of the spinal cord specialty program addresses:**

a. The etiology of spinal cord dysfunction.

b. Levels of spinal cord injury.

c. Completeness of spinal cord dysfunction.

d. Comorbidities.

e. The unique aspects of delivering care to persons with spinal cord dysfunction in the following areas:

(1) Medical/physiological sequelae:

(a) Abnormal tone.
(b) Autonomic dysfunction.
(c) Bladder function.
(d) Body composition.
(e) Bowel function.
(f) Circulation.
(g) Dysphagia.
(h) Fertility.
(i) Infection management.
(j) Medication.
(k) Men's health issues.
(l) Musculoskeletal complications.
(m) Neurological changes.
(n) Nutrition.
(o) Pain.
(p) Respiration.
(q) Sexual function.
(r) Skin integrity.
(s) Ventilation support.
(t) Women's health issues.

(2) Functional:

(a) Activities of daily living.
(b) Assistive technology.
(c) Behavior.
(d) Cognition.
(e) Communication.
(f) Community integration.
(g) Driving.
(h) Durable medical equipment.
(i) Emergency preparedness.
(j) Environmental modifications.
(k) Leisure and recreation.
(l) Mobility.
(m) Occupation.
(n) Orthoses.
(o) Personal care assistants.
(p) Prostheses.
(q) Seating.

(3) Psychosocial:

(a) Adjustment to disability.
(b) Behavioral health.
(c) Substance use.
(d) Family/support system counseling.
(e) Peer support services.
(f) Sexual adjustment.

(4) Education and training for:

(a) Persons served.
(b) Families/support systems.
(c) The community.
(d) The professional community.

(5) Research capability.
(6) Transitions across the lifespan.
(7) Case management.
(8) Resource management.
(9) Follow-up.
(10) Health promotion and wellness.
(11) Independent living and community integration.

(12) Prevention related to potential risks and secondary health conditions due to impairments, activity limitations, participation restrictions, and the environment.

(13) Safety for persons served in the environments in which they participate.

Intent Statements

This standard expands upon Standards 2.A.1. and 2.B.1., which address the scope of the program.

Defining the scope provides the program with an opportunity to carefully consider its expertise and resources to meet the needs of persons with spinal cord dysfunction. Sharing the scope with potential persons served, families/support systems, referral sources, payers, and other relevant stakeholders provides information that helps them understand what the spinal cord specialty program has to offer and determine whether it will meet the needs of the persons served.

1.e.(1)(a) Abnormal tone includes spasticity and low tone.

1.e.(1)(b) Autonomic dysfunction includes autonomic dysreflexia and hypotension.

1.e.(2)(m) The concept of occupation is broader than employment and might include other roles such as parent, homemaker, student, volunteer, etc.

Examples

The documented scope of the spinal cord specialty program may address:

- **1.e.(1)(d)** The program's capacity to assess body composition, the provision of education on how body composition may change over time due to spinal cord dysfunction, the availability of proper equipment to accommodate a person who is morbidly obese, etc.
- **1.e.(1)(i)** A resource related to infection management might include the MRSA Educational Toolkit developed by SCI QUERI: **www.queri.research.va.gov/tools/sci_mrsa**
- **1.e.(1)(k)** Assessment, interventions, education, and resources related to sexual desire, sexual function, fertility, and contraception; accessibility of office space, exam tables, and diagnostic equipment to men with spinal cord dysfunction; osteoporosis prevention and management; how to conduct self-examinations for prostate and urological health.
- **1.e.(1)(l)** Screening and services to address bone and joint integrity, such as identification of fractures elsewhere in the body, heterotopic ossification, and spinal stability.
- **1.e.(1)(n)** Team member expertise or the availability of consultation services to address general nutrition, changes in nutrition following the onset of spinal cord dysfunction, and consideration of comorbid conditions that may impact nutrition.
- **1.e.(1)(t)** Assessment, interventions, education, and resources related to sexual function, sexual desire, fertility, pregnancy, contraception, and childbirth; availability of mammograms, bone density scans, and gynecological services that are accessible to women with spinal cord dysfunction; osteoporosis prevention and management.

4.E. **2. A comprehensive integrated inpatient rehabilitation spinal cord specialty program demonstrates efforts to optimize outcomes for the persons served through:**

a. Collaboration with acute medical services.

b. Exchange of information on factors facilitating the achievement of optimal outcomes.

c. Exchange of information on barriers to the achievement of optimal outcomes.

d. Participation as a team member with the acute providers, as feasible.

e. Collaboration with healthcare providers on the selection and timing of interventions.

Intent Statements

Team members with expertise in spinal cord dysfunction are involved as early as possible with the persons served, their surgeons, and other healthcare providers to facilitate

achievement of optimal rehabilitation outcomes and function.

Examples

2.b.–c. Information exchanged could include comorbidities, cardiovascular fitness, emotional and psychological status, social support, prior diagnostic and therapeutic interventions, positioning to avoid skin breakdown, durable medical equipment and technology needs, and goals and expectations of the persons served.

Note: *A comprehensive integrated inpatient rehabilitation spinal cord specialty program does not have to meet Standard 8. in Section 3.A. CIIRP.*

4.E. **3. To meet the needs of the persons served, the spinal cord specialty program provides or arranges for diagnostic services to screen for and assess the status of:**

- **a. Bladder function.**
- **b. Bowel function.**
- **c. Cardiac function.**
- **d. Cognitive function.**
- **e. Metabolic function.**
- **f. Musculoskeletal function.**
- **g. Neurological function.**
- **h. Psychological function.**
- **i. Respiratory function.**
- **j. Sexual function.**
- **k. Skin integrity.**
- **l. Swallowing.**
- **m. Thromboembolic disease.**
- **n. Other common secondary health conditions.**

Examples

3.d. Assessment may address the presence of traumatic brain injury, dementia, learning disabilities, etc.

3.h. The program may screen for anxiety, depression, PTSD, anger issues, substance use, or other psychological conditions to determine whether additional assessments or services are indicated.

3.n. Other common secondary conditions might include traumatic brain injury, pain, substance use, comorbid conditions such as diabetes or high blood pressure, etc.

4.E. **4. On an ongoing basis, the program addresses the impact of spinal cord dysfunction on the family/support system of the person served, including, but not limited to his or her:**

- **a. Children.**
- **b. Parents.**
- **c. Siblings.**
- **d. Spouse/significant other.**
- **e. Other members of the support system.**

Intent Statements

Please refer to the Glossary for the definition of *family/support system.*

Examples

The impact on various members of the person's family/support system may include abandonment, anger, denial, depression, divorce, separation, embarrassment, fear, and/or financial hardship.

4.a. Children may be self-conscious about having a parent who uses a power wheelchair attend parent-teacher conferences or their sports events.

4.b. Parents are trying to balance the needs of their child with spinal cord dysfunction and the needs of their other children and family members.

4.c. A young child may not understand why her older sister with a spinal cord injury cannot play with her the same way she used to.

4.d. The spouse/significant other of the person served may be resentful of having to take on additional responsibilities related to childcare and/or household upkeep.

4.e. Other members of the support system might include friends and colleagues who are concerned but limit conversation about the person served in order to maintain her privacy. In the case of a person served who is elderly, caregivers who already had a relationship with the person might wonder if they could have done something to prevent the injury or worry whether they have the skills to continue providing support.

Note: *A comprehensive integrated inpatient rehabilitation spinal cord specialty program does not have to meet Standard 7. in Section 3.A. CIIRP.*

4.E. **5. To meet the identified needs of the persons served, the spinal cord specialty program provides or arranges for resources, services, supports, and/or interventions in the following areas:**

- **a. Adjustment to disability.**
- **b. Advocacy.**
- **c. Aging with a disability.**
- **d. Assistive technology.**
- **e. Benefits.**
- **f. Bowel and bladder management.**
- **g. Communication.**
- **h. Driving.**
- **i. Edema management.**
- **j. Environmental modification.**
- **k. Fall prevention.**
- **l. Financial counseling.**
- **m. Functional training.**
- **n. Insight of the person served.**
- **o. Leisure and recreation.**
- **p. Life roles.**
- **q. Nutrition.**
- **r. Orthotics.**
- **s. Pain management.**
- **t. Parenting skills.**
- **u. Physical activity.**
- **v. Prosthetics.**
- **w. Pulmonary management.**
- **x. School continuance or re-entry.**
- **y. Sexual function and reproductive assessment and management.**
- **z. Skin care.**
- **aa. Socialization.**
- **ab. Specific healthcare services.**
- **ac. Spouse/significant other relations.**
- **ad. Substance use counseling and education.**
- **ae. Supervision needs.**
- **af. Tone management.**
- **ag. Transportation needs.**
- **ah. Volunteerism.**
- **ai. Wellness.**
- **aj. Work continuance or re-entry.**

Intent Statements

If the spinal cord specialty program does not directly provide any of the above services, it ensures that the services are provided and integrated into the rehabilitation and service process for the person served. Making a referral without following up does not meet the standard.

Examples

5.c. With the increased life expectancy of persons with spinal cord dysfunction, the natural course of aging can bring an onset of new medical, psychological, functional, and/or social problems that differ from those that resulted from the original injury or illness. These may include increased risk for or earlier onset of cardiovascular disease, bone loss, loss of strength, decreased function, and challenges to family life and the work environment. Likewise, as older adults pursue active lives and live longer, the age at which persons experience the initial onset of spinal cord dysfunction and injury has increased, and this presents different issues related to the already occurring biological, physical, social, and psychological processes that occur throughout the lifespan.

5.e. The program may link the person served to advisors or counselors who can educate and advise on benefits such as health insurance, employment, veterans, retirement, and disability benefits.

5.o. An assessment identifies the person's interests and choices related to leisure and recreation so that the program can address adaptations to equipment and supplies that may be needed for the person to continue to participate. Information is made available to persons served regarding adaptive sports, recreation, and arts opportunities in the local community.

5.s. The program may provide or arrange for consultation services by a physician, psychologist, or pharmacist with expertise in pain management; offer education on complementary health approaches and integrative health; or

refer the person served to an interdisciplinary pain rehabilitation program.

5.ab. Specific healthcare services might include physician services, wound management, tendon transfers, plastic surgery.

5.ad. The program may provide education on risks related to the continued use of substances such as alcohol, tobacco, marijuana, and other drugs.; provide or arrange for services to address substance use; or have agreements with local or regional providers of behavioral health or opioid treatment services.

4.E. **6. Throughout the spinal cord specialty program, the persons served have opportunities to try new equipment and technology to best address their medical and functional needs.**

Intent Statements

The funding of the person served does not influence opportunities to try equipment and technology. When equipment or technology is deemed appropriate to meet the needs of the person, funding is explored. This may include insurance funding, charitable foundations, and other alternative resources.

Examples

Loaner equipment and technology from vendors and donated equipment and technology from vocational services entities, employers, schools, and technology companies are available for the persons served to try.

4.E. **7. The spinal cord specialty program addresses the mobility needs of the persons served, including practice in home and community settings.**

Intent Statements

This standard expands upon Standard 33. in Section 2.B., which addresses the equipment and supplies needed for each person served. Instruction and training in the use of postural and seating supports, wheeled mobility, ambulation aids, etc. includes practice in the settings in which the person served functions.

4.E. **8. As desired by the persons served and their families/support systems, individual plans address:**

- **a. Intimacy.**
- **b. Sexual health issues.**

Examples

Individual plans may address:

- Referrals to urology, OB/GYN, or sexual counseling.
- Couples counseling.
- Education on the impact of spinal cord dysfunction on relationships, sexual desire and function, fertility and birth control, and the body's response to intimacy, e.g., neurological, skin, vital signs, and bowel and bladder response.
- Opportunities for intimacy for the person served and his or her partner during rehabilitation.

4.E. **9. The spinal cord specialty program provides a systematic education program about spinal cord dysfunction that:**

- **a. Is appropriate to the needs of:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **b. Considers the readiness of the person served and the family/support system to receive the education.**
- **c. Is reinforced:**
  - **(1) Among members of the interdisciplinary team.**
  - **(2) Throughout the rehabilitation process.**
- **d. Provides for, but is not limited to, education regarding:**
  - **(1) Medical/physiological sequelae.**
  - **(2) Function.**
  - **(3) Psychosocial issues.**
  - **(4) Transitions across the lifespan.**
  - **(5) Resource management.**
  - **(6) Health promotion and wellness.**
  - **(7) Independent living and community integration.**

(8) Prevention related to potential risks and secondary health conditions.

(9) Safety for persons served in the environments in which they participate.

Examples

Education can occur in a variety of ways, such as classroom/lecture style, one-on-one, peer supporter, videos, audio recordings, or written information.

9.c. The rehabilitation nurse, rehabilitation physician, occupational therapist, physical therapist, recreation therapist, and peer supporter reinforce the importance of relieving pressure on the skin during their individual encounters with the person served and his or her family/support system.

Proper transfer techniques are reinforced by team members during all therapy sessions and bedside activities with the person served.

9.d.(3) Psychosocial issues might include prognosis for recovery, adjustment to disability, role changes, mental health needs, cultural adjustment issues, delineation of roles, and social perceptions.

9.d.(9) Education might include risks to be aware of in the environment, use of wheeled mobility in a variety of settings, how members of the family/support system can safely and effectively assist the person served, and emergency preparedness at home and in the community.

4.E. **10. The program provides information to the persons served and their families/support systems about laws and regulations pertaining to the following, as appropriate:**

a. Accessibility.
b. Education.
c. Employment.
d. Health.
e. Rights.
f. Social supports.

4.E. **11. The program educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.**

Intent Statements

The health and safety of persons served is paramount. However, in a person-centered approach to service delivery, the preferences of the person served may take precedence over the advice of family members, providers, or others. Under these circumstances the spinal cord specialty program educates the persons served about the consequences associated with choices and behaviors that pose potential risks to their health or safety, providing the opportunity for the persons served to make an informed decision to engage or not engage in the behavior.

Examples

The program educates the person served about the risks of choosing to:

- Continue smoking cigarettes or drinking alcohol following a spinal cord injury.
- Not use a shower chair or walker when there are known issues with balance.
- Not follow through with changing positions to relieve pressure on the skin.
- Not follow through with the prescribed medication or bowel and bladder regimen.
- Continue using the stove when home alone despite sensory or cognitive deficits.

4.E. **12. The spinal cord specialty program serves as a resource for information for persons with spinal cord dysfunction, including, but not limited to, information on:**

a. Consumer organizations.
b. Personal assistant services.
c. Respite care.
d. Specialists in spinal cord dysfunction care.
e. Support groups.

4.E. **13. In accordance with their needs, the spinal cord specialty program provides or arranges for education to the persons served about paid personal assistant services, including:**

- **a. The need for personal assistants.**
- **b. Access to funding.**
- **c. Hiring.**
- **d. Expectations of the person served.**
- **e. How to direct care.**
- **f. Training personal assistants.**
- **g. Boundaries.**
- **h. Recognizing and reporting:**
  - **(1) Abuse.**
  - **(2) Neglect.**
- **i. Termination.**

Intent Statements

The spinal cord specialty program may directly provide education about personal assistant services or partner with another resource to provide it.

Examples

13.c. The program may provide information about and links to websites and other resources where the person served can find qualified candidates.

13.d. Expectations of the person served may include both expectations of behavior and responsibilities of the paid personal assistant in the employer/employee relationship and expectations of the person served as an employer to treat the assistant respectfully.

13.g. Education on boundaries might address personal relationships between the person served and personal care assistant, witnessing or co-signing of legal or financial documents, social media engagement, and the personal care assistant entering into the person's family dynamics.

Resources

- Managing Personal Assistants: A Consumer Guide: **www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/persasstfc6d.pdf**
- Hiring and Management of Personal Care Assistants for Individuals with Spinal Cord Injury: **www.tbi-sci.org/pdf/pas.pdf**
- Spinal Cord Injury or Disorder (SCI/D): Hiring a Caregiver/Personal Assistant: **www.veteranshealthlibrary.org/142,41199_VA**
- How to Successfully Hire and Manage a Personal Care Assistant—for People with Spinal Cord Injury: **www.sfphysio.fr//docs/2015131740_how-to-successfully-hire-and-manage-a-personal-care-assistant-for-people-with-spinal-cord-injury.pdf**

4.E. **14. The spinal cord specialty program implements:**

- **a. Written procedures for the recruitment of peer supporters.**
- **b. Competency-based training for peer supporters that:**
  - **(1) Is based on a peer-support curriculum or a curriculum designed and developed with the input of peer supporters.**
  - **(2) Is provided with the involvement of peer supporters, as appropriate.**
  - **(3) Includes:**
    - **(a) Initial training on current practices in peer support services.**
    - **(b) Ongoing training on current practices in peer support services.**
  - **(4) Is provided in a manner that is understandable.**

Intent Statements

The spinal cord specialty program may directly provide a peer support program or partner with another resource to provide it.

Examples

14.b.(3) Training may address topics such as engagement with the persons served, effective use of sharing life experiences, personal advocacy, community resources, and adjustment to disability.

Resources

Please refer to Appendix D for resources related to peer support services and training for peer supporters.

4.E. **15. The spinal cord specialty program:**

- **a. Provides peer support services that:**
  - **(1) Reflect the characteristics of the persons served.**
  - **(2) Address the preferences and choices of the persons served.**
  - **(3) Address the needs of the persons served.**
- **b. Engages peer supporters in the rehabilitation process of the persons served, including, but not limited to:**
  - **(1) Support.**
  - **(2) Education.**

Examples

15.a. Peer supporters assigned reflect the ages, characteristics, interests, and life roles of the persons served to facilitate effective guidance.

15.b. Peer support might facilitate successful life transitions; adjustment to disability; and awareness of and access to community resources, advocacy groups, and activities.

4.E. **16. The program minimizes barriers related to:**

- **a. Family/support system.**
- **b. Discharge/transition planning.**
- **c. Follow-up.**

Examples

16.a. Barriers could include the dynamics of the family/support system, family responsibilities or lack of transportation that prohibit involvement with program, financial issues that put the family at risk, and unrealistic family expectations for recovery.

16.b. Barriers could include lack of provider resources with expertise in spinal cord dysfunction in the local community of the person served, accessibility barriers in the person's home, and delays in obtaining needed durable medical equipment.

4.E. **17. Health and wellness for the persons served are promoted through activities that:**

- **a. Are based on input from the persons served.**
- **b. Reflect their choices.**
- **c. Consider input from families/ support systems.**
- **d. Consider prior level of participation of the persons served in health and wellness activities.**
- **e. Provide for structured and unstructured activities.**
- **f. Promote healthy attitudes and behavior.**
- **g. Align with their cognitive capabilities.**
- **h. Align with their communication capabilities.**
- **i. Align with their physical capabilities.**
- **j. Promote their personal growth.**
- **k. Promote self-responsibility.**
- **l. Enhance their self-image.**
- **m. Improve or maintain their functional levels.**
- **n. Allow for social interaction.**
- **o. Allow for autonomy.**
- **p. Facilitate opportunities for community inclusion.**
- **q. Are documented in the individual plan for each person served.**

Examples

Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

17.e. Examples of ways to provide for unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.

- Large-print and audio books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.
- Persons served have access to websites and literature on volunteer opportunities in the community.
- Brochures and pamphlets listing activities offered at local community centers are available in the outpatient waiting room.

Resources

Please refer to Appendix D for resources related to wellness.

4.E. **18. The spinal cord specialty program provides or arranges for adaptive sports, recreation, and arts, including:**

- **a. Instruction in adaptive sports, recreation, and arts.**
- **b. The provision of appropriate adaptive equipment.**
- **c. Facilitation of teams, recreation, and arts activities by coordination, sponsorship, or other support.**
- **d. The identification of linkages in the community.**

Examples

The program provides or arranges for a variety of opportunities for the persons served to participate in individual and group sports, recreation, and arts activities. Activities might include golf, bowling, bicycling, boating, exercise classes, horticulture, going to a movie theater or symphony, pottery, and painting.

4.E. **19. The spinal cord specialty program:**

- **a. Provides or arranges for follow-up care for those persons who remain in its service area.**
- **b. Identifies a central point of contact to act as a resource to address follow-up issues.**
- **c. Establishes a plan of follow-up for each person served that provides for:**
  - **(1) Designation of the individuals to be responsible for the coordination of the follow-up plans of the person served.**
  - **(2) Communication of discharge recommendations.**
  - **(3) Communication of identified risks.**
- **d. Facilitates follow-up care for persons who leave the program's geographic service area.**
- **e. Collaborates with primary care and specialty physicians and other healthcare providers after discharge.**

Examples

19.c.(1) Individuals responsible for coordinating the follow-up plans of the person served might be the person served, a family member, a case manager, a primary care physician, or another healthcare provider.

4.E. **20. In accordance with the scope of the program, the spinal cord specialty program offers comprehensive annual reviews for persons served that:**

- **a. Address:**
  - **(1) Adjustment to disability.**
  - **(2) Community participation.**
  - **(3) Education status.**
  - **(4) Equipment status.**
  - **(5) Functional status.**
  - **(6) Life-long care plans.**
  - **(7) Medical status.**
  - **(8) Occupational status.**
  - **(9) Sexual health.**
  - **(10) Transportation.**
  - **(11) Previously identified risks.**
- **b. Include the provision of findings and recommendations to:**
  - **(1) The person served.**
  - **(2) Other relevant stakeholders.**

Intent Statements

Annual reviews are offered to persons participating in the program longer than a year and to persons who have been discharged and would benefit from such a review.

Examples

The spinal cord specialty program offers an annual review of status through teleconference, follow-up appointment, or calls involving the person served and members of the family/support system.

20.a.(1) Annual reviews may address psychological well-being and participation in life roles; pursuit of avocational interests; social interaction; and adjustment to aging and associated healthcare needs, some of which may be greater due to spinal cord dysfunction.

20.a.(2) Community participation may include volunteering; social interaction and activities with family and friends; participation in adaptive sports, recreation, and arts; and cultural and spiritual activities that are important to the person served.

20.a.(6) Life-long care plans might include issues related to aging with spinal cord dysfunction, financial planning for life-long needs, and anticipated changes in social supports.

4.E. **21. The spinal cord specialty program:**

- **a. Gathers follow-up information on a representative sample of the persons served on:**
  - **(1) Rehospitalizations.**
  - **(2) Adjustment to disability.**
  - **(3) Health promotion.**
  - **(4) Independence and autonomy.**
  - **(5) Return to productive activity.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for:**
    - **(a) Rehospitalizations.**
    - **(b) Adjustment to disability.**
    - **(c) Health promotion.**
    - **(d) Independence and autonomy.**
    - **(e) Return to productive activity.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Healthcare providers.**
    - **(d) Others, as appropriate.**

Intent Statements

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

Examples

21.a.(3) Measures of health promotion may address participation in adaptive sports, recreation, and arts; return for follow-up health visits; and management of nutritional status to minimize comorbidities such as diabetes and skin integrity issues.

21.b.(5)(d) Education and training may be provided to employers, schools, or community groups.

4.E. **22. To facilitate advocacy for persons served, the spinal cord specialty program demonstrates knowledge of:**

- **a. Regulations.**
- **b. Legislation.**
- **c. Financial issues.**
- **d. Funding availability.**
- **e. Service availability.**
- **f. Protection and advocacy resources.**
- **g. The healthcare delivery system.**
- **h. Resources and services related to aging.**

4.E. **23. The spinal cord specialty program demonstrates efforts to educate the community about:**

- **a. Prevention of spinal cord injury.**
- **b. Spinal cord dysfunction.**
- **c. Services for people with spinal cord dysfunction.**
- **d. Accessibility.**
- **e. Reasonable accommodations.**

Intent Statements

23.d. This standard relates to the standards in Section 1.L Accessibility, including the identification of barriers to accessibility, plans to reduce or eliminate those barriers, and advocacy on behalf of persons with spinal cord dysfunction.

23.e. Refer to the Glossary for the definition of *reasonable accommodations.*

Examples

The program may educate community leaders, employers, and business operators about accessibility legislation; curb cuts, ramps, automated doors, elevators or lifts, and other features that increase accessibility in the environment; and opportunities for participation by persons with spinal cord dysfunction.

Resources

23.d.–e. Please refer to Appendix D for resources related to accessibility.

4.E. **24. The spinal cord specialty program works with community leaders in emergency preparedness concerning the unique needs of persons with spinal cord dysfunction to address:**

- **a. Emergency preparedness.**
- **b. Evacuation.**
- **c. Shelter.**
- **d. Recovery.**
- **e. Transportation.**
- **f. Power restoration.**

Intent Statements

The program works with community leaders in emergency preparedness (e.g., civil defense, homeland security, Red Cross, Red Crescent) to educate them about the unique needs of persons with spinal cord dysfunction and how to ensure those needs can be met in the event of an emergency.

24.d. Recovery after a disaster means the return of the person served to his or her home or community setting.

Examples

24.d. Recovery might include transportation from the recovery center; home repairs due to damage from fire, water, wind, etc.; utility recovery; or public health assessment for safe/healthy living conditions.

Resources

Please refer to Appendix D for resources related to emergency preparedness education for persons served and other stakeholders.

4.E. **25. The spinal cord specialty program acts as a resource for other providers of services regarding:**

- **a. Evidence-based practice.**
- **b. Development of innovative service models and programs for persons served following completion of rehabilitation.**
- **c. Outreach, training, and support.**

4.E. **26. To advance the field of spinal cord rehabilitation, leadership supports:**

- **a. Outreach and education initiatives promoting integration of spinal cord rehabilitation services.**
- **b. The program's participation in research opportunities.**
- **c. Consideration by the program of a spinal cord common data set.**
- **d. The provision of information:**
  - **(1) About available:**
    - **(a) Research opportunities.**
    - **(b) Clinical trials.**
  - **(2) To persons served.**
  - **(3) To families/support systems.**

Intent Statements

26.b. It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

26.b. The leadership encourages the spinal cord specialty program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program when finalized.

The leadership allows the spinal cord specialty program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The spinal cord specialty program is part of a larger entity that includes a research center and the leadership promotes rehabilitation studies on its research agenda.

26.c. National and international spinal cord data sets include, but are not limited to:

- Spinal Cord Injury Model Systems National Dataset: **https://www.nscisc.uab.edu/PublicDocuments/reports/pdf/Using%20the%20SCIMS%20National%20Dataset.pdf**
- Neurological Disorders and Stroke Common Data Elements:**www.commondataelements.ninds.nih.gov/SCI.aspx#tab=Data_Standards**
- International Spinal Cord Injury Data Sets: **www.nature.com/sc/data_sets.html**
- International Spinal Cord Society—International Spinal Cord Injury (SCI) Data Sets: **www.iscos.org.uk/international-sci-data-sets**

Resources

Please refer to Appendix D for resources related to clinical trials and evidence-based practice and research.

4.E. **27. Documented, competency-based education is provided to personnel that includes, but is not limited to:**

- **a. Medical/physiological sequelae.**
- **b. Function.**
- **c. Psychosocial issues.**
- **d. Transitions across the lifespan.**
- **e. Resource management.**
- **f. Health promotion and wellness.**
- **g. Resources for independent living and community integration.**
- **h. Prevention related to potential risks and secondary health conditions.**
- **i. Safety for persons served in the environments in which they participate.**

Intent Statements

Competency-based training for personnel relates to the scope of the program as defined in Standard 1. in this section and the personnel resources and expertise required to execute the scope.

4.E. **28. To fulfill the program's commitment to respond to the changing needs of the persons served, education is provided to all personnel who interact with the persons served on:**

- **a. Indications that the status of the person served has changed.**
- **b. How to respond to information about persons served that may be reported by other sources.**
- **c. How to protect the privacy of the persons served.**
- **d. How to protect the dignity of the persons served.**
- **e. How to, on an ongoing basis:**
  - **(1) Observe for changes in persons served.**
  - **(2) Communicate observed or reported changes.**

Intent Statements

In addition to team members who are routinely involved with the persons served, a variety of other personnel interact with the persons served.

Any of them may notice signs that something about the person served has changed or may need attention. Education about what personnel might watch for and how to respond will minimize health and safety risks and complications for the persons served.

Examples

Examples of how various personnel might observe issues or concerns about persons served that require attention could include:

- The person served makes comments to the aide who is transporting him to therapy that his wife is not coping well with his injury and is overwhelmed with taking care of their family, working, and visiting him, leaving him very anxious about discharge.
- The receptionist overhears comments the person served makes to his mother that he thinks his friends are avoiding him or that he is depressed and wishes he did not survive the accident that caused his spinal injury.
- The van driver who transports the person served to therapy appointments notices newspapers piled up at the door, an odor that something has burned in the house, or meals that have been delivered but not eaten.
- The therapist observes the person served is having difficulty with more complex tasks, a decreased level of alertness that may be due to a recent change in medication, or the beginning of skin breakdown, and speaks with other team members about additional assessments and interventions that may be indicated.
- The peer supporter notices the person served is often late or does not show up to their meetings.

Additional Resources

- Model Systems Knowledge Translation Center: **http://www.msktc.org/sci**
- Shepherd Center—Introduction to Spinal Cord Injury: **http://www.myshepherd-connection.org/sci**

F. Stroke Specialty Program

Description

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.
- Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.

Applicable Standards

If an organization chooses to add the optional Stroke Specialty Program (SSP) designation to one or more appropriate programs/services in Section 3, the program description and standards in this section apply as follows:

- All Stroke Specialty Programs apply Standards 4.F.1.–20.
- If the SPP in linked to 3.A. Comprehensive Integrated Inpatient Rehabilitation Program or to 3.D. Residential Rehabilitation Program, also apply Standards 4.F.21.–24.

Additionally, the standards in the following sections apply as follows:

- Sections 1.A. and 1.C.–1.N.; 1.B. Governance is optional
- Section 2.A.
- Sections 2.B. and/or 2.C. based on the programs/services for which SSP accreditation is sought (see guidelines in Section 2)
- Section 2.D. based on diagnostic categories served (see guidelines in Section 2)
- Section 2.E. if the program serves *any* children/adolescents and is not seeking accreditation as a Pediatric Specialty Program. (Not applicable for Home and Community Services SSP; see guidelines in Section 2)

4.F. **1. The stroke specialty program defines its interventions in the following areas:**

- **a. Prevention, recognition, assessment, and treatment of conditions related to stroke and its complications.**
- **b. Promotion of lifestyle changes that focus on reducing the risk factors for recurrent stroke.**
- **c. Functional independence.**
- **d. Psychological and social coping and adaptation skills.**
- **e. Community integration and participation in life roles.**
- **f. Services for families/support systems.**

Intent Statements

The stroke specialty program defines its interventions so that persons served and other stakeholders can understand the scope of services provided and make informed decisions about whether participation in the program will meet their current needs.

Examples

1.a. Conditions related to stroke and its complications may include angina, anxiety, bladder dysfunction, bowel dysfunction, cardiac arrhythmias, central post-stroke pain syndrome, congestive heart failure, contracture, complex regional pain syndrome, dehydration, deconditioning, degenerative joint disease, dementia, depression, diabetes mellitus, dyslipidemia, dysphagia, emotional lability, exercise intolerance, falls and injuries, fatigue, hypertension, malnutrition, obesity, orthostatic hypotension, pneumonia, pressure ulcers, recurrent stroke, sexual dysfunction, seizure, shoulder dysfunction, sleep disturbances, spasticity/abnormal muscle tone, thromboembolic disease, urinary tract infection, and ventilatory insufficiency.

1.b. Risk factors for recurrent stroke may include hypertension, coronary disease, obesity, thromboembolic disease, smoking, diabetes mellitus, high alcohol intake, and high cholesterol. Lifestyle changes to reduce these risks might include promoting exercise and increased activity levels, smoking cessation, improved control of blood glucose levels, and diet modifications.

1.c. Interventions to address functional independence could address impairments in cognitive, memory, and language skills; balance; and motor function.

1.d. Interventions may include counseling, support groups, or individual approaches to specific situations. For example, a social coping and adaptation skill may be practicing how to ask others to speak more slowly or repeat instructions to allow the person who has had a stroke increased time to process information.

1.e. Interventions to address community integration and participation in life roles might include arranging for transportation for the person served to attend services at his or her usual place of worship or training to play golf with modified equipment. Another example is the therapeutic recreation specialist going to a restaurant with the person served and working with him or her to order food that fits in the person's dietary parameters.

1.f. Families/support systems are integral to assisting the persons served to attain maximal function and quality of life. Services for families/support systems might include support groups and group or individual education sessions.

4.F. **2. The program facilitates collaboration with the person served and family/support system in decision making through the following:**

- **a. Accessible information.**
- **b. Timing for provision and exchange of information.**
- **c. Identification of their level of understanding of the rehabilitation process.**

Intent Statements

To facilitate the decision-making roles of the person served and family/support system they are given information in a way that is understandable and in sufficient time to make informed decisions.

Examples

2.c. The level of understanding of the rehabilitation process may be identified through the preadmission assessment or assessment processes, through asking the person served or family/support system to summarize discussions and decisions made in team conferences, or through verification by the case manager or care coordinator.

4.F. **3. Based on the evidence available regarding the intensity of treatment, the stroke specialty program demonstrates a systematic approach to maximizing the intensity of participation of the persons served in the rehabilitation process.**

Intent Statements

In view of increasingly limited resources it is critical to maximize utilization of the time spent in therapy, within the constraints of what the person served can tolerate, by reducing barriers such as

interruptions to therapy, distractions in therapy, not getting to therapy in a timely manner, etc.

4.F. **4. Prior to the implementation of specific treatments, personnel:**

- **a. Provide the rationale for those treatments to the:**
  - **(1) Person served.**
  - **(2) Family/support system.**
- **b. Provide options, as appropriate, based on the feedback received.**

Intent Statements

Treatments are not always self-explanatory. To increase understanding and engagement in the rehabilitation process, the persons served and families/support systems are provided with the rationale for specific treatments, including options if appropriate, before those treatments are implemented. This may range from explanations for various discipline's interventions to specific tasks to be undertaken at a given session.

If members of the family/support system are not available prior to implementation of a specific treatment, personnel provide the information to them at the earliest possible opportunity. Likewise, in accordance with the preference of the person served, if members of the family/support system do not participate on the team they are not part of these discussions.

4.F. **5. The schedule for each person served reflects his or her:**

- **a. Preferences.**
- **b. Needs, including:**
  - **(1) Behavioral.**
  - **(2) Cognitive.**
  - **(3) Communication.**
  - **(4) Cultural.**
  - **(5) Developmental.**
  - **(6) Medical.**
  - **(7) Physical.**
  - **(8) Resources.**
  - **(9) Spiritual.**
- **c. Feedback.**
- **d. Choice to participate in personally meaningful activities.**

Examples

5.a. Given several options to obtain outpatient medical rehabilitation, an individual seeks services at a location close to his place of work so that appointments can be scheduled during lunch or immediately before or after work, minimizing time away from the work place.

The person served prefers to stay awake late into the evening, so the therapy schedule begins mid-morning instead of early morning.

5.b.(1) A person served who displays aggressive behavior in a group setting is scheduled for individual therapy sessions when no one else will be using the physical therapy gym.

5.b.(8) To accommodate the transportation resources she has available, the person served is scheduled in the afternoon so her daughter, who works in the morning, can provide her transportation to therapy sessions.

A person served has a limited number of visits that will be covered by his insurance so the case manager, in consultation with the person served and the rest of the team, establishes a schedule that will allow visits to be spread out over a longer period of time.

5.c. A person served provides feedback that he would like to modify his schedule for outpatient visits to accommodate a change in his work schedule.

A person served provides feedback that she no longer needs a break between therapy sessions and would like to revise the schedule to have back-to-back sessions.

4.F. **6. Based on the individual needs of the persons served, the program provides or arranges for:**

- **a. Services to address:**
  - **(1) Anxiety.**
  - **(2) Aphasia and other communication disorders.**
  - **(3) Cardiovascular status.**
  - **(4) Cognitive function.**
  - **(5) Comorbidities.**
  - **(6) Continence.**
  - **(7) Depression.**

(8) Dysphagia.
(9) Hearing.
(10) Hydration.
(11) Mood disturbances.
(12) Motor function.
(13) Nutrition.
(14) Perceptual deficits.
(15) Sexuality and intimacy.
(16) Skin integrity.
(17) Visual deficits.

b. Health promotion.
c. Services that prevent illness.
d. Health screenings.
e. Healthcare delivery.

Intent Statements

Services may be provided directly or arranged through other providers depending upon the scope and resources of the program. The stroke specialty program should be aware of all factors necessary to determine the most appropriate and beneficial interventions for the person served.

6.e. If the program does not directly provide healthcare, it should be prepared to demonstrate to the survey team how it accesses the healthcare delivery system when needed.

Examples

6.a.(1) The program provides training in the use of relaxation techniques and other therapeutic methods and medications to manage the anxiety of the person served.

6.a.(2) Other communication disorders could include dysathria or apraxia.

6.a.(3) Cardiovascular status could include blood pressure, lipids, congestive heart failure, atrial fibrillation, pulmonary embolism, or deconditioning.

6.a.(5) Comorbidities could include other medical conditions that are not directly related to the stroke, such as cancer or arthritis.

6.a.(6) Continence includes continence of both bladder and bowel and knowledge of any special regimens or programs to address continence.

6.a.(7) Services might include cognitive-behavioral techniques, supportive therapy, and other therapeutic methods and/or medications to manage the depression of the person served.

6.a.(10) Assessment of hydration could include monitoring for signs of dehydration or maintaining intake and output records.

6.a.(11) Mood disturbances could include lability, impulsivity, or mania.

6.a.(12) Motor function could include ataxia, balance, mobility, paresis, or spasticity.

6.a.(13) Nutrition could include weight management, special diets such as low salt or low cholesterol, monitoring for signs of malnutrition, maintaining intake records, and noting balance of foods eaten.

6.a.(14) Perceptual deficits could include unilateral neglect.

6.a.(16) Assessment of skin integrity could include regular skin checks and routine checking of skin during care such as toileting or transfers/repositioning.

6.a.(17) Visual deficits could include visual acuity and deficits such as hemianopsia or diplopia. Services might include low vision clinics, optometry, ophthalmology, and neuro-ophthalmology.

6.b. Health promotion could include arranging for a speaker from the American Heart Association or the American Stroke Association/National Stroke Association. It could also include encouraging or facilitating participation in wellness programs.

6.c. Providing or arranging for vaccinations is an example of services that prevent illness.

6.d. Health screenings could include breast cancer screening, colon cancer screening, oral cancer screening, bone density screening, blood sugar screening, or blood pressure screening.

4.F. **7. Based on the individual needs of the persons served, the stroke specialty program provides or arranges for resources, services, supports, and/or interventions:**

a. In the following areas:
(1) Adaptation to disability.
(2) Aging with a disability.

(3) **Community participation, including:**
- (a) **Advocacy.**
- (b) **Fitness.**
- (c) **Leisure.**
- (d) **Socialization.**
- (e) **Volunteerism.**
- (f) **Wellness.**

(4) **Driving.**
(5) **Falls.**
(6) **Insight of the person served.**
(7) **Life roles.**
(8) **Nutrition.**
(9) **Parenting skills.**
(10) **Peer support.**
(11) **School re-entry.**
(12) **Spousal/significant other relations.**
(13) **Supervision needs.**
(14) **Transportation needs.**
(15) **Work re-entry.**

b. **At each of the following times:**
- (1) **Beginning of services.**
- (2) **Appropriate intervals.**
- (3) **Discharge/transition.**

Intent Statements

While not every person served will have needs in all areas, an assessment is performed at points in time to ensure that all relevant needs are identified and addressed. The extensiveness of the assessment in each of the areas listed may vary by individual.

Examples

7.a.(3)(b) and **7.a.(14)** To facilitate getting to the fitness center on weekdays the person served will need to use public transportation. The program provides contact numbers and scheduling information for several options in the community.

7.a.(6) An assessment of the insight of the person served might consider whether the person is able to identify cognitive, functional, and/or physical limitations and areas of preservation that are consistent with what members of the team, including members of the family/support system, identify. The assessment might also consider whether the person served is able to self-manage identified limitations, seeking assistance and/or resources as needed.

7.a.(7) Life roles could address the role of the person served in his or her family; e.g., as a spouse, significant other, parent, and/or sibling; as a worker; as a volunteer; or any other role relating to the person's participation in life situations.

7.a.(12) Spousal/significant other relations might include issues related to sexuality and changes in roles within the family.

Resources

Please refer to Appendix D for resources related to peer support services and training for peer supporters.

4.F. 8. **In response to the preferences of the person served, the stroke specialty program:**
- a. **Assesses the person's use of complementary health approaches.**
- b. **Educates the person served on the efficacy and safety of interventions.**
- c. **Provides information and resources on integrative health, as appropriate.**

Examples

According to the National Institutes of Health National Center for Complementary and Integrative Health (**nccih.nih.gov/health/integrative-health**), the terms complementary and alternative refer to the use of healthcare approaches developed outside of mainstream Western, or conventional, medicine. Complementary medicine is the use of a non-mainstream approach together with conventional medicine. Alternative medicine is the use of a non-mainstream approach in place of conventional medicine. Most use of non-mainstream approaches by Americans is complementary. Integrative health incorporates complementary health approaches into mainstream healthcare.

Complementary health approaches may include:

- Use of natural products, such as dietary supplements.
- Mind and body practices, such as acupuncture, massage therapy, meditation, movement therapies, yoga, and relaxation techniques.
- Homeopathy, naturopathy, and traditional healers.

Resources

Please refer to Appendix D for resources related to complementary health approaches.

4.F. **9. The stroke specialty program addresses prevention of secondary complications.**

Intent Statements

The program addresses prevention/minimization of conditions and complications related to stroke through ongoing monitoring of the status of the person served, education of the person served and the family/support system, and training in self-management of health and the potential residual effects of a stroke.

Examples

Secondary complications of stroke may include:

- Cardiovascular complications, such as issues with blood pressure management, edema, deep venous thrombosis (DVT), and pulmonary embolus.
- Deficiencies, such as dehydration; osteoporosis; and nutritional deficiencies related to swallowing difficulties, decreased appetite and intake, or inability to prepare meals.
- Deformities, such as spasticity, shoulder subluxation, joint hyperextension, and contractures.
- Infections, such as pneumonia, urinary tract infections, cellulitis, c. difficile, and osteomyelitis.
- Mood disturbances, such as anxiety and depression.
- Pain caused by complex regional pain syndrome or positional factors.
- Physical deconditioning and inactivity.
- Trauma, such as cuts, bruises, abrasions, burns, falls, fractures, tendon overuse/abuse, and decubiti.

4.F. **10. Wellness for the persons served is promoted through activities that:**

a. Are based on input from the persons served.
b. Consider input from families/ support systems.
c. Are purposeful.
d. Provide for daily structured and unstructured activities.
e. Promote healthy behavior.
f. Meet their interests.
g. Align with their cognitive capabilities.
h. Align with their communication capabilities.
i. Reflect their choices.
j. Promote their personal growth.
k. Enhance their self-image.
l. Improve or maintain their functional levels whenever possible.
m. Allow for social interaction.
n. Allow for autonomy.
o. Include opportunities for community integration.
p. Are documented in the individual plan for each person served.

Examples

Well-rounded wellness programming may address aspects such as physical, social, spiritual, emotional, occupational, and intellectual.

10.d. Examples of unstructured activities might include:

- A person accustomed to working nights enjoys late night movies, the radio, a good book, or time to surf the internet.
- The availability of jigsaw puzzles, crossword puzzles, games, cards, or other similar activities may encourage persons served to participate either alone or with others.

- Large print books may be available or can be obtained from a local library that visits biweekly.
- Persons served plant seasonal flowers or create an herb garden.

Resources

Please refer to Appendix D for resources related to wellness.

4.F. **11. To meet the needs of the persons served, the stroke specialty program demonstrates knowledge and appropriate utilization of assistive technology.**

Intent Statements

Technology has an ever-increasing presence in the lives of persons served. It is important that service providers are attuned to the role and impact of technology on the lives of the persons served.

Please see the Glossary for a definition of *assistive technology*.

Examples

Electronic aids to daily living, emergency response systems, environmental controls, and environmental modifications could all be considered assistive technology. The assistive technology used by a person served may range from sophisticated systems prescribed, designed, and built to meet individual needs to technology that is available at retail hardware or home goods stores.

Resources

Please refer to Appendix D for resources related to assistive technology.

4.F. **12. The program educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.**

Intent Statements

The health and safety of persons served is paramount. However, in a person-centered approach to service delivery, the preferences of the person served may take precedence over the advice of family members, providers, or others. Under these circumstances the stroke specialty program educates the persons served about the consequences associated with choices and behaviors that pose potential risks to their health and safety, providing the opportunity for the person served to make an informed decision to engage or not engage in the behavior.

Examples

The program educates the person served about the risks of choosing to:

- Continue smoking cigarettes following a stroke.
- Jogging on the side of the road despite a reduced field of vision.
- Not using a shower chair when there are known issues with balance.
- Continue using the stove when home alone despite sensory or cognitive deficits.

4.F. **13. The stroke specialty program demonstrates how education for the persons served and families/support systems:**

- **a. Is coordinated.**
- **b. Is reinforced:**
  - **(1) Throughout the rehabilitation process.**
  - **(2) Among members of the interdisciplinary team.**
- **c. Is age appropriate.**
- **d. Fosters self-management.**
- **e. Is appropriate to the needs of:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**
- **f. Addresses:**
  - **(1) Accessing emergency care if necessary.**
  - **(2) Adaptation to stroke.**
  - **(3) Aging with a disability.**
  - **(4) Assistive devices.**
  - **(5) Caregiver support.**
  - **(6) Cognition.**
  - **(7) Communication.**
  - **(8) Health risks.**
  - **(9) Home modifications.**
  - **(10) Home safety.**

(11) Hydration.
(12) Nutrition.
(13) Prevention of:
- **(a) New conditions.**
- **(b) Worsening of existing conditions.**

(14) Self-advocacy.
(15) Sexuality and intimacy.
(16) Signs and symptoms of and response to recurring stroke.
(17) Smoking cessation.
(18) Specific healthcare procedures and techniques.
(19) Swallowing problems.
(20) Upper and lower extremity orthotics, including:
- **(a) How to apply and adjust the fit.**
- **(b) Limb and orthotic hygiene.**
- **(c) Individual utilization.**
- **(d) Training.**

Intent Statements

This standard expands upon the education addressed in Standards 2.B.30.–31.

13.c. Age-appropriate education is tailored to the age, developmental level, and cognitive level of the person receiving it. Content and presentation are modified to meet the needs of a young child compared to a teenager, adult, or older adult.

13.d. The concept of self-management recognizes that assistance, supports, and external resources may be necessary for successful management of one's own health.

Examples

13.f.(2) Adaptation to stroke could include education for the persons served and families/support systems on adaptation to disability, resuming sexual activity, emotional lability, and coping with confabulation.

13.f.(6) Cognition may include memory, problem solving, and executive function.

13.f.(7) Education on communication might address strategies for communicating with peers, members of the family/support system, and other care providers. Strategies for communicating with other care providers could include teaching the persons served and families to plan for conversations with providers, preparing questions, being organized, and taking their portable healthcare profile to appointments.

13.f.(8) Health risks could include cardiovascular complications, deconditioning, deficiencies, deformities, inactivity, infections, mood disturbances, pain, obesity, and trauma.

13.f.(12) Nutrition could include weight management, special diets such as low salt or low cholesterol, how to monitor for signs of dehydration or malnutrition, and how to maintain intake records.

13.f.(13) Prevention education could address anxiety, aspiration pneumonia, back pain due to changes in ambulation, bowel and bladder issues, changes in skin integrity due to decreased sensation or from use of an orthotic, deep venous thrombosis (DVT), depression, fatigue due to deconditioning, hip/other fractures, hypertension management, nutritional disorders, obesity, signs and symptoms of myocardial infarction, osteoarthritis, osteoporosis, pressure ulcers, seizure, shoulder pain, smoking cessation, and urinary tract infection.

13.f.(16) American Stroke Association/National Stroke Association signs and symptoms of stroke are good resources for education to recognize recurrent stroke.

13.f.(18) Specific healthcare procedures could include video swallow studies, diagnostic procedures, or surgical procedures. Specific healthcare techniques are related to the individual needs of the persons served.

13.f.(20)(b) Limb hygiene includes skin integrity and the identification of pressure areas, skin breakdown, or altered fit of the orthotic due to fluctuation in the limb.

Resources

Please refer to Appendix D for resources related to education for persons served, families/support systems, and caregivers.

4.F. **14. The program provides information to the person served and family/support system about the following, as appropriate:**

- **a. Financial resources.**
- **b. Healthcare benefits, including insurance.**
- **c. Laws and regulations pertaining to:**
  - **(1) Accessibility.**
  - **(2) Education.**
  - **(3) Health.**
  - **(4) Rights.**
  - **(5) Social supports.**
- **d. Service options available in the community.**

Examples

14.c.(2) The families/support systems of children/adolescents who have sustained a stroke are provided information on Individualized Education Programs (IEPs).

14.c.(3) The program provides the persons served with information on the implications of state/provincial or national requirements related to payment for services to address certain health conditions.

14.d. Persons who have sustained a stroke and families/support systems may access a wide variety of services in the community throughout different phases of recovery and community integration. Stroke specialty programs throughout the continuum of services provide information that allows the persons served and their families/support systems to explore and access service options that will meet their needs and preferences. These might include respite, day care, support groups, fitness, transportation, residential options, and social services.

4.F. **15. To facilitate transition to the community, an individualized plan is established for each person served that addresses:**

- **a. Factors facilitating transition to the community.**
- **b. Barriers to transition to the community.**
- **c. As appropriate, identification of other resources in the community that are or will be involved with the person served.**
- **d. Mechanisms for coordination with other resources.**

4.F. **16. Prior to the day of discharge/transition, the stroke specialty program:**

- **a. Develops a follow-up plan for each person served.**
- **b. Arranges for follow-up care, including care for persons who leave the program's geographic service area.**
- **c. Designates the individual(s) who will be responsible for coordination of the follow-up plan of each person served.**

Examples

16.c. Examples of individuals responsible for coordinating the follow-up plans of the person served might be the person served, a family member, a case manager, a primary care physician, or another healthcare provider.

4.F. **17. The stroke specialty program demonstrates its advocacy role within the community for persons who have sustained a stroke.**

Examples

The program's efforts to build awareness and understanding in the community of the needs and interests of persons who have sustained a stroke might include:

- Providing educational workshops to community members.
- Participating in community events and initiatives, e.g., festivals and charity events such as walks/runs for a cause.
- Entering collaborations with local governments and community-based groups to enhance services.
- Promoting integrated/inclusive community events, e.g., integrated arts such as theatre and dance and community meals.

4.F. **18. The stroke specialty program acts as a resource for providers throughout the phases of stroke care from emergency through community-based services regarding:**

- **a. Evidence-based practice.**
- **b. Development of service models and programs for persons served.**
- **c. Outreach and support.**
- **d. Training of personnel in stroke rehabilitation.**

4.F. **19. To advance the field of stroke rehabilitation, leadership supports:**

- **a. The program's participation in research opportunities.**
- **b. The provision of information about available clinical trials to:**
  - **(1) Persons served.**
  - **(2) Families/support systems.**

Intent Statements

19.a. It is not expected that every program will have its own research center. There are many opportunities to support research projects by participating and/or giving feedback to research groups on proposed tools, practices, etc.

Examples

19.a. The leadership encourages the program to provide input on proposed regulatory changes published for a specified period or on tools proposed that would subsequently be implemented by the program once finalized.

The leadership allows the rehabilitation program to participate in demonstration projects, investigational studies, and other research opportunities conducted by external entities.

The program is part of a larger entity that includes a research center and the leadership promotes studies related to stroke rehabilitation on its research agenda.

Resources

Please refer to Appendix D for resources related to clinical trials.

4.F. **20. The stroke specialty program:**

- **a. Gathers follow-up information on a representative sample of the persons served, including information on:**
  - **(1) Aspiration pneumonia.**
  - **(2) Falls.**
  - **(3) Falls with injuries.**
  - **(4) Other injuries.**
  - **(5) Re-hospitalizations.**
  - **(6) Unplanned medical visits/ encounters.**
- **b. At least annually conducts a written analysis that addresses:**
  - **(1) Performance in relationship to established targets for follow-up information regarding:**
    - **(a) Aspiration pneumonia.**
    - **(b) Falls.**
    - **(c) Falls with injuries.**
    - **(d) Other injuries.**
    - **(e) Re-hospitalizations.**
    - **(f) Unplanned medical visits/ encounters.**
  - **(2) Trends.**
  - **(3) Actions for improvement.**
  - **(4) Results of performance improvement plans.**
  - **(5) Necessary education and training of:**
    - **(a) Persons served.**
    - **(b) Families/support systems.**
    - **(c) Healthcare providers.**

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards. CARF does not specify the timeframe for gathering follow-up information. Timeframes will vary based on the type of program provided; e.g., inpatient, outpatient, home and community services, residential, etc.

Please see the Glossary for a definition of *representative sample*.

Examples

Follow up can be conducted a variety of ways including by phone; mail, email, or internet survey; at a doctor's visit or return visit to the program, or some combination of the above, as long as the questions posed are the same regardless of the mechanism used.

20.a.(4) Other injuries include burns, cuts, and other trauma resulting from stroke or its complications.

20.a.(6) Unplanned medical visits/encounters might include visits to the emergency room or urgent care and emergent office visits to see a physician related to the stroke or its complications.

Applicable Standards

All programs seeking accreditation as a Stroke Specialty Comprehensive Integrated Inpatient Rehabilitation Program or Stroke Specialty Residential Rehabilitation Program must also meet Standards 21.–24.

4.F. **21. The organization addresses the opportunity for families/support systems to remain with the persons served 24 hours a day, if desired by both the families/support systems and the persons served and deemed appropriate by the program.**

Intent Statements

The opportunity for members of the family/support system to remain with the person served is based on consideration of the desire of the person served and the family/support system and the program's determination that it is appropriate and the physical facility is conducive to such arrangements.

4.F. **22. To ensure the safety of the person served, medications prescribed for the person served at time of discharge/transition are consistent with the available resources:**

- **a. To obtain them.**
- **b. Needed to adhere to recommended administration.**

Examples

Resources that might impact obtaining medications and/or adhering to recommended administration include payment sources, the availability of medication samples, caregiver support, packaging of the medications, and transportation to pick them up at the pharmacy. Similarly, language barriers, literacy, or cognitive issues on the part of the person served or caregivers may pose challenges to adhering to recommended administration.

4.F. **23. Based on the individual needs of each person served, the stroke specialty program addresses at discharge/transition a plan to manage:**

- **a. Deconditioning.**
- **b. Diabetes.**
- **c. Hyperlipidemia.**
- **d. Hypertension.**
- **e. Physical inactivity.**
- **f. Stroke prophylaxis.**

4.F. **24. The stroke specialty program:**

- **a. Has indicators to measure the percentage of persons served who, at the time of discharge/transition, are in compliance with evidence-based guidelines to manage:**
  - **(1) Diabetes.**
  - **(2) Hyperlipidemia.**
  - **(3) Hypertension.**
  - **(4) Stroke prophylaxis.**

b. At least annually conducts a written analysis that addresses:

(1) Performance in relationship to established targets for the percentage of persons served who, at the time of discharge/transition, are in compliance with evidence-based guidelines to manage:

(a) Diabetes.

(b) Hyperlipidemia.

(c) Hypertension.

(d) Stroke prophylaxis.

(2) Trends.

(3) Actions for improvement.

(4) Results of performance improvement plans.

(5) Necessary education and training of:

(a) Persons served.

(b) Families/support systems.

(c) Healthcare providers.

Intent Statements

Gathering and analyzing information and identifying actions plans for the areas identified is considered and integrated into performance measurement, management, and improvement programs addressed in Section 1 of the standards.

Examples

24.a.(1) An American Diabetes Association guideline is that persons with diabetes should receive self-management education. The stroke specialty program provides the instruction and measures its effectiveness through a post-test.

24.a.(2) An evidenced-based practice guideline states that all patients with hyperlipidemia should be prescribed a lipid lowering therapy. The program counts the number of persons with hyperlipidemia and measures how many were prescribed a lipid lowering therapy at discharge.

24.a.(3) The program measures the percentage of persons served who are compliant with specific diet/food choices at the time of discharge to assist in management of hypertension.

Resources

Please refer to Appendix D for resources related to evidence-based practice and research.

Appendix A

Required Written Documentation

The following tables list standards that explicitly require some form of written evidence in order to achieve full conformance.

When interpreting CARF standards, the following terms *always* indicate the need for written evidence: *policy*, *plan*, *documented*, *documentation*, and *written*. Other terms may also indicate the need for specific written information.

This list of standards is not inclusive of all the documentation that will be reviewed during the survey of your organization.

Note: *This appendix is available in an editable electronic format at* ***www.carf.org/Documentation_and_Time_Lines*** *or through the Resources section in Customer Connect (****https://customerconnect.carf.org****).*

Section 1. ASPIRE to Excellence®

Standard(s)	Requirements
1.A. Leadership	
1.A.5.a.	Cultural competency and diversity plan
1.A.6.a., b.	Written ethical codes of conduct and written procedures to deal with allegations of violations of ethical codes
1.A.7.a.	For U.S. organizations receiving federal funds, policy on corporate compliance adopted by organization leadership
1.A.7.b.	Written procedures that address exclusion of individuals and entities from federally funded healthcare programs.
1.A.7.c.(1)	Documentation of staff member designated to serve as the organization's compliance officer
1.A.9.a.	Written procedures related to organizational fundraising, if applicable
1.B. Governance (Optional)	
1.B.1.	Governance policies to facilitate ethical governance, assure stakeholders that governance is active and accountable, and meet legal requirements
1.B.2.	Governance policies regarding board selection, orientation, development, education, leadership, structure, and performance
1.B.5.	Governance policies addressing executive leadership development and evaluation, including a written performance review and succession plan

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements
1.B.6.	Governance policies, written statements, and documented processes addressing executive compensation
1.C. Strategic Planning	
1.C.2.a.–c.	Strategic plan
1.E. Legal Requirements	
1.E.2.	Written procedures to guide personnel in responding to subpoenas, search warrants, investigations, and other legal actions
1.E.3.	Policies and written procedures on records
1.F. Financial Planning and Management	
1.F.2.a., b.(1), b.(3)	Written budgets
1.F.4.e.	If appropriate, financial solvency remediation plans
1.F.6.a.	Fiscal policies and written procedures including internal control practices
1.F.9.	Written procedures for managing funds of persons served (if applicable)
1.F.10.	Annual review or audit of financial statements by an independent, authorized accountant
1.F.11.	If a review or audit generates a management letter, both the letter and management's response
1.G. Risk Management	
1.G.1.a.	Risk management plan
1.G.3.	Written procedures regarding communications, including media relations and social media
1.H. Health and Safety	
1.H.2.	Written procedures that promote the safety of persons served and personnel
1.H.4.	Documentation of competency-based training in health and safety for personnel both upon hire and at least annually
1.H.5.	Written emergency and evacuation procedures
1.H.7.d.	Written evidence of unannounced tests of all emergency procedures, including analysis

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements
1.H.9.	Written procedures regarding critical incidents
1.H.10.	Written analysis of critical incidents
1.H.12.h.	Written emergency procedures related to transportation services
1.H.13.b.	External health and safety inspection reports
1.H.14.b.	Health and safety self-inspection reports
1.H.15.	Written procedures concerning hazardous materials, if applicable
I. Workforce Development and Management	
1.I.1.	Documentation of the composition of the organization's workforce
1.I.3.b.	Written job descriptions
1.I.4.	Written procedures related to verification of workforce backgrounds, credentials, and fitness for duty
1.I.6.d.	Policies and written procedures related to workforce engagement
1.I.8.	Written procedures for performance appraisals
1.J. Technology	
1.J.1.a.	Technology and system plan
1.J.2.a.	Written procedures related to use of information and communication technologies to deliver services, if applicable
1.K. Rights of Persons Served	
1.K.1.	Policies on the rights of persons served
1.K.3.a.	Policy and written procedure by which persons served may make a formal complaint
1.K.3.b.	Complaint forms, if applicable
1.K.3.c.	Documentation of formal complaints
1.K.4.	Documented analysis of all formal complaints
1.L. Accessibility	
1.L.2.	Accessibility plan
1.L.3.d.	Documentation of requests for reasonable accommodations

Section 1. ASPIRE to Excellence® (Continued)

Standard(s)	Requirements
1.M. Performance Measurement and Management	
1.M.1.	Written description of performance measurement and management system
1.M.3.d.(1)	Written business function objectives, performance indicators, and performance targets
1.M.3.d.(2)	Written service delivery objectives, performance indicators, and performance targets for each program seeking accreditation
1.N. Performance Improvement	
1.N.1.	Written performance analysis
1.N.1.c.(2)	Performance improvement action plan

Section 2. The Rehabilitation and Service Process for the Persons Served

Standard	Requirement
Section 2.A. Program/Service Structure for all Medical Rehabilitation Programs	
2.A.1.a.	Documentation of scope of program
2.A.3.	Documentation of entry, transition, and exit criteria
2.A.9.	Written procedures related to mobile unit services
2.A.12.	Documentation of personnel training provided at orientation and regular intervals
2.A.15.	Written analysis of denials, ineligible service referrals, and interrupted services
2.A.17.	Documented preventive maintenance program
2.A.18.	Policy for advance directives and resuscitation
2.A.19.i.	Emergency plan takes into consideration the unique needs of persons served who require ventilatory services
2.A.20.	Initial and ongoing assessments of each person served that document information about skin integrity, as identified in the standard
2.A.22.a.	Written protocols for wound care needs that are within the scope of the program, including a plan for follow-up care
2.A.22.b.	Written protocols for referrals to or coordination with appropriate specialists for wound care needs that are not within the scope of the program

Section 2. The Rehabilitation and Service Process for the Persons Served

Standard	Requirement
2.A.25.	Documentation of competency-based training for personnel who provide services related to skin integrity and wound care, provided at orientation and regular intervals
2.A.26.b.	Written analysis of information gathered on persons served regarding wounds that developed during the program and wounds that worsened during the program
Section 2.B. The Rehabilitation and Services Process for Persons Served	
2.B.1.	Documentation of scope regarding parameters of persons served
2.B.8.	Individualized written disclosure statements with current information provided to each person served through the stay
2.B.12.a.	Agreement outlining responsibilities for inpatient medical director
2.B.19.c.	Decisions reflecting personal preferences of the persons served are documented in the records of the persons served
2.B.22.	Written communication regarding the team process
2.B.26.a.	Documentation of family/support system conferences
2.B.36.	Written discharge/transition recommendations
2.B.45.	All records of the persons served
2.B.46.	Written analysis of a representative sample of records of the persons served conducted at least annually
Section 2.C. The Service Process for Persons Served in Home and Community Services	
2.C.7.	Written communication regarding the service process
2.C.10.	All records of the persons served
2.C.11.	Written analysis of a representative sample of records of persons served conducted at least annually
2.C.16.	Education plans for children/adolescents
2.C.19.	Individualized plan for each child/adolescent to facilitate transition to the community
2.C.22.	If seeking accreditation as a brain injury specialty program, documentation of scope regarding parameters of persons served
Section 2.D. The Rehabilitation and Service Process for Specific Diagnostic Categories	
2.D.12.	If any persons served with spinal cord dysfunction and not seeking spinal cord specialty program accreditation, documented scope of program addresses etiology of spinal cord dysfunction, levels of spinal cord injury, completeness of spinal cord dysfunction, and comorbidities

Section 2. The Rehabilitation and Service Process for the Persons Served

Standard	Requirement
2.D.16.	If any persons served with spinal cord dysfunction and not seeking spinal cord specialty program accreditation, individual plans address intimacy and sexual health issues
2.D.23.q.	If any persons served with spinal cord dysfunction and not seeking spinal cord specialty program accreditation, individual plans for each person served include documentation of activities to promote health and wellness
2.D.24.	If any persons served with spinal cord dysfunction and not seeking spinal cord specialty program accreditation, documentation of competency-based training for personnel that includes all areas identified in the standard
Section 2.E. The Rehabilitation and Service Process for Children and Adolescents Served	
2.E.2.	If the program is inpatient or residential, policies and written procedures address the opportunity for the families to remain with the children/adolescents served 24 hours a day
2.E.8.	Education plans for children/adolescents
2.E.12.	Individualized plan for each child/adolescent to facilitate transition to the community

Section 3. Program Standards

Standard	Requirement
Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program	
3.A.1.	Documentation of arrangements for diagnostic imaging and medical, laboratory, and pharmacy services
3.A.2.	Policies and written procedures address physician services, medical management, rehabilitation management, access to consulting physicians, rehabilitation nursing services, and prevention
3.A.5.	Preadmission assessment of each person served.
3.A.15.	Written analysis of information gathered on persons served regarding unplanned transfers to acute medical facilities, discharges to long-term care, and expiration
3.A.16.	Written analysis of follow-up information gathered on persons served regarding activity, environment, health status, and participation

Section 3. Program Standards (Continued)

Standard	Requirement
Section 3.B. Outpatient Medical Rehabilitation Program	
3.B.4.	Written analysis of no-shows, cancellations, and dropouts
3.B.5.	Written procedures for actions to occur to verify backgrounds of personnel
Section 3.C. Home and Community Services ()	
3.C.3.	Written procedures for actions to occur to verify backgrounds of personnel
3.C.5.	Policies and written procedures addressing all listed service delivery issues
3.C.8.	Emergency plans include assessment of current knowledge, physical environment, modifications necessary, community resources, utility needs, program continuation, provisions for communication, contingency plans, emergency preparedness
3.C.11.	Policies and written procedures to facilitate collaboration with family/support system
Section 3.D. Residential Rehabilitation Program	
3.D.11.	Individual plans identify and address barriers to community inclusion, accessing community activities, and opportunities for community participation
3.D.17.	The individual service plan reflects the changing life span issues of the persons served
Section 3.E. Vocational Services	
3.E.5.	Individual plan for vocational services addresses all criteria listed
3.E.8.	Policy that addresses accepting work from businesses being affected by labor strikes and employing persons in such businesses
Section 3.F. Interdisciplinary Pain Rehabilitation Program	
3.F.1.	Documentation of arrangements for medical, diagnostic, laboratory, and pharmacy services
3.F.2.	Written procedures to verify backgrounds of all personnel and respond to information received
3.F.5.b.	Agreement outlining responsibilities for medical director
3.F.8.a.	If team includes healthcare professionals under service agreement with external resources, documentation of roles and responsibilities within the organization for negotiating and authorizing service agreements.

Section 3. Program Standards (Continued)

Standard	Requirement
3.F.8.b.	If team includes healthcare professionals under service agreement with external resources, written service agreements that specify terms under which the services are provided
3.F.14.	Documentation of methods used to collect finding related to development of treatment approaches, supports, and/or strategies, and analysis of these findings
3.F.23.	Policies and written procedures related to medications and the responsibility of persons served concerning medication safety issues
3.F.25.	Policies and written procedures addressing drug-screening practices
3.F.32.	Written analysis of no-shows, cancellations, and dropouts
3.F.33.	Written analysis of performance indicators
3.F.34.	Written analysis of the services provided
3.F.35.	Written admission criteria to ensure that persons admitted require the level of intensity of services provided by an inpatient program
3.F.38.	Written analysis of information gathered on persons served
Section 3.G. Occupational Rehabilitation Program	
3.G.4.	Documented assessment of each person served
3.G.12.d.	Progressive plan for return to work, if appropriate
3.G.14.c.	Written analysis of information gathered on persons served
Section 3.H. Independent Evaluation Services	
3.H.1.a.–b.	Documented parameters regarding scope of services and persons served
3.H.19.	Policies and written procedures addressing cancellations, no-shows, noncompliance, observers, recording devices, and the final report
3.H.22.	Written service agreements for the provision of evaluation services by additional qualified evaluators, if applicable
3.H.23.	If services are provided under agreement with external resources, documented roles and responsibilities for negotiation/authorization and written service agreements that specify all required elements
3.H.25.	Documented preventative maintenance program
3.H.27.	Written communication regarding the evaluation process
3.H.28.	Evaluation reports
3.H.29.	Written analysis of services provided
3.H.30.	Written analysis of no-shows and cancellations

Section 3. Program Standards (Continued)

Standard	Requirement
Section 3.I. Case Management	
3.I.13.	Individual plans
3.I.14.	Individualized written disclosure statements
3.I.25.	Written discharge/transition summaries
3.I.29.b.	Written analysis of information gathered on persons served
3.I.30.	All records of the persons served

Section 4. Specialty Program Designation Standards

Standard	Requirement
Section 4.A. Pediatric Specialty Program	
4.A.2.	Policies and written procedures to facilitate collaboration in decision making
4.A.17.	Individual plans to facilitate transition to the community
4.A.19.a.	In programs that are part of a larger entity, budget that supports the scope of the Pediatric Specialty Program
4.A.19.d.	In programs that are part of a larger entity, policies and written procedures address unique needs of children/adolescents and integration of the Pediatric Specialty Program into the larger organization
4.A.23.	Emergency plans take into consideration the unique needs of the children/adolescents
4.A.25.	Policies and written procedures that address the opportunity for families to remain with the child/adolescent 24 hours per day (inpatient and residential settings)
Section 4.B. Amputation Specialty Program	
4.B.9.	Documented evidence of training of peer supporters
4.B.14.	Written discharge/transition recommendations
4.B.15.c.	Plan of follow-up for each person served
4.B.17.	Written analysis of information gathered on persons served, including follow-up information, conducted at least annually
Section 4.C. Brain Injury Specialty Program	
4.C.5.	Initial and ongoing assessments; documentation requirements
4.C.15.o.	Wellness activities for the person served, documented in individual plans of persons served

Section 4. Specialty Program Designation Standards (Continued)

Standard	Requirement
4.C.25.b.(4)	Contingency plans, addressed in discharge/transition planning
4.C.25.b.(13)	Follow-up plan for each person served, addressed in discharge/transition planning
4.C.33.b.	Written analysis of information gathered from persons served, families/support systems, and other relevant stakeholders
Section 4.D. Cancer Rehabilitation Specialty Program	
4.D.7.	Initial and ongoing assessments of each person served that document the information listed in the standard
4.D.18.q.	Wellness activities for the person served, documented in individual plans of persons served
4.D.23.b.(6)	Contingency plans, addressed in discharge/transition planning
4.D.23.b.(15)	Follow-up plan for each person served, addressed in discharge/transition planning
4.D.30.	Documentation of competency-based education for personnel that addresses the unique needs of persons diagnosed with cancer provided at orientation and regular intervals that includes all areas listed in the standard
4.D.31.b.	Written analysis of follow-up information gathered on persons served
Section 4.E. Spinal Cord Specialty Program	
4.E.1.	Documented scope of spinal cord specialty program
4.E.8.	Individual plans address intimacy and sexual health issues
4.E.14.	Written procedures for recruitment of peer supporters
4.E.17.q.	Individual plans for each person served include documentation of activities to promote health and wellness
4.E.19.c.	Follow-up plans established for each person served
4.E.21.	Written analysis of follow-up information gathered on persons served
4.E.27.	Documentation of competency-based training for personnel that includes all areas identified in the standard
Section 4.F. Stroke Specialty Programs	
4.F.10.p.	Documentation of activities promoting the wellness of persons served
4.F.15.	Individualized plans addressing transition to the community
4.F.16.a.	Follow-up plans developed prior to discharge/transition

Section 4. Specialty Program Designation Standards (Continued)

Standard	Requirement
4.F.20.b.	Written analysis of follow-up information gathered on persons served
4.F.23.	Written discharge/transition plans addressing deconditioning, diabetes, hyperlipidemia, hypertension, physical inactivity, and stroke prophylaxis
4.F.24.	Written analysis of discharge/transition performance indicators

Appendix B

Operational Timelines

The following tables list CARF standards that require activities be conducted at specific time intervals. The documents assembled as part of survey preparation should provide evidence that these activities occur.

Standards that specify an activity be conducted *at least* or *no less than* a specific time period are listed in the table for the maximum timeframe within which they may occur. During an original survey the organization is expected to demonstrate, for standards that specify an activity be conducted on or within a specific time period (e.g., at least quarterly, at least annually), that the activity has occurred at least once within such period prior to the survey.

Standards that require a policy that includes a timeframe, such as for the reporting of complaints or recording information into the records of the persons served, are not included in this appendix. Standards that require activities be conducted on an *ongoing* or *as needed* basis are also not included here.

The timelines for the standards listed in the last table, *Activities to be Conducted at a Frequency Determined by the Organization*, may be influenced by various factors, such as local regulations or the needs of the organization and the persons served—e.g., verification of backgrounds, credentials, and fitness for duty of members of the workforce, or data collected about persons served at appropriate intervals during services. For these standards, you should identify the frequency with which these activities are scheduled. The surveyors will want to see evidence that you are following your identified timelines.

Note: *This appendix is available in an editable electronic format at* ***www.carf.org/Documentation_and_Time_Lines*** *or through the Resources section in Customer Connect (****https://customerconnect.carf.org****).*

Activities to be Conducted at Least Annually

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.A.3.k.	Review of the organization's policies, as guided by leadership
1.A.5.c.	Cultural competency and diversity plan reviewed for relevance
1.B.2.g.(3), (5)–(6)	Board conducts self-assessment of the entire board; written conflict-of-interest and ethical code of conduct declarations signed
1.B.5.a.–b.	Review of executive leadership performance and executive leadership succession plan
1.B.6.e.(6)	Review of executive compensation records
1.B.7.	Review of governance policies

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity
1.C.2.e.	Strategic plan reviewed for relevance
1.F.2.	Budgets are prepared and approved
1.F.10.	Review or audit of the financial statements of the organization by an independent accountant authorized by the appropriate authority
1.G.1.b.(1)	Risk management plan reviewed for relevance
1.G.2.a.(2)	Review of organization's insurance package for adequacy
1.G.4.d.	Review of contracted services, if applicable
1.H.4.	Personnel receive training in health and safety practices, identification of unsafe environmental factors, emergency and evacuation procedures, identification and reporting of critical incidents, reducing physical risks, workplace violence, and, if appropriate, medication management
1.H.7.	Unannounced tests of all emergency procedures, including complete actual or simulated physical evacuation drills, tested on each shift at all locations
1.H.10.	Written analysis of all critical incidents conducted by or provided to leadership
1.H.12.l.	If transportation services are contracted, contract reviewed against Standards 1.H.12.a.–k.
1.H.13.	Comprehensive external health and safety inspection conducted, resulting in a written report
1.J.1.c.	Technology and system plan reviewed for relevance
1.K.2.a.(3)	Rights of persons served shared with persons served who have been in the program longer than one year
1.K.4.	Written analysis of all formal complaints that documents whether formal complaints were received, trends, areas needing performance improvement, actions to be taken, and actions taken or changes made
1.L.2.b.	Accessibility plan reviewed for relevance
1.N.1.	Written analysis of performance indicators that identifies areas needing improvement, results in an action plan to address the improvements needed, and identifies actions taken or changes made
Section 2.A. Program/Service Structure for all Medical Rehabilitation Programs	
2.A.1.c.	Scope of services reviewed and updated if necessary
2.A.15.	Written analysis of denials, ineligible service referrals, interrupted services

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity
2.A.26.b.	Written analysis of information gathered on persons served that includes performance in relationship to established targets for wounds that developed and wounds that worsened during the program; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and personnel
Section 2.B. The Rehabilitation and Service Process for the Persons Served	
2.B.38.c.	Information provided to persons served from the information outcomes management system is updated
2.B.46.a.	Written analysis of representative sample of records of persons served
Section 2.C. The Service Process for the Persons Served in Home and Community Services	
2.C.11.a.	Written analysis of representative sample of records of persons served
Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program	
3.A.15.b.	Written analysis that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel, payers, and regulatory agencies
3.A.16.c.	Written analysis that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers
Section 3.B. Outpatient Medical Rehabilitation Program	
3.B.4.	Written analysis of no-shows, cancellations, and dropouts
Section 3.D. Residential Rehabilitation Program	
3.D.13.	Preference of persons served for alternative living arrangements are addressed
Section 3.F. Interdisciplinary Pain Rehabilitation Program	
3.F.32.	Written analysis of no-shows, cancellations, and dropouts
3.F.33.b.	Written analysis that addresses performance in relationship to established targets, trends, actions for improvement, results of performance improvement plans, and necessary education of persons served, families/support systems, and healthcare providers
3.F.34.	Written analysis of services provided

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity
3.F.38.b.	Written analysis that includes performance in relationship to established targets for discharges to long-term care, expiration, and unplanned transfers to acute medical facilities; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel, payers, and regulatory agencies
Section 3.G. Occupational Rehabilitation Program	
3.G.14.c.	Written analysis that includes performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel, payers, and regulatory agencies
Section 3.H. Independent Evaluation Services	
3.H.1.d.	Scope of services reviewed and updated if necessary
3.H.30.	Written analysis of no-shows and cancellations that includes performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel
Section 3.I. Case Management	
3.I.29.b.	Written analysis of information gathered on persons served
3.I.31.a.	Analysis of representative sample of records of persons served
Section 4.B. Amputation Specialty Program	
4.B.17.c.	Written analysis of information gathered on persons served, including follow-up information, that includes performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and personnel
Section 4.C. Brain Injury Specialty Program	
4.C.24.	Comprehensive annual reviews for persons served longer than one year
4.C.33.b.	Written analysis of information gathered on satisfaction that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, healthcare providers, and personnel
Section 4.D. Cancer Rehabilitation Specialty Program	
4.D.31.b.	Written analysis of follow-up information gathered on persons served that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers

Activities to be Conducted at Least Annually (Continued)

Related Standard	Activity
Section 4.E. Spinal Cord Specialty Program	
4.E.20.	Comprehensive annual reviews for persons served
4.E.21.b.	Written analysis of follow-up information gathered on persons served that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, healthcare providers, and others as appropriate
Section 4.F. Stroke Specialty Program	
4.F.20.b.	Written analysis of follow-up information gathered on persons served that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers
4.F.24.b.	Written analysis of discharge/transition information that addresses performance in relationship to established targets; trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers

Activities to be Conducted at Least Semiannually

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.H.14.	Comprehensive health and safety self-inspections conducted on each shift, resulting in a written report
Section 3.H. Independent Evaluation Services	
3.H.29.	The organization conducts a written analysis of the services provided

Activities to be Conducted at Least Quarterly

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.F.7.	Review of representative sample of bills of the persons served to determine accuracy and identify necessary corrective actions

Activities to be Conducted at Least Monthly

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.F.3.c.	Review of actual financial results
1.F.9.f.	If responsible for funds of the persons served, monthly account reconciliation provided to persons served

Activities to be Conducted at a Frequency Determined by the Organization

Related Standard	Activity
Section 1. ASPIRE to Excellence®	
1.B.2.g.(4)	Periodic self-assessment of individual members of board
1.H.12.b.	Regular review of driving records of all drivers
1.H.12.k.	Maintenance of vehicles owned or operated by the organization according to manufacturer's recommendations
1.I.4.c.(2)	Verification of workforce backgrounds, credentials, and fitness for duty throughout employment
1.I.7.c.	Timeframes/frequencies related to the competency assessment process
1.I.8.e.	Timeframes/frequencies related to the performance appraisal process
1.M.5.b., d.	Data collected on the persons served at appropriate intervals during services and at points in time following services
Section 2.A. Program/Service Structure for all Medical Rehabilitation Programs	
2.A.12.	Training provided to personnel at regular intervals
2.A.25.a.(2)	Training provided at regular intervals to personnel who provide services related to skin integrity and wound management
Section 2.D. The Rehabilitation and Service Process for Specific Diagnostic Categories	
2.D.11.	Education for personnel that addresses the unique needs of persons with brain injury, provided at regular intervals
Section 3.A. Comprehensive Integrated Inpatient Rehabilitation Program	
3.A.16.a.	Defined timeframe for collecting long-term, follow-up information on durability of outcomes

Activities to be Conducted at a Frequency Determined by the Organization (Continued)

Related Standard	Activity
Section 3.C. Home and Community Services	
3.C.3.b.	Verification of backgrounds of all personnel at stated intervals
Section 3.G. Occupational Rehabilitation Program	
3.G.14.b.	At points after discharge, program gathers information from persons served
Section 4.C. Brain Injury Specialty Program	
4.C.32.a.(2)	Education for personnel that addresses the unique needs of persons with brain injury, provided at regular intervals
Section 4.D. Cancer Rehabilitation Specialty Program	
4.D.30.a.(2)	Education for personnel that addresses the unique needs of persons diagnosed with cancer, provided at regular intervals

Appendix C

Required Education and Training

The following three tables list standards that explicitly require an organization to provide some form of education or training to personnel, persons served, families/support systems, and/or other stakeholders. Education and training are inherent to program operations and the service delivery process. Therefore the lists below are not all inclusive of the education and training that might be delivered to any of these groups and should be used in combination with the standards, intent statements, examples, and resources in the corresponding sections of the standards manual.

Note: *This appendix is available in an editable electronic format at* ***www.carf.org/Documentation_and_Time_Lines*** *or through the Resources section in Customer Connect (****https://customerconnect.carf.org****).*

Education and Training for Personnel

Standard(s)	Requirements
Section 1. ASPIRE to Excellence®	
1.A.6.c.	Education on ethical codes of conduct
1.A.7.d.	Training on corporate compliance
1.A.8.	Education to stay current in the field
1.A.9.	Training related to fundraising written procedures, if applicable
1.F.6.b.	Training related to fiscal policies and written procedures (Frequency: initial and ongoing)
1.H.4.	Documented competency-based training in health and safety practices, identification of unsafe environmental factors, emergency and evacuation procedures, identification and reporting of critical incidents, medication management (if appropriate), reducing physical risks, and workplace violence (Frequency: upon hire and at least annually)
1.H.7.c.(4)	Unannounced tests of all emergency procedures are analyzed for performance that addresses necessary education and training of personnel
1.H.10.b.(5)	Written analysis of all critical incidents addresses necessary education and training of personnel
1.H.11.b.	Training regarding infections and communicable diseases
1.I.5.b.	On-the-job training included in onboarding and engagement activities
1.I.7.f.	Education and training included in workforce development activities

Education and Training for Personnel (Continued)

Standard(s)	Requirements
1.J.3.	As appropriate, if services are delivered using information and communication technology, competency-based training on equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting
2.A. Program/Service Structure for all Medical Rehabilitation Programs	
2.A.12.	Documented training that includes information on psychological and social/cultural issues of the persons served; performance measurement, management, and improvement systems, tools, data collection methods, comparative data, and use of outcomes information; legal requirements affecting the organization or personnel; documentation and record keeping requirements; suicide prevention; and specific training directly related to the program (Frequency: orientation and regular intervals)
2.A.13.b.	Leadership fosters a continuous learning environment that provides education opportunities that reflect the learning styles, needs, and strengths of personnel
2.A.15.e.(5)(a)	Written analysis of all denials, service referrals determined to be ineligible, and all interrupted services addresses necessary education and training of personnel
2.A.21.a.(6)(c)	Education related to identified skin integrity risks that are within the scope of the program
2.A.22.a.(6)(c)	Education related to identified wound care needs that are within the scope of the program
2.A.25.	Documented, competency-based training for personnel who provide services related to skin integrity and wound management that includes all areas identified in the standard (Frequency: orientation and regular intervals)
2.A.26.b.(5)(c)	Analysis of performance in relationship to established targets for wounds that developed during the program and wounds that worsened during the program includes necessary education and training of personnel
2.B. The Rehabilitation and Service Process for the Persons Served	
2.B.42.e.(1)	The program promotes a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs
2.B.46.c.(5)	Analysis of a representative sample of records of the persons served includes necessary education and training of personnel
2.C. The Service Process for the Persons Served in Home and Community Services	
2.C.11.c.(5)	Analysis of a representative sample of records of the persons served includes necessary education and training of personnel
2.C.25.e.(1)	The service promotes a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs
2.D. The Rehabilitation and Service Process for Specific Diagnostic Categories	
2.D.11.	If any persons with acquired brain injury are served and not seeking accreditation as a Brain Injury Specialty Program, education for personnel that addresses areas identified in 2.D.11.b.(1)–(9) (Frequency: orientation and regular intervals)

Education and Training for Personnel (Continued)

Standard(s)	Requirements
2.D.24.	If any persons with spinal cord dysfunction served and not seeking accreditation for Spinal Cord Specialty Program, competency-based education for personnel that includes the areas identified in 2.D.24.a.–i.
3.A. Comprehensive Integrated Inpatient Rehabilitation Program	
3.A.15.b.(5)(a)	Analysis of information on unplanned transfers to acute medical facilities, discharges to long-term care, and expiration addresses necessary education and training of personnel
3.A.16.c.(5)(c)	Analysis of information on durability addresses necessary education and training of healthcare providers
3.B. Outpatient Medical Rehabilitation Program	
3.B.4.b.(5)(c)	Analysis of no-shows, cancellations, and dropouts addresses necessary education and training of personnel
3.F. Interdisciplinary Pain Rehabilitation Program	
3.F.4.g.	The program director has the responsibility and authority to guide and direct educational activities for the program personnel
3.F.5.c.(9)	The medical director actively participates in educational activities with the program personnel
3.F.25.e.(3)	If drug screening is provided, polices and written procedures address drug-screening practices including education for personnel
3.F.32.b.(5)(c)	Analysis of no-shows, cancellations, and dropouts addresses necessary education and training of personnel
3.F.33.b.(5)(c)	Analysis of indictors addresses necessary education and training of healthcare providers
3.F.34.e.(5)	Analysis of a representative sample of records of the persons served includes necessary education and training of personnel
3.F.38.b.(5)(a)	Analysis of information on discharges to long-term care, expiration, and unplanned transfers to acute medical facilities addresses necessary education and training for personnel
3.G. Occupational Rehabilitation Program	
3.G.14.c.(5)(c)	Analysis of information on work capability of persons served at discharge and follow-up information includes necessary education and training of personnel
3.H. Independent Evaluation Services	
3.H.29.e.(5)	Analysis of the services provided includes necessary education and training of personnel
3.H.30.b.(5)	Analysis of no-shows and cancellations includes necessary education and training of personnel

Education and Training for Personnel (Continued)

Standard(s)	Requirements
3.I. Case Management	
3.I.27.e.(1)	When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs for personnel
3.I.29.b.(5)(c)	Analysis of information on changes in severity of conditions, comorbidity, mortality, and nonmedical interruptions in the delivery of services addresses necessary education of personnel
3.I.31.c.(5)	Analysis of a representative sample of records of the persons served includes necessary education and training of personnel
4.B. Amputation Specialty Program	
4.B.17.c.(5)(c)	Analysis of information gathered on persons served addresses necessary education and training of personnel
4.C. Brain Injury Specialty Program	
4.C.32.b.	Education for personnel that addresses the areas identified in 3.H.32.b.(1)–(16) (Frequency: orientation and regular intervals)
4.C.33.b.(5)(d)	Analysis of satisfaction information addresses necessary education and training of personnel
4.D. Cancer Rehabilitation Specialty Program	
4.D.30.	Documented, competency-based education for personnel addresses the unique needs of persons diagnosed with cancer that includes areas identified in 3.I.30.b.(1)–(17) (Frequency: orientation and regular intervals)
4.D.31.b.(5)(c)	Analysis of follow-up information addresses necessary education and training of healthcare providers
4.E. Spinal Cord Specialty Program	
4.E.27.	Competency-based education for personnel that includes the areas identified in 4.E.27.a.–i.
4.E.28.	Education for all personnel who interact with persons served that includes the areas identified in 4.E.28.a.–e.
4.F. Stroke Specialty Program	
4.F.20.b.(5)(c)	Analysis of follow-up information addresses necessary education and training of healthcare providers
4.F.24.b.(5)(c)	Analysis of discharge/transition information addresses education and training of healthcare providers

Education and Training for Persons Served and/or Families/Support Systems

Standard(s)	Requirements	Person Served	Family/ Support System
Section 1. ASPIRE to Excellence®			
1.H.3.	Education designed to reduce identified physical risks	✓	
1.H.11.b.	Training regarding infections and communicable diseases	✓	
1.J.4.	As appropriate, if services are delivered using information and communication technology, instruction and training on equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting	✓	✓
2.A. Program/Service Structure for all Medical Rehabilitation Programs			
2.A.19.h.	If the program serves persons who require ventilatory assistance, training for persons served and families/support systems	✓	✓
2.A.21.a.(6)(b)–(c)	Education related to identified skin integrity risks that are within the scope of the program	✓	✓
2.A.22.a.(6)(a)–(b)	Education related to identified wound care needs that are within the scope of the program	✓	✓
2.A.26.b.(5)(a)–(b)	Analysis of performance in relationship to established targets for wounds that developed during the program and wounds that worsened during the program includes necessary education and training of persons served and families/support systems	✓	✓
2.B. The Rehabilitation and Service Process for the Persons Served			
2.B.2.	Opportunities available to orient and educate potential persons served about the rehabilitation program(s)	✓	
2.B.25.b.(1), (4)	Interdisciplinary team provides or arranges for each family/ support system, as needed, services including advocacy education, and education		✓
2.B.29.a.	The program fosters a continuous learning environment that provides educational opportunities that reflect individual learning styles, needs, strengths, and preferences	✓	✓
2.B.30.a.–d., g.	Depending upon individual needs, the program provides education and training to each person served that addresses prevention, primary healthcare, utilization of healthcare resources, health promotion, transition to other components of the continuum of services or discharge location	✓	

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
2.B.30.e., f.	Depending upon individual needs, the program provides education and training that addresses the skill sets necessary to be successful in the discharge/transition environment for the persons served and their families/support systems and a mechanism to demonstrate the skills achieved prior to discharge by the persons served and their families/support systems	✓	✓
2.B.31.	The program provides education on medication as appropriate that addresses areas identified in 2.B.31.b.(1)–(12)	✓	✓
2.B.33.d.	The program provides or arranges for instruction and training about equipment and supplies	✓	
2.B.34.c.(1)	If the person served does not have a system or tool in place to record personal health information to provide to healthcare providers and/or in case of an emergency, the program provides education on the importance of having such a system or tool	✓	✓
2.B.35.	The program educates each person served about the importance of developing and updating a record of personal health information that addresses his or her needs	✓	
2.B.39.	Based on an assessment of the learning needs and desires of the person served, the availability of a computer, and access to the internet, the organization provides or arranges for formal and informal educational opportunities	✓	
2.B.42.a.(1), (2)	The program promotes a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behavior	✓	✓
2.B.42.e.(2)	The program promotes a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs		✓
2.C. The Service Process for the Persons Served in Home and Community Services			
2.C.21.	If any children/adolescents served and not seeking accreditation for Pediatric Specialty Program, education and training program for the family/support system addresses areas identified in 2.C.21.a.–k.		✓
2.C.24.b.(1), (4)	If seeking accreditation as a Brain Injury Specialty Program or Stroke Specialty Program, the services provided or arranged for each family/support system, as needed, include advocacy education, and education		✓

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
2.C.25.a.(1), (2)	If seeking accreditation for specialty programs as identified in the applicable standards note, the service promotes a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behavior	✓	✓
2.C.25.e.(2)	The service promotes a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs		✓
2.C.27.c.(1)	If seeking accreditation for specialty programs as identified in the applicable standards notes, if the person served does not have a system or tool in place to record personal health information to provide to healthcare providers and/or in case of an emergency, the program provides education on the importance of having such a system or tool	✓	✓
2.D. The Rehabilitation and Service Process for Specific Diagnostic Categories			
2.D.1.a., i.	If any persons with limb loss served and not seeking accreditation for Amputation Specialty Program, depending on the needs of the persons served, the program/service provides or makes arrangements for limb loss education regarding self-management, and training in the use of durable medical equipment	✓	
2.D.17.	If any persons with spinal cord dysfunction served and not seeking accreditation for Spinal Cord Specialty Program, the program/service provides a systematic education program about spinal cord dysfunction that addresses the areas identified in 2.D.17.d.(1)–(9)	✓	✓
2.D.19.	If any persons with spinal cord dysfunction served and not seeking accreditation for Spinal Cord Specialty Program, the program/service educates persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.	✓	
2.D.20.	If any persons with spinal cord dysfunction served and not seeking accreditation for Spinal Cord Specialty Program, the program/service provides or arranges for education to persons served about paid personal assistant services	✓	
2.E. The Rehabilitation and Service Process for Children and Adolescents Served			
2.E.15.	If any children/adolescents served and not seeking accreditation for Pediatric Specialty Program, the education and training program for the family/support system addresses areas identified in 2.E.15.a.–o.		✓

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
3.A. Comprehensive Integrated Inpatient Rehabilitation Program			
3.A.16.c.(5)(a), (b)	Analysis of information on durability addresses necessary education and training of persons served and families/support systems	✓	✓
3.B. Outpatient Medical Rehabilitation Program			
3.B.4.b.(5)(a), (b)	Analysis of no-shows, cancellations, and dropouts addresses necessary education and training of persons served and families/support systems	✓	✓
3.C. Home and Community Services			
3.C.10.a.(8)	In accordance with the choice of the person served, home and community services partner with the family/support system throughout the service delivery process, including ongoing consideration of the family/support system's educational needs		✓
3.C.12.b.	The home and community services provide education in accordance with identified needs that addresses areas identified in 3.C.12.b.(1)–(9)	✓	✓
3.C.17.	Depending on individual needs, the home and community services provide ongoing education and training to each person served that addresses areas identified in 3.C.17.a.–f.	✓	
3.C.18.	The home and community services provide education on medication as appropriate that addresses areas identified in 3.C.18.b.(1)–(14)	✓	✓
3.D. Residential Rehabilitation Program			
3.D.19.	Education if needed regarding end-of-life choices	✓	✓
3.F. Interdisciplinary Pain Rehabilitation Program			
3.F.19.b.	Education on the efficacy and safety of interventions related to use of complementary health approaches	✓	
3.F.25.e.(1), (2)	If drug screening is provided, policies and written procedures address drug-screening practices including education for persons served and families/support systems	✓	✓
3.F.30.a.	Education and training regarding nature and value of interdisciplinary pain rehabilitation	✓	
3.F.32.b.(5)(a), (b)	Analysis of no-shows, cancellations, and dropouts addresses necessary education and training of persons served and families/support systems	✓	✓

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
3.F.33.b.(5)(a), (b)	Analysis of indictors addresses necessary education and training of persons served and families/support systems	✓	✓
3.G. Occupational Rehabilitation Program			
3.G.7.d.	On a systematic, organized basis, and based on the needs of the persons served, the program provides or arranges for education on safe work practices	✓	
3.G.8.c.	Dependent on the needs of the persons served, services provided include education about injury prevention	✓	
3.G.14.c.(5)(a), (b)	Analysis of information on work capability of persons served at discharge and follow-up information includes necessary education and training of persons served and families/support systems	✓	✓
3.I. Case Management			
3.I.27.a.(1), (2)	When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behaviors	✓	✓
3.I.27.e.(2)	When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that addresses training in the implementation of behavior management programs for families/support systems		✓
3.I.29.b.(5)(a), (b)	Analysis of information on changes in severity of conditions, comorbidity, mortality, and nonmedical interruptions in the delivery of services addresses necessary education of persons served and families/support systems	✓	✓
4.A. Pediatric Specialty Program			
4.A.13.	Education and training program for the child/adolescent served addresses, as developmentally and age appropriate and based on need, the areas identified in 4.A.13.a.–k.	✓	
4.A.14.	Education and training program for the family/support system, based on need, addresses the areas identified in 3.F.14.a.–o.		✓

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
4.B. Amputation Specialty Program			
4.B.7.a., h.	Depending on the needs of the persons served, the program/ service provides or makes arrangements for limb loss education regarding self-management, and training in the use of durable medical equipment	✓	
4.B.13.	Education facilitates self-management and addresses the areas identified in 3.G.13.c.(1)–(31)	✓	✓
4.B.17.c.(5)(a)–(b)	Analysis of information gathered on persons served includes necessary education and training of persons served and families/support systems	✓	✓
4.C. Brain Injury Specialty Program			
4.C.21.	The program provides an organized education program about brain injury that addresses the areas identified in 3.H.21.b.(1)–(15)	✓	✓
4.C.22.a.	Education on respite care	✓	✓
4.C.33.b.(5)(a), (b)	Analysis of satisfaction information addresses necessary education and training of persons served and families/support systems	✓	✓
4.D. Cancer Rehabilitation Specialty Program			
4.D.12.a.(8)	Based on individual needs, the program provides or arranges for services to address identified educational needs	✓	
4.D.14.b.	Education on the efficacy and safety of interventions related to the use of complementary health approaches	✓	
4.D.19.c.	Education, if needed, regarding end-of-life choices	✓	✓
4.D.21.	Demonstration of how education is coordinated, is reinforced, is age and culturally appropriate, fosters self-management, and addresses, as appropriate to needs, the areas identified in 3.I.21.f.(1)–(5)	✓	✓
4.D.26.a.	Education and training regarding nature and value of cancer rehabilitation	✓	
4.D.31.b.(5)(a), (b)	Analysis of follow-up information addresses necessary education and training of persons served and families/support systems	✓	✓

Education and Training for Persons Served and/or Families/Support Systems (Continued)

Standard(s)	Requirements	Person Served	Family/ Support System
4.E. Spinal Cord Specialty Program			
4.E.9.	Organized education program about spinal cord dysfunction that addresses the areas identified in 4.E.9.d.(1)–(9)	✓	✓
4.E.11.	Education for persons served regarding the consequences associated with choices and behaviors that pose a potential risk to their health or safety.	✓	
4.E.13.	Education about personal assistance services	✓	
4.E.18.	Instruction in adaptive sports, recreation, and arts	✓	
4.E.21.b.(5)(a)–(b)	Analysis of follow-up information addresses necessary education and training of persons served and families/support systems	✓	✓
4.F. Stroke Specialty Program			
4.F.8.b.	Education on the efficacy and safety of interventions related to use of complementary health approaches	✓	
4.F.12.	Education regarding consequences associated with choices and behaviors that pose a potential risk to health and safety	✓	
4.F.13.	Demonstration of how education is coordinated, is reinforced, is age appropriate, fosters self-management, and addresses the areas identified in 3.K.13.f.(1)–(20)	✓	✓
4.F.20.b.(5)(a), (b)	Analysis of follow-up information addresses necessary education and training of persons served and families/support systems	✓	✓
4.F.24.b.(5)(a), (b)	Analysis of discharge/transition information addresses necessary education and training of persons served and families/support systems	✓	✓

Education and Training for Other Stakeholders

Standard(s)	Requirements	Stakeholder
Section 1. ASPIRE to Excellence®		
1.A.6.c.	Education on ethical codes of conduct	Other stakeholders
1.B.2.b., d.	Governance policies address board member orientation and board education	Board members

Education and Training for Other Stakeholders (Continued)

Standard(s)	Requirements	Stakeholder
1.H.11.b.(1)	Training regarding infections and communicable diseases	Other stakeholders
1.H.12.g.	If transportation is provided for the persons served, training of drivers regarding the organization's transportation procedures and the unique needs of the persons served	Drivers
1.J.4.	As appropriate, if services are delivered using information and communication technology, instruction and training on equipment features, set up, use, maintenance, safety considerations, infection control, and troubleshooting	Others, as appropriate
2.A. Program/Service Structure for all Medical Rehabilitation Programs		
2.A.15.e.(5)(b), (c)	Written analysis of all denials, service referrals determined to be ineligible, and all interrupted services addresses necessary education and training	Payers and regulatory agencies
2.A.24.c.	Education to optimize outcomes for persons served with skin integrity and wound care needs	Other healthcare providers
2.B. The Rehabilitation and Service Process for the Persons Served		
2.B.42.a.(3)	The program promotes a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behavior	Community members with whom the persons served regularly interact
2.C. The Service Process for the Persons Served in Home and Community Services		
2.C.25.a.(3)	If seeking accreditation for specialty programs as identified in applicable standards notes, the service promotes a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behavior	Community members with whom the persons served regularly interacts
3.A. Comprehensive Integrated Inpatient Rehabilitation Program		
3.A.15.b.(5)(b), (c)	Analysis of information on unplanned transfers to acute medical facilities, discharges to long-term care, and expiration addresses necessary education and training of payers and regulatory agencies	Payers and regulatory agencies
3.A.16.c.(5)(c)	Analysis of information on durability addresses necessary education and training of healthcare providers	Healthcare providers
3.C. Home and Community Services		
3.C.12.	The home and community services provide education in accordance with identified needs that addresses areas identified in 3.C.12.b.(1)–(9)	Other relevant stakeholders

Education and Training for Other Stakeholders (Continued)

Standard(s)	Requirements	Stakeholder
3.F. Interdisciplinary Pain Rehabilitation Program		
3.F.30.b., c.	Education and training regarding nature and value of interdisciplinary pain rehabilitation	External stakeholders and the general public
3.F.33.b.(5)(c)	Analysis of indictors addresses necessary education and training of healthcare providers	Healthcare providers
3.F.38.b.(5)(b), (c)	Analysis of information on discharges to long-term care, expiration, and unplanned transfers to acute medical facilities addresses necessary education and training of payers and regulatory agencies	Payers and regulatory agencies
3.G. Occupational Rehabilitation Program		
3.G.7.e.	On a systematic, organized basis, and based on the needs of the persons served, the program provides or arranges for education of the employer and/or employee representative as to the implications of the present status of the person served	Employers; employee representatives
3.G.14.c.(5)(d)	Analysis of information on work capability of persons served at discharge and follow-up information includes necessary education and training of others	Others
3.I. Case Management		
3.I.27.a.(3)	When services/programs used by case management use interventions to change behavior, case management verifies that the interventions promote a positive, consistent, therapeutic approach to behavior management that addresses education through modeling of socially and culturally acceptable behavior	Community members with whom the persons served regularly interacts
3.I.29.b.(5)(d)	Analysis of information on changes in severity of conditions, comorbidity, mortality, and nonmedical interruptions in the delivery of services address necessary education of others	Others
4.B. Amputation Specialty Program		
4.B.9.	Training of peer supporters	Peer supporters
4.C. Brain Injury Specialty Program		
4.C.29.	Efforts to educate the community about prevention of traumatic brain injury, impact of acquired brain injury, need for brain injury rehabilitation, accessibility and reasonable accommodation, and inclusion	Community
4.C.33.b.(5)(c)	Analysis of satisfaction information addresses necessary education and training of healthcare providers	Healthcare providers

Education and Training for Other Stakeholders (Continued)

Standard(s)	Requirements	Stakeholder
4.D. Cancer Rehabilitation Specialty Program		
4.D.26.b., c.	Education and training regarding the nature and value of cancer rehabilitation	External stakeholders and the general public
4.D.27.	Acts as a resource to providers from acute through community-based services regarding training of personnel in cancer rehabilitation	Personnel of other providers from acute through community-based services
4.D.31.b.(5)(c)	Analysis of follow-up information addresses necessary education and training of healthcare providers	Healthcare providers
4.E. Spinal Cord Specialty Program		
4.E.14.b.	Competency-based training for peer supporters (Frequency: initial and ongoing)	Peer supporters
4.E.21.b.(5)(c)–(d)	Analysis of follow-up information addresses necessary education and training of persons served and families/support systems	Healthcare providers and others as appropriate
4.E.23.	Efforts to educate the community about prevention of spinal cord dysfunction, spinal cord dysfunction, services for people with spinal cord dysfunction, accessibility, and reasonable accommodations	Community
4.F. Stroke Specialty Program		
4.F.18.	Acts as a resource to providers from emergency through community-based services regarding training of personnel in stroke rehabilitation	Personnel of other providers from acute through community-based services
4.F.20.b.(5)(c)	Analysis of follow-up information addresses necessary education and training of healthcare providers	Healthcare providers
4.F.24.b.(5)(c)	Analysis of discharge/transition information addresses necessary education and training of healthcare providers	Healthcare providers

Appendix D

Resources

Following are some resources that may be helpful to your organization in implementing or conforming to the CARF standards. Resources are organized by topic and may be relevant to multiple standards.

CARF does not endorse or expect the use of any specific products, companies, or resources. Resources listed are not inclusive of all resources available on a topic and are provided as guidance only.

Resources include references to websites, organizations, and publications. When available, links are provided. Some websites contain multiple helpful resources.

Resources and links may change or be updated periodically. Please visit the CARF website **www.carf.org/resources** for current resource listings throughout the year.

If you discover a broken link, or would like to submit a resource you feel may be helpful, please submit your feedback for consideration to **documents@carf.org**.

Accessibility

- Americans with Disabilities Act, U.S. Department of Justice
  www.ada.gov
- Amputee Coalition, Limb Loss Resource Center, Adaptive Technology
  www.amputee-coalition.org/limb-loss-resource-center/resources-by-topic/adaptive-technology/index.html
- National Public Website on Assistive Technology
  assistivetech.net
- United States Access Board
  www.access-board.gov/guidelines-and-standards
- Voting, U.S. Department of Justice
  www.justice.gov/crt/about/vot
- World Wide Web Consortium Web Accessibility Initiative
  www.w3.org/WAI
- Ontario accessibility laws
  www.ontario.ca/page/accessibility-laws

Assistive technology

CARF does not endorse specific products or companies. The following list provides links to a variety of technology products and services currently available.

- Michigan Disability Rights Coalition, Michigan Assistive Technology Program
  www.mymdrc.org/assistive-tech
- Training Assistive Technology in the Environment (TATE), Center on Brain Injury Research and Training
  www.cbirt.org/our-projects/training-assistive-technology-environment-tate
- Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)
  www.resna.org/about/consumer-and-public-information
- Assistive technology industry associations

Cancer rehabilitation resources

CARF acknowledges and thanks Nicole L. Stout, DPT, CLT-LANA, for her contributions to and assistance with identifying resources for this section.

- Silver, J. K., Baima, J. and Mayer, R. S. (2013), Impairment-driven cancer rehabilitation: An essential component of quality care and survivorship. CA: A Cancer Journal for Clinicians, 63: 295-317. doi: 10.3322/caac.21186
- **http://onlinelibrary.wiley.com/doi/10.3322/caac.21186/abstract**
- Brief Pain Inventory (BPI):
  www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html
- M.D. Anderson Symptom Inventory (MDASI):
  www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/mdanderson-symptom-inventory.html
- Brief Fatigue Inventory (BFI):
  www.mdanderson.org/education-and-research/departments-programs-and-labs/departments-and-divisions/symptom-research/symptom-assessment-tools/brief-fatigue-inventory-bfi.html
- Functional Assessment of Cancer Therapy:
  www.facit.org/FACITOrg/Questionnaires
- Comprehensive Inventory of Functioning-Cancer:
  www.ncbi.nlm.nih.gov/pubmed/17510584
- Oncology Section, American Physical Therapy Association
  www.oncologypt.org
- Voice and Voice Disorders Special Interest Group, American Speech-Language-Hearing Association
  www.asha.org/SIG/03
- American Cancer Society
  www.cancer.org

- American Congress of Rehabilitation Medicine
  www.acrm.org
- International Society of Physical and Rehabilitation Medicine
  Scientific Committee on Cancer Rehabilitation
  www.isprm.org
- National Cancer Institute
  www.cancer.gov
- American Society of Clinical Oncology
  www.asco.org
- National Academies of Medicine:
  - **www.nationalacademies.org/hmd/Reports/2005/From-Cancer-Patient-to-Cancer-Survivor-Lost-in-Transition.aspx**
  - **www.nationalacademies.org/hmd/Reports/2013/Delivering-High-Quality-Cancer-Care-Charting-a-New-Course-for-a-System-in-Crisis.aspx**

- Canadian Association of Psychosocial Oncology (CAPO)
  www.capo.ca

- Cancer Care Ontario
  www.cancercare.on.ca

- American Society of Clinical Oncology
  - **www.asco.org**
  - **www.asco.org/practice-guidelines/quality-guidelines/guideline**s
- National Comprehensive Cancer Network (NCCN)
  www.nccn.org
- Oncology Nursing Society Putting Evidence into Practice (PEP)
  www.ons.org/practice-resources/pep
- American Physical Therapy Association, Oncology Section
  www.oncologypt.org
- Wiley Online Library:
  - Ca: A Cancer Journal for Clinicians
    http://onlinelibrary.wiley.com/journal/10.3322/(ISSN)1542-4863
  - Cancer
    http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-0142
  - European-American Dialogues on Cancer Survivorship: Current Perspectives and Emerging Issues, Supplemental issue of Cancer journal
    http://onlinelibrary.wiley.com/doi/10.1002/cncr.v119.S11/issuetoc
  - A Prospective Surveillance Model for Rehabilitation for Women with Breast Cancer
    http://onlinelibrary.wiley.com/doi/10.1002/cncr.v118.8s/issuetoc
- Livestrong
  www.livestrong.org
- Cancer Rehabilitation Networking Group—An interdisciplinary cancer rehabilitation network, American Congress of Rehabilitation Medicine
  www.acrm.org/acrm-communities/cancer

- American Occupational Therapy Association
  www.aota.org/Practice/Rehabilitation-Disability/Emerging-Niche/Cancer.aspx
- Center for Medicare and Medicaid Innovation (CMMI)
  https://innovation.cms.gov/initiatives/oncology-care/
- Commission on Cancer
  https://www.facs.org/quality-programs/cancer/coc/standards
- American College of Surgeons
  www.facs.org/search/cancer-program
- American Association for Cancer Research (AACR)
  www.aacr.org
- Cancer.net—Patient information from the American Society for Clinical Oncology
  www.cancer.net
- National Hospice and Palliative Care Organization
  www.nhpco.org
- National Cancer Institute Designated Cancer Centers
  www.cancer.gov/research/nci-role/cancer-centers
- Association of Community Cancer Centers
  www.accc-cancer.org
- Archives of Physical Medicine and Rehabilitation—Toward a National Initiative in Cancer Rehabilitation: Recommendations from a Subject Matter Expert Group
  www.archives-pmr.org/article/S0003-9993(16)30182-4/pdf

Clinical trials

- Registry and results database of clinical studies, U.S. National Institutes of Health
  www.clinicaltrials.gov
- Stroke Trials Registry, Internet Stroke Center, Washington University School of Medicine
  www.strokecenter.org/trials
- CenterWatch Clinical Trials
  www.centerwatch.com
- National Cancer Institute Clinical Trials
  www.cancer.gov/about-cancer/treatment/clinical-trials
- American Society of Clinical Oncology
  www.asco.org/research-progress/clinical-trials/clinical-trial-resources
- National Cancer Institute Community Oncology Research Program
  www.ncorp.cancer.gov/about/
- Patient Advocate Foundation
  www.patientadvocate.org/resources.php?p=42

Complementary health approaches

- National Center for Complementary and Integrative Health (NCCIH)
  nccih.nih.gov
- National Cancer Institute Pain Control: Support for People with Cancer
  www.cancer.gov/publications/patient-education/pain-control

- National Cancer Institute: Complementary and Alternative Medicine
  www.cancer.gov/about-cancer/treatment/cam
- National Institutes of Health Office of Dietary Supplements
  ods.od.nih.gov
- MedlinePlus Herbs and Supplements
  www.nlm.nih.gov/medlineplus/druginfo/herb_All.html
- American Cancer Society Complementary and Alternative Medicine
  www.cancer.org/treatment/treatmentsandsideeffects/complementaryandalternativemedicine/index
- US Food and Drug Administration Dietary Supplements
  www.fda.gov/food/dietarysupplements
- Mayo Clinic: **www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/alternative-medicine/art-20045267**
- Public Health Agency of Canada
  www.phac-aspc.gc.ca/chn-rcs/cah-acps-eng.php

Conceptual framework and terminology for the standards

- World Health Organization
  www.who.int
- Towards a Common Language for Functioning, Disability, and Health
  www.who.int/classifications/icf/training/icfbeginnersguide.pdf

Corporate compliance

- Office of Inspector General, U.S. Department of Health and Human Services:
  - **http://oig.hhs.gov**
  - **http://oig.hhs.gov/compliance/101/index.asp**
  - **http://oig.hhs.gov/compliance/compliance-guidance/index.asp**
  - Health Care Fraud Prevention and Enforcement Actions Team (HEAT), comparison of anti-kickback statute and Stark Law
    https://oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf
  - **http://exclusions.oig.hhs.gov/**
- System for Award Management (exclusion)
  www.sam.gov/portal/public/SAM/
- Centers for Medicare and Medicaid Services (CMS):
  - Regulations and guidance
    www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html?redirect=/home/regsguidance.asp
  - Outreach and education
    www.cms.gov/Outreach-and-Education/Outreach-and-Education.html

- Federal Register (final rulings for regulations)
  www.federalregister.gov
- U.S. Department of Health and Human Services, Office for Civil Rights
  www.hhs.gov/ocr/office/index.html
- Health Insurance Portability and Accountability Act (HIPAA)
  www.hhs.gov/hipaa/index.html
- Health Information Technology for Economic and Clinical Health Act (HITECH)
  www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html
- U.S. Department of Justice, Civil Right Division, Americans with Disabilities Act (ADA)
  www.ada.gov/
- Social Security (Title XIX, grants to states for medical assistance programs)
  www.ssa.gov/OP_Home/ssact/title19/1900.htm

Cultural competency and diversity

- Professional, educational, and advocacy organizations
- The Society of Human Resource Management
  www.shrm.org
- The Seven Dimensions of Culture
  www.mindtools.com/pages/article/seven-dimensions.htm
- National Center for Cultural Competence, Georgetown University
  nccc.georgetown.edu
- Culture, Language and Health Literacy, Health Resources and Services Administration, U.S. Department of Health and Human Services
  www.hrsa.gov/culturalcompetence/index.html
- Think Cultural Health, U.S. Department of Health and Human Services
  www.thinkculturalhealth.hhs.gov
- LGBT Cultural Competency, U.S. Department of Health and Human Services:
  www.hhs.gov/programs/topic-sites/lgbt/enhanced-resources/competency-training/index.html
- 2016 National Quality and Disparities Report: **https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/nhqdr16/2016qdr.pdf**

Education for persons served, families/support systems, and caregivers

- Find Good Health Information, Medical Library Association
  www.mlanet.org/resources/userguide.html
- National Stroke Association Lifelong Education and Advocacy Program
  www.stroke.org/search/node/LEAP
- Next Step in Care
  www.nextstepincare.org

- Toolkit: Medication Management, Next Step in Care
  www.nextstepincare.org/providers/toolkit/medication/
- National Stroke Association
  www.stroke.org/stroke-resources/resource-library
- StrokeSmart Magazine, National Stroke Association
  www.stroke.org/stroke-resources/strokesmart-magazine
- Facing Forward: Life After Cancer Treatment
  www.cancer.gov/publications/patient-education/facing-forward
- Limb Loss Resource Center, Amputee Coalition
  www.amputee-coalition.org/limb-loss-resource-center
- Brain Injury Association of America
  www.biausa.org/brain-injury-community.htm
- Personal Care Manuals and Guides, Shepherd Center
  www.shepherd.org/resources/ebooks
  - Personal Care Manual: Education–The Key to Independence (Spinal Cord Injury)
  - Brain Injury: A Guide for Caregivers Brain Injury: A Guide for Caregivers
  - Spinal Cord Injury: A Guide for Caregivers
  - Living with Stroke: Strategies to Live A Healthy Life Living with Stroke
  - How to Successfully Hire and Manage a Personal Care Assistant for People with Spinal Cord Injury
- Facing Disability for families facing spinal cord injuries
  www.facingdisability.com
- Paralyzed Veterans of America Clinical Practice Guidelines & Consumer Guides:
  www.pva.org/site/c.ajIRK9NJLcJ2E/b.6305831/k.4943/Clinical_Practice_Guidelines__Consumer_Guides.htm

Emergency preparedness education for persons served and other stakeholders

- Prepare My Family for a Disaster, U.S. Department of Homeland Security
  www.dhs.gov/how-do-i/prepare-my-family-disaster
- Inclusive Preparedness Center, Inclusion Research Institute
  www.inclusivepreparedness.org
- Occupational Safety and Health Administration, U.S. Department of Labor
  www.osha.gov/SLTC/emergencypreparedness/index.html
- Office of Disability Employment Policy, U.S. Department of Labor
  www.dol.gov/odep/topics/EmergencyPreparedness.htm
- Emergency Preparedness
  www.disability.gov
- Emergency Preparedness, Harris Family Center for Disability and Health Policy
  hfcdhp.org/products
- Disaster Resources for People with Disabilities and Others with Access and Functional Needs, Emergency Managers & Planners & Disability-focused

Organizations, June Isaacson Kailes
www.jik.com/disaster.html

- disability911: Disaster Preparedness for People with Disabilities
  www.ilru.org/projects/disability911
- Disasters and Emergency Management, Disasters U.S.
  http://www.disastersrus.org/MyDisasters/disability/disability_preparedness.htm
- Federal Emergency Management
  www.ready.gov
  www.listo.gov (Spanish)
- Emergency Preparedness, Amputee Coalition of America
  www.amputee-coalition.org/limb-loss-resource-center/resources-by-topic/emergency-preparedness
- When Disaster Strikes-A Pocket Survival Guide, Amputee Coalition of America
  www.amputee-coalition.org/resources/when-disaster-strikes/
- Get Ready Quick, Totally Unprepared
  www.totallyunprepared.com/get-ready-quick
- National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities, National Resource Center
  www.diversitypreparedness.org
- The International Red Cross and Red Crescent Movement:
  www.icrc.org/en/who-we-are/movement
- Disaster Recovery Information Exchange
  www.drie.org
- Public Safety Canada
  www.publicsafety.gc.ca
- Canadian Red Cross
  www.redcross.ca
- Get Prepared
  www.getprepared.gc.ca/

Emergency preparedness, planning, and procedures

- Federal and state/provincial/territorial regulations
- City/municipal and county disaster preparedness groups
- Local Red Cross associations
  www.redcross.org
- Research and Training Center of Independent Living, Emergency Preparedness
  www.rtcil.org/emergencypreparedness
- Developing and Maintaining Emergency Operations Plans, Federal Emergency Management Agency (FEMA)
  www.fema.gov/media-library/assets/documents/25975?id=5697
- Emergency Preparedness, Disability.gov
  www.disability.gov

- An ADA Guide for Local Governments, U.S. Department of Justice
  www.ada.gov/emergencyprepguide.htm
- Prepare My Family for a Disaster, U.S. Department of Homeland Security
  www.dhs.gov/how-do-i/prepare-my-family-disaster
- Inclusive Preparedness Center, Inclusion Research Institute
  www.inclusivepreparedness.org
- Emergency Preparedness and Response, Occupational Safety and Health Administration, U.S. Department of Labor
  www.osha.gov/SLTC/emergencypreparedness/index.html
- Emergency Preparedness, Office of Disability Employment Policy, U.S. Department of Labor
  www.dol.gov/odep/topics/EmergencyPreparedness.htm
- Emergency Preparedness, Harris Family Center for Disability and Health Policy
  hfcdhp.org/products
- Checklist for Integrating People with Disabilities and Others with Access and Functional Needs into Emergency Preparedness, Planning, Response & Recovery, Harris Family Center for Disability and Health Policy, June Isaacson Kailes
  www.jik.com/plancklst.pdf
- Disaster Resources for People with Disabilities and Others with Access and Functional Needs, Emergency Managers & Planners & Disability-focused Organizations, June Isaacson Kailes
  www.jik.com/disaster.html
- disaster 911: Disaster Preparedness for People with Disabilities
  www.ilru.org/projects/disability911/
- Emergency Preparedness, Amputee Coalition of America
  www.amputee-coalition.org/limb-loss-resource-center/resources-by-topic/emergency-preparedness
- When Disaster Strikes-A Pocket Survival Guide, Amputee Coalition of America
  www.amputee-coalition.org/resources/when-disaster-strikes
- Public Health Emergency planning for users of electrical powered medical and assistive devices
  www.phe.gov/empowermap/Pages/default.aspx
- Public Health Emergency planning for active-shooter incidents
  www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf
- Tips for Retaining and Caring for Staff after a Disaster:
  https://asprtracie.s3.amazonaws.com/documents/tips-for-retaining-and-caring-for-staff-after-disaster.pdf
- After the Disaster: Recovery:
  https://naricspotlight.wordpress.com/2017/08/28/after-the-disaster-recovery/
- Disaster Recovery Information Exchange
  www.drie.org
- Public Safety Canada
  www.publicsafety.gc.ca

- Canadian Red Cross
  www.redcross.ca

Evidence-based practice and research

- Professional associations
- National Rehabilitation Information Center
  www.naric.com
- American Physical Therapy Association Hooked on Evidence
  www.hookedonevidence.com
- American Speech-Language-Hearing Association Practice Portal
  www.asha.org/Practice-Portal
- American Occupational Therapy Association
  www.aota.org/Practice/Rehabilitation-Disability/Evidence-Based.aspx
- Centers for Disease Control and Prevention
  - **www.cdc.gov/TraumaticBrainInjury**
  - **www.cdc.gov/Stroke**
- Veterans Health Initiative:
  - **www.publichealth.va.gov/vethealthinitiative/traumatic_brain_injury.asp**
  - **www.publichealth.va.gov/vethealthinitiative/spinal_cord.asp**
  - **www.publichealth.va.gov/vethealthinitiative/traumatic_amputation.asp**
- National Center for Dissemination of Disability Research
  www.ncddr.org
- Center on Knowledge Translation for Disability and Rehabilitation Research (KTDRR)
  www.ktdrr.org
- Rehabilitation Research and Development, U.S. Department of Veterans Affairs
  www.rehab.research.va.gov
- Center for International Rehabilitation Research Information and Exchange
  www.cirrie.buffalo.edu
- National Institute for Health and Care Excellence
  www.nice.org.uk/guidance
- Generalized search for Peer-reviewed articles, books, abstracts and articles
  www.scholar.google.com
- U.S. National Library of Medicine, National Institutes of Health
  www.ncbi.nlm.nih.gov/pubmed/
- National Guidelines Clearinghouse, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
  www.guideline.gov
- Clinical Search Engine, Trip
  www.tripdatabase.com
- Common Data Elements, NINDS, National Institute of Health (NIH)
  www.commondataelements.ninds.nih.gov

- Evidence Based Practice, American Congress of Rehabilitation Medicine
  www.acrm.org/resources
- American Heart Association
  www.heart.org/HEARTORG/HealthcareResearch/Healthcare-Research_UCM_001093_SubHomePage.jsp
- American Diabetes Association
  www.diabetes.org
- Clinical Practice Recommendations, American Diabetes Association
  professional.diabetes.org
- Management of Stroke Rehabilitation, U.S. Department of Veterans Affairs
  www.healthquality.va.gov/guidelines/Rehab/stroke/
- Guidelines for the Prevention of Stroke in Patients With Stroke or Transient Ischemic Attack
  stroke.ahajournals.org/content/strokeaha/42/1/227.full.pdf
- Stroke, American Heart Association
  stroke.ahajournals.org
- Evidence-Based Review of Stroke Rehabilitation, The Canadian National Survey on Rehabilitation Practices for Stroke
  www.ebrsr.com
- Evidence-Based Neurological Practice Neurology Section, American Physical Therapy Association (APTA)
  http://www.neuropt.org/professional-resources/evidence-based-neurologic-practice
- Advances in Clinical Neuroscience and Rehabilitation (ACNR)
  www.acnr.co.uk
- Neuro-QOL, National Institute of Neurological Disorders and Stroke (NINDS)
  www.neuroqol.org
- Federal Interagency Traumatic Brain Injury Research database (FITBIR), National Institutes of Health (NIH)
  https://fitbir.nih.gov
- The Center for Outcome Measurement in Brain Injury (COMBI)
  www.tbims.org/combi
- elearnSCI, International Spinal Cord Society
  www.elearnsci.org
- Spinal Cord Injury Rehabilitation Evidence (SCIRE)
  www.scireproject.com
- Spinal Cord Outcomes Partnership Endeavor
  www.scopesci.org
- International Campaign for Cures of Spinal Cord Injury Paralysis (ICCP)
  www.campaignforcure.org

Health literacy

- Health Literacy Out Loud:
  www.healthliteracyoutloud.com
- Health Literacy Information, Rehabilitation Institute of Chicago
  www.ric.org/research/centers/cror/projects/rrtc/quality/health-literacy
- Health Literacy, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
  www.ahrq.gov/health-care-information/topics/topic-health-literacy.html
- The Patient Education Materials Assessment Tool (PEMAT) and User's Guide, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
  www.ahrq.gov/pemat
- Health Literacy: A Toolkit for Communicators, America's Health Insurance Plans
  www.ahip.org/HealthLiteracy
- Center for Plain Language
  www.centerforplainlanguage.org
- Health Literacy, National Network of Libraries of Medicine (NNLM)
  nnlm.gov/professional-development/topics/health-literacy
- About Health Literacy, Health Resources and Services Administration, U.S. Department of Health and Human Services
  www.hrsa.gov/about/organization/bureaus/ohe/healthliteracy/index.html
- Canada's Public Health Leader
  www.cpha.ca/en/pls.aspx
- Directory of Plain Language Health Information, Canadian Public Health Association
  www.cpha.ca/uploads/portals/h-l/directory_e.pdf
- Language Portal of Canada
  www.noslangues-ourlanguages.gc.ca
- Literacy and Clear Language, Decoda Literacy Solutions
  www.decoda.ca/resources
- Canadian Literacy and Learning Network
  www.literacy.ca/?q=literacy/clearwriting

Home care

- World Homecare and Hospice Association
  www.whho.org
- National Association of Home Care and Hospice
  www.nahc.org
- Canadian Home Care Association
  www.cdnhomecare.ca

Infection control

- State or provincial/territorial departments of health outbreak manuals
- Centers for Disease Control and Prevention
  www.cdc.gov
- Association for Professionals in Infection Control and Epidemiology
  www.apic.org
- MRSA Educational Toolkit developed by SCI QUERI:
  www.queri.research.va.gov/tools/sci_mrsa/
- Public Health Agency of Canada
  www.phac-aspc.gc.ca
- Infection Prevention and Control Canada
  www.ipac-canada.org

Information and communication technologies

- American Telemedicine Association
  www.americantelemed.org
- VA Telehealth Services
  www.telehealth.va.gov/real-time
- International Journal of Telerehabilitation
  telerehab.pitt.edu/ojs/index.php/Telerehab
- U.S. Department of Health and Human Services Health Resources and Services Administration
  www.hrsa.gov/ruralhealth/telehealth
- Department of Health and Human Services Centers for Medicare & Medicaid Services Telehealth Services
  www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
- Center for Connected Health Policy National Telehealth Policy Resource Center
  http://cchpca.org
- The Canadian Medical Protective Association:
  www.cmpa-acpm.ca/en/advice-publications/browse-articles/2013/tele-medicine-challenges-and-obligations

Peer support services and training for peer supporters

- Amputee Coalition Certified Peer Visitor (CPV) program
  www.amputee-coalition.org/support-groups-peer-support/certified-peer-visitor-program
- Christopher and Dana Reeve Foundation
  www.christopherreeve.org/get-involved/become-a-peer-mentor/overview
- Hanger Clinic Amputee Support Group and Resource Center
  www.hangerclinic.com/new-patient/ampower/Pages/Peer-Support.aspx
- United Spinal Association
  www.spinalcord.org/spinal-network/support-groups/

- Apparelyzed—Spinal cord injury peer support
  www.apparelyzed.com
- Back Up Trust.org
  www.backuptrust.org.uk/mentor
- Spinalpedia
  https://spinalpedia.com/index.php
- The Brain Injury Peer Visitor Association
  www.braininjurypeervisitor.org
- CARF.org
  www.carf.org/blogpost.aspx?id=25762&blogid=499
- Hanger Clinic Amputee Support Group and Resource Center:
  www.hanger.com/doing/Pages/aep.aspx
- Families facing spinal cord injuries:
  https://facingdisability.com

Performance Measurement, Management, and Improvement

- Rehabilitation Measures Database:
  www.rehabmeasures.org/rehabweb/allmeasures.aspx?PageView=Shared
- Agency for Healthcare Rehabilitation and Quality:
  www.ahrq.gov
- American Hospital Association Committee on Performance Improvement:
  www.aha.org/about/org/cpi.shtml

Person-centered care

- Person-centred care: from ideas to action, The Health Foundation
  www.health.org.uk/publication/person-centred-care-ideas-action
- Institute for Patient- and Family-Centered Care:
  www.ipfcc.org/about/pfcc.html

Personal health information systems and tools

CARF does not endorse or expect the use of specific products. The following list provides links to a variety of tools currently available.

- Emergency Health Information: Savvy Health Care Consumer Series, Harris Family Center for Disability and Health Policy
  www.hfcdhp.org/products
- Building Your Care Notebook, National Center For Medical Home Implementation
  www.medicalhomeinfo.org/for_families/care_notebook
- myPHR, American Health Information Management Association
  www.myphr.com

- NoMoreClipboard.com
  www.nomoreclipboard.com
- Your Family Member's Personal Health Record, Next Step in Care
  www.nextstepincare.org/caregiver_home/Personal_Health_Record
- My health*e*Vet, U.S. Department of Veterans Affairs
  www.myhealth.va.gov
- Taking Care of Myself: A Guide for When I Leave the Hospital, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services:
  - **www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome/index.html**
  - **www.ahrq.gov/patients-consumers/diagnosis-treatment/hospitals-clinics/goinghome-esp/goinghomesp.html** (Spanish)

Protection and advocacy

- National Disability Rights Network
  www.ndrn.org

Skin integrity and wound care

- American Board of Wound Management
  www.abwmcertified.org
- Registered Nurses' Association of Ontario
  rnao.ca/bpg/guidelines/pressure-injuries
- Evidence-Based Approach to Advanced Wound Care Products
  www.ncbi.nlm.nih.gov/pubmed/26429618
- Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury: A Clinical Practice Guideline for Health-Care Professionals
  www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/CPG_Pressure%20Ulcer.pdf
- European Pressure Ulcer Advisory Panel
  www.epuap.org
- National Pressure Ulcer Advisory Panel
  www.npuap.org
- Wound, Ostomy and Continence Nurses Society (WOCN)
  www.wocn.org
- Wounds a Compendium of Clinical Research and Practice
  www.woundsresearch.com/node
- Wounds International
  www.woundsinternational.com
- Association for the Advancement of Wound Care
  aawconline.org
- Braden Scale for Predicting Pressure Sore Risk
  www.bradenscale.com/images/bradenscale.pdf
- United Spinal Association
  www.unitedspinal.org/our-programs

Social media

- CDC Social Media Tools, Guidelines & Best Practices, Centers for Disease Control and Prevention
  www.cdc.gov/SocialMedia/Tools/guidelines/?s_cid=tw_eh_78
- Policy Database, Social Media Governance
  www.socialmediagovernance.com/policies.php?f=4

Suicide Prevention Training

- Connect Suicide Prevention/Intervention Training:
  www.theconnectprogram.org
- Suicide Prevention Resource Center—Assessing and Managing Suicide Risk:
  www.sprc.org/training-institute/amsr
- SAFETALK:
  www.livingworks.net/programs/safetalk/
- QPR Institute:
  www.qprinstitute.com
- ASIST:
  www.livingworks.net/programs/asist
- Zero Suicide Toolkit:
  http://zerosuicide.sprc.org/toolkit
- American Foundation for Suicide Prevention:
  www.afsp.org
- Suicide Awareness Voices of Education:
  www.save.org
- The Linehan Institute Behavioral Tech Research:
  http://behavioraltech.org/index.cfm
- Quantum Units Education:
  www.QuantumUnitsEd.com
- OnlineCE:
  www.chirocredit.com
- State Laws: Training for Health Professionals in Suicide Assessment, Treatment, and Management:
  http://afsp.org/wp-content/uploads/2016/04/Health-Professional-Training-Issue-Brief.pdf

Technology plan

- Hot Nonprofit Trends
  www.nonprofit.about.com

Wellness

- International Council on Active Aging
  www.icaa.cc
- National Wellness Institute
  www.nationalwellness.org
- Wellness Webinar Series, Lifeways Institute on Aging
  www.matherlifewaysinstituteonaging.com/senior-living-providers/wellness-webinar-series
- People with Disabilities: Living Healthy, Centers for Disease Control and Prevention
  www.cdc.gov/ncbddd/disabilityandhealth/healthyliving.html
- Healthy Aging and Physical Disability:
  http://agerrtc.washington.edu/info/factsheets/exercise

Workforce planning

- American Hospital Association: The Imperative for Strategic Workforce Planning and Development: Challenges and Opportunities
  www.aha.org/about/cpi/imperative-strategic-workforce-planning.shtml

Glossary

Note: *This glossary has been prepared for use with all CARF standards manuals. Terms have been selected for definition because they are subject to a wide range of interpretation and therefore require clarification of their usage in CARF's standards and materials. The glossary does not define practices or disciplines.*

CARF has not attempted to provide definitions that will be universally applicable. Rather, the intention is to define the meanings of the terms as they are used by CARF.

These definitions apply to all programs and services seeking accreditation. In some instances, glossary terms are used differently in different standards manuals. In such cases, the applicable manual is noted in parentheses after the term heading and before the definition.

Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

Acquired brain injury: Acquired brain injury (ABI) is an insult to the brain that affects its structure or function, resulting in impairments of cognition, communication, physical function, or psychosocial behavior. ABI includes both traumatic and nontraumatic brain injury. Traumatic brain injuries may include open head injuries (e.g., gun shot wound, other penetrating injuries) or closed head injuries (e.g., blunt trauma, acceleration/deceleration injury, blast injury). Nontraumatic brain injuries may include those caused by strokes, nontraumatic hemorrhage (e.g., ruptured arterio-venous malformation, aneurysm), tumors, infectious diseases (e.g., encephalitis, meningitis), hypoxic injuries (e.g., asphyxiation, near drowning, anesthetic incidents, hypovolemia), metabolic disorders (e.g., insulin shock, liver or kidney disease), and toxin exposure (e.g., inhalation, ingestion). ABI does not include brain injuries that are congenital, degenerative, or induced by birth trauma.

Acquired impairment: An impairment that has occurred after the completion of the birthing process.

Acquisition: The purchase by one legal entity of some or all of the assets of another legal entity. In an acquisition, the purchasing entity may or may not assume some or all of the liabilities of the selling entity. Generally, the selling entity continues in existence.

Activities of daily living (ADL): The instructional area that addresses the daily tasks required to function in life. ADL encompass a broad range of activities, including maintaining personal hygiene, preparing meals, and managing household chores.

Activity: The execution of a task or action by an individual. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF]*.)

Activity limitations: Difficulties an individual may have in executing activities. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF]*.)

Adaptive equipment: Equipment or devices, such as wheelchairs, walkers, communication devices, adapted utensils, and raised toilet seats, that help persons perform their activities of daily living.

Adjudicated: (Behavioral Health, Child and Youth Services) Sentenced by a juvenile court or criminal court.

Administration: The act of managing or supporting management of an organization's business affairs. Business affairs include activities such as strategic planning, financial planning, and human resources management.

Administrative location: Sites where the organization carries out administrative operations for the programs or services seeking accreditation and/or personnel who provide the programs or services seeking accreditation are located.

Adolescence: The period of life of an individual between childhood and adulthood, beginning at puberty and ending when one is legally recognized as an adult in one's state or province.

Advance directives: Specific instructions given by a person served to a care provider regarding the level and extent of care he or she wishes to receive. The intent is to aid competent adults and their families to plan and communicate in advance their decisions about medical treatment and the use of artificial life support. Included is the right to accept or refuse medical or surgical treatment. Includes psychiatric advance directives where allowed by law.

Adverse events: An untoward, undesirable, and usually unanticipated event such as a death of a person served, an employee, a volunteer, or a visitor in a provider organization. Incidents such as a fall or improper administration of medications are also considered adverse events even if there is no permanent effect on the individual or person served.

Advocacy services: Services that may include one or more of the following for persons with disabilities or other populations historically in need of advocacy:

- Personal advocacy: one-on-one advocacy to secure the rights of the person served.
- Systems advocacy: seeking to change a policy or practice that affects the person served.
- Legislative advocacy as permitted by law: seeking legislative enactments that would enhance the rights of and/or opportunities for the person served.
- Legal advocacy: using the judicial and quasi-judicial systems to protect the rights of the person served.
- Self-advocacy: enabling the person served to advocate on his/her own behalf.

Affiliation: A relationship, usually signified by a written agreement, between two organizations under the terms of which one organization agrees to provide specified services and personnel to meet the needs of the other, usually on a scheduled basis.

Affirmative enterprises: Operations designed and directed to create substantial economic opportunities for persons with disabilities.

Assessment: Process used with the person served to collect information related to his or her history and strengths, needs, abilities, and preferences in order to determine the diagnosis, appropriate services, and/or referral.

Assistive technology: Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase or improve functional capabilities of individuals.

Aversive conditioning: Procedures that are punishing, physically painful, emotionally frightening, deprivational, or put a person served at medical risk when they are used to modify behaviors.

Behavioral health: A category of medicine and rehabilitation that combines the areas of alcohol and other drug services, mental health, and psychosocial rehabilitation.

Board: See *Governing board*.

Catastrophe: A disaster or accident that immediately impacts an organization's ability to provide its programs or services or significantly impacts how the programs or services will be provided in the future.

Child/adolescent: An individual up to the age at which one is legally recognized as an adult according to state or provincial law.

Commensurate wage: A wage that is proportionate to the prevailing wage paid to experienced workers in the vicinity for essentially the same type of work. It is based on the quantity and quality of work produced by the worker with a disability compared to the work produced by experienced workers.

Communication skills: The instructional area that teaches the use of adaptive skills and assistive technology for accomplishing tasks such as

reading, writing, typing, managing finances, and storing and retrieving information.

Community integration: (Aging Services, Child and Youth Services) Being part of the mainstream of family and local community life, engaging in typical roles and responsibilities, and being an active and contributing member of one's social groups, local town or area, and of society as a whole.

Community relations plan: (Opioid Treatment Program) Supports program efforts to help minimize negative impact on the community, promote peaceful coexistence, and plan for change and program growth.

Community resources: Services and/or assistance programs that are available to the members of a community. They commonly offer persons help to become more self-reliant, increase their social connectedness, and maintain their human rights and well being.

Community settings: Locations in the community that are owned or leased and under the control of another entity, organization, or agency, and where organization personnel go for the purpose of providing services to persons in those locations. Examples include: community job sites that are owned or leased by the employer(s) where the organization may provide employment supports such as job coaching, vocational evaluation, or work adjustment; school settings where services such as early intervention or prevention services may be provided during the school's regular school, pre-school, or after-school program hours; or public or private sites such as libraries, recreational facilities, shopping malls, or museums where services such as community integration, case management, or community support may be provided.

Comparative analysis: The comparison of past and present data to ascertain change, or the comparison of present data to external benchmarks. Consistent data elements facilitate comparative analysis.

Competency: The criteria established for the adequate skills, knowledge, and capacity required to perform a specific set of job functions.

Competency-based training: An approach to education that focuses on the ability to demonstrate adequate skills, knowledge, and capacity to perform a specific set of job functions.

Computer access training: The instructional area that teaches the skills necessary to use specialized display equipment in order to operate computers. This includes evaluating the person served with large print, synthetic speech, and Braille access devices in order to perform word processing functions and other computer-related activities.

Concurrent physician care: Services delivered by more than one physician.

Concurrent services: Services delivered by multiple practitioners to the same person served during the same time period.

Congenital impairment: An impairment that is present at the completion of the birthing process.

Consolidation: The combination of two or more legal entities into a single legal entity, where the entities unite to form a new entity and the original entities cease to exist. In a consolidation, the consolidated entity has its own name and identity and acquires the assets and liabilities of the disappearing entities.

Consumer: The person served. When the person served is legally unable to exercise self-representation at any point in the decision-making process, *person served* also refers to those persons willing and able to make decisions on behalf of the person served. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the person served, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his or her own interests should be granted the right to choose whether family, significant others, or advocates may participate in the decision-making process. In standards that deal with infants, children, and/or adolescents, the family may be referenced directly as the family may serve as a person served in such situations.

Continuum of care/Continuum of services: A system of services addressing the ongoing and/or intermittent needs of persons at risk or with functional limitations resulting from disease, trauma, aging, and/or congenital and/or developmental conditions. Such a system of services may be achieved by accessing a single provider, multiple providers, and/or a network of providers. The intensity and diversity of services may vary depending on the functional and psychosocial needs of the persons served.

Contract: A written agreement between two or more parties that sets forth enforceable obligations between or among the parties.

Controlled/operated: The right or responsibility to exercise influence over the physical conditions of a facility where service delivery/administrative operations occur. An organization is considered in control of all facilities where it delivers services to persons who are present at the time of service delivery for the sole purpose of receiving services from the organization (e.g., services provided to students at a school outside of the school's regular school, pre-school, or after-school program hours). An organization is not considered in control of facilities where it delivers services to persons who are present at the time of service delivery for purposes other than receiving services from the organization (e.g., services provided at a school to students who are present at the school to participate in the school's regular school, pre-school, or after-school programs).

Co-pharmacy: (Behavioral Health, Child and Youth Services, and Opioid Treatment Program) The use of two or more medications from the same class, e.g., two antidepressant medications or two antipsychotic medications.

Core values: The essential and enduring tenets of an organization. They are a small set of timeless guiding principles that require no external justifications. They have intrinsic value and importance to those inside the organization.

Corporate citizenship: An organization's efforts, activities, and interest in integrating, contributing, and supporting the communities where it delivers services to better address the needs of persons served.

Corporate status: The existence of an entity as a corporation under applicable law. Maintenance of corporate status typically requires ongoing compliance with state requirements.

Costs: The expenses incurred to acquire, produce, accomplish, and maintain organizational goals. These include both direct costs, such as those for salaries and benefits, materials, and equipment, and indirect costs, such as those for electricity, water, building maintenance, and depreciation of equipment.

Cultural competency: An organization's ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs, and values that reflect an individual's racial, ethnic, religious, and/or social groups or sexual orientation.

Culturally normative: Providing the persons served with an opportunity to experience patterns and conditions of everyday life that match as closely as possible those patterns and conditions typical of the mainstream experience in the local society and community. This requires the use of service delivery systems and settings that adapt to the changing norms and patterns of communities in which the persons served function so as to incorporate the following features:

- Rhythms of the day, week, and year and life cycles that are "normal" or typical of the community.
- A range of choices, with personal preferences and self-determination receiving full respect and consideration.
- A variety of social interactions and settings, including family, work, and leisure settings and opportunities for personal intimacy.
- Normal economic standards.
- Life in housing typical of the local neighborhoods.

Culture: The integrated pattern of human behavior that includes the thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, social, or other group.

Customers: The persons served, families, communities, funding agencies, employers, etc., who receive or purchase services from the organization.

Data: A set of values of qualitative or quantitative variables, e.g., facts, objective information, or statistics collected, assembled, or compiled for reference, analysis and use in decision-making.

Demonstrate: To show, explain, or prove by evidence presented in program documentation, interviews, and behavior how an organization or a program consistently conforms to a given standard.

Debt covenants: Requirements found in loan documents that require an organization to meet certain predefined performance targets to be measured at predefined time periods. The performance targets can be financial (for example, the organization must maintain a certain level of days with cash on hand) or nonfinancial (an organization must maintain a certain occupancy level).

Detoxification treatment: (Opioid Treatment Program) Dispensing an opioid agonist treatment medication in decreasing doses to an individual to alleviate adverse physical or psychological effects of withdrawal from the continuous or sustained use of an opioid drug and as a method of bringing the individual to a drug-free state within such period.

Discharge summary: (Aging Services, Behavioral Health, Child and Youth Services, and Opioid Treatment Program) A document prepared at discharge by the staff members designated with the responsibility for service coordination that summarizes the person's course of treatment, level of goal(s) achievement, final assessment of current condition, and recommendations and/or arrangements for further treatment and/or aftercare.

Diversion control plan: (Opioid Treatment Program) A document that contains specific measures to reduce the possibility of diversion of controlled substances from legitimate treatment use and must assign specific responsibility to medical and administrative staff for implementation.

Diversity: Differences due to cognitive or physical ability, culture, ethnicity, language, religion, economic status, gender, age, or sexual orientation.

Donated location/space: Physical space not owned or leased by the organization but made available to the organization without charge for the purposes of delivering services or for administrative operations on an ongoing basis and which the organization controls or operates during the time of service delivery/administrative operations. The location and availability of the space does not vary at the discretion of the donating entity.

Durability: Maintenance or improvement over time of outcomes achieved by persons served at the time of discharge.

Duty of care: Obligation of governing board members to act with the care that an ordinarily prudent person in a similar position would use under similar circumstances. This duty requires governing board members to perform their duties in good faith and in a manner they reasonably believe to be in the organization's best interest.

Duty of loyalty: Obligation of governing board members to refrain from engaging in personal activities that would harm or take advantage of the organization. This duty prohibits governing board members from using their position of trust and confidence to further their private interests. It requires an undivided loyalty to the organization and demands that there be no conflict between a governing board member's corporate duty and self-interest.

Duty of obedience: Obligation of governing board members to perform their duties according to applicable statutes and the provisions of the organization's articles of incorporation and bylaws.

Effectiveness: Results achieved and outcomes observed for persons served. Can apply to different points in time (during, at the end of, or at points in time following services). Can apply to different domains (e.g., change in disability or impairment, function, participation in life's

activities, work, and many other domains relevant to the organization.)

Efficacy: The ability to produce an effect, or effectiveness.

Efficiency: Relationship between resources used and results or outcomes obtained. Resources can include, for example, time, money, or staff/FTEs. Can apply at the level of the person served, program, or groups of persons served or at the level of the organization as a whole.

Employee-owner: An individual who delivers administration or services on behalf of an organization if such individual is also:

- with respect to a for-profit organization, a person holding an ownership interest in the organization; or
- with respect to a nonprofit organization, a person with the right to vote for the election of the organization's directors, unless that right derives solely from the person's status as a delegate or director.

Entitlements: Governmental benefits available to persons served and/or their families.

Executive leadership: The organization's principal management employee, often referred to as the chief executive officer, president, or executive director. The executive leadership is hired and evaluated directly by the organization's governing board and is responsible for leading management in conducting the organization's business and affairs.

Family/support system: (Aging Services, Continuing Care Retirement Communities, and Medical Rehabilitation) A group of persons of multiple ages bonded by affection, biology, choice, convenience, necessity, or law for the purpose of meeting the individual needs of its members.

Family: (Behavioral Health, Child and Youth Services, Employment and Community Services, Vision Rehabilitation Services) A person's parents, spouse, children, siblings, extended family, guardians, legally authorized representatives, or significant others as identified by the person served.

Family of origin: Birth family or first adoptive parents.

Fee schedule: A listing of prices for services rendered. These prices may be designed for and used with third-party payers, outside funding sources, and/or the persons served, their families, and caregivers.

Functional literacy: The ability to read, comprehend, and assimilate the oral and written language and numerical information required to function in a specific work or community environment. Accommodation strategies for those with reduced functional literacy may include picture instructions and audio or video recordings.

Governance authority: (Medical Rehabilitation, Opioid Treatment Program) The individual or group that provides direction, guidance, and oversight and approves decisions specific to the organization and its services. This is the individual or group to which the chief executive reports.

Governing board: The body vested with legal authority by applicable law to direct the business and affairs of a corporate entity. Such bodies are often referred to as boards of directors, trustees, or governors. Advisory and community relations boards and management committees do not constitute governing boards.

Governmental: Regarding any city, county, state, federal, tribal, provincial, or similar jurisdiction.

Grievance: A perceived cause for complaint.

Home: (Employment and Community Services) The individual's living environment as impacted by the individual's personal articles, friends, roommates, or significant others. Individuals' homes are considered central to their identity.

Host organization: Employer of an individual eligible for employee assistance program services.

Impairment: Problems in body function or structure such as a significant deviation or loss. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF]*.)

Independent (board representation): The absence of conflict of interest by a governing

board member with respect to any organizational transaction. A governing board member is typically independent with respect to a transaction if neither the individual nor any related person or entity benefits from the transaction or is subject to the direction or control of a person or entity that benefits from the transaction. (See definition of *unrelated*.) For purposes of the foregoing, direction or control is often evidenced by the existence of an employment relationship or other compensation arrangement.

Indigenous: Indigenous people are the descendants—according to a common definition—of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. CARF is using the term *indigenous* as a generic term as defined by the United Nations for many years. Practicing unique traditions, indigenous people retain social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live. In some countries, there may be preference for other terms including tribes, first peoples, or Aboriginals; specific examples include Native Americans, First Nations, Métis, and Inuit.

Individual plan: An organized statement of the proposed service/treatment process to guide a provider and a person served throughout the duration of service/treatment. It identifies the input from the person served regarding goals and objectives and services to be provided, persons responsible for providing services, and input from the person served.

Information: Understanding derived from looking at facts; conclusions from looking at data.

Informed choice: A decision made by a person served that is based on sufficient experience and knowledge, including exposure, awareness, interactions, or instructional opportunities, to ensure that the choice is made with adequate awareness of the alternatives to and consequences of the options available.

Integration: (Behavioral Health, Child and Youth Services) Presence and participation in the mainstream of community life. *Participation* means that the persons served maintain social relationships with family members, peers, and others in the community who do not have disabilities. In addition, the persons served have equal access to and full participation in community resources and activities available to the general public.

Integration: (Aging Services, Continuing Care Retirement Communities, Employment and Community Services, Medical Rehabilitation, Vision Rehabilitation Services) The opportunity for involvement in all aspects of community life. Integration into communities, work settings, and schools provides all individuals opportunities to be active, fully participating members of those communities or environments. In integrated settings, diversity is viewed as a goal; it is recognized that diversity enriches all community members.

Interdependence: Movement from dependence toward interdependence may be demonstrated by an increase in self-sufficiency, self-advocacy, or self-determination, with offsetting decreases in artificial or paid services.

Interdisciplinary: Characterized by a variety of disciplines that participate in the assessment, planning, and/or implementation of a person's program. There must be close interaction and integration among the disciplines to ensure that all members of the team interact to achieve team goals.

Investigation: A detailed inquiry or systematic examination by a third party into the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

Joint venture: A business undertaking by two or more legal entities in which profits, losses, and control are shared, which may or may not involve the formation of a new legal entity. If a new entity is formed, the original entities continue to exist.

Kinship care: (Child and Youth Services) Kinship care is the full-time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any

adult who has a kinship bond with a child. This definition is designed to be inclusive and respectful of cultural values and ties of affection. It allows a child to grow to adulthood in a family environment. (This definition is from the Child Welfare League of America [CWLA].)

Leadership: Leadership creates and sustains a focus on the persons served, the organization's core values and mission, and the pursuit of organizational and programmatic performance excellence. It is responsible for the integration of the organization's core values and performance expectations into its management system. Leadership promotes and advocates for the organization's and community's commitment to the persons served.

Linkages: Established connections and networks with a variety of agencies, companies, and persons in the community.

Living arrangements: (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.

Long-term detoxification treatment: (Opioid Treatment Program) Detoxification treatment for more than 30 days but no more than 180 days.

Maladaptive behavior: Behavior that is destructive to oneself, others, or the environment, demonstrating a reduction or lack of the ability necessary to adjust to environmental demands.

Manual skills: The instructional area that is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

Material litigation: A legal proceeding initiated by a third party concerning the appropriateness of acts by an organization or its personnel, if such acts: (a) relate directly to conformance or nonconformance to applicable standards; or (b) are of such breadth or scope that the organization's entire operations may be affected.

Medical director: (Opioid Treatment Program) A physician, licensed to practice medicine in the jurisdiction in which the opioid treatment program is located, who assumes responsibility for administering all medical services performed by the program either by performing them directly or delegating specific responsibility to authorized program physicians and healthcare professionals functioning under the medical director's direct supervision.

Medically complex: (Behavioral Health, Child and Youth Services) Persons who have a serious ongoing illness or a chronic condition that meets at least one of the following criteria:

- Has lasted or is anticipated to last at least twelve months.
- Has required at least one month of hospitalization.
- Requires daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members.
- Requires the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.
- The medically complex condition of the person served presents an ongoing threat to his or her health status.

Medically fragile: (Employment and Community Services) An individual who has a serious ongoing illness or a chronic physical condition that has lasted or is anticipated to last at least 12 months or who has required at least one month of hospitalization. Additionally, this individual may require daily ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members. Moreover, this individual may require the routine use of a medical device or the use of assistive technology to compensate for the loss of usefulness of a body function needed to participate in activities of daily living.

Medically supervised withdrawal (MSW): A medically supervised, gradual reduction or tapering of dose over time to achieve the elimination of tolerance and physical dependence to methadone or other opioid agonists or partial agonists.

Medication-assisted treatment: (Opioid Treatment Program) Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Research shows that when treating substance use disorders, a combination of medication and behavioral therapies is most successful. MAT is clinically driven with a focus on individualized patient care. (Definition from SAMHSA)

Medication control: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. This would include medications self-administered by the persons served or the use of samples.

Medication management: (Aging Services, Employment and Community Services, Medical Rehabilitation, Vision Rehabilitation Services) The practice of prescribing, administering, and/or dispensing medication by qualified personnel.

It is considered management when personnel in any way effect dosage, including taking pills out of a bottle or blister pack; measuring liquids; or giving injections, suppository, or PRN medications.

Medication management: (Opioid Treatment Program) The practice of prescribing, administering, and/or dispensing any medications approved for the treatment of opioid use disorder by qualified medical personnel.

Medication monitoring: (Employment and Community Services, Vision Rehabilitation Services) The practice of providing a secure storage area and controlled access for medications that are brought into a program and used by the person served. The person served must take the medication without any assistance from personnel.

Medication unit: (Opioid Treatment Program) A facility that is part of but geographically separate from an opioid treatment program from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication or collect samples for drug testing or analysis.

Medication use: (Aging Services, Behavioral Health, Child and Youth Services, Employment and Community Services, Opioid Treatment Program) The practice of handling, prescribing, dispensing and/or administering medication to persons served in response to specific symptoms, behaviors, and conditions for which the use of medications is indicated and deemed efficacious.

Mental status: A person's orientation, mood, affect, thought processes, developmental status, and organic brain function.

Merger: The combination of two or more legal entities into a single legal entity, where one entity continues in existence and the others cease to exist. In a merger, the surviving entity retains its name and identity and acquires the assets and liabilities of the disappearing entities.

Mission: An organization's reason for being. An effective mission statement reflects people's idealistic motivations for doing the organization's work.

Natural proportions: A principle that states that the number of persons served in any given setting, such as a work setting, should be in proportion to the number of persons with disabilities in the general population.

Natural supports: (Behavioral Health, Child and Youth Services) Supports provided that assist the persons served to achieve their goals of choice and facilitate their integration into the community. Natural supports are provided by persons who are not paid staff members of a service provider but may be initiated or planned, facilitated in partnership with such a provider.

Natural supports: (Employment and Community Services, Vision Rehabilitation Services) Supports that occur naturally in the community, at work, or in a social situation that enable the persons served to accomplish their goals in life without the use of paid supports.

Offender: An inmate, detainee, or anyone under the community supervision of a criminal justice agency.

On-the-job evaluation: An evaluation performed in a work setting located outside the organization in which a person is given the opportunity to experience the requirements necessary to do a specific job. Real work pressures are exerted by the employer, and the person's performance is evaluated by the employer and the evaluator.

Opioid agonist treatment medication: (Opioid Treatment Program) Any opioid agonist drug approved by the U.S. Food and Drug Administration under Section 505 of the Federal Food, Drug, and Cosmetic Act for use in the treatment of opioid use disorder.

Organization: A legal entity that provides an environment within which services or programs are offered.

Orientation and Mobility (O&M): The instructional area that addresses the use of the remaining senses in combination with skill training utilizing protective techniques and assistive devices in order to travel independently in a safe, efficient, and confident manner in both familiar and unfamiliar environments.

Outcome: Result or end point of care or status achieved by a defined point following delivery of services.

Outcomes measurement and outcomes management: A systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of the individuals' satisfaction with those results. An outcomes management system measures outcomes by obtaining, aggregating, and analyzing data regarding how well the persons served are functioning after transition/exit/discharge from a specific service. Outcomes measures should be related to the goals that recent services were designed to achieve. Other measures in the outcomes management system may include progress measures that are appropriate for long-term services (longer than six months in duration) that serve persons demonstrating a need for a slower pace in order to achieve gains or changes in functioning.

Paid work: Employment of a person served that results in the payment of wages for the production of products or provision of services. Paid work meets the state and/or federal definition of employment.

Participation: An individual's involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF]*.)

Participation restrictions: Problems an individual may experience in involvement in life situations. (This definition is from the World Health Organization's *International Classification of Functioning, Disability, and Health [ICF]*.)

Pathological aging: Changes due to the impact of disease versus the normal aging process.

Pediatric medicine: The branch of medicine dealing with the growth, development, and care of infants, children, and adolescents and with the treatment of their diseases.

Performance indicator: A quantitative expression that can be used to evaluate key performance in relation to objectives. It is often expressed as a percent, rate, or ratio. For example, a performance indicator on return to work might be: percentage of clients in competitive employment 90 days after closure.

Performance target: Measurable level of achievement identified to show progress toward an overall objective. This could be set internally by the program, organization, or it could be a target established by an external entity. The performance target could be expressed as a certain percentage, ratio, or number to be reached.

Periodically: Occurring at intervals determined by the organization. The organization uses information about and input from the persons

served and other stakeholders to determine the frequency of the intervals.

Person served: The primary consumer of services. When this person is unable to exercise self-representation at any point in the decision-making process, *person served* also refers to those willing and able to make decisions on behalf of the primary consumer. These individuals may include family members, significant others, legal representatives, guardians, and/or advocates, as appropriate. The organization should have a means by which a legal representative of the primary consumer, if any, is invited to participate at appropriate points in the decision-making process. By the same token, a person who is legally able to represent his/her own interests should be granted the right to choose whether other members of the family, significant others, or advocates may participate in that decision-making process.

Personal care: Services and supports, including bathing, hair care, skin care, shaving, nail care, and oral hygiene; alimentary procedures to assist one with eating and with bowel and bladder management; positioning; care of adaptive personal care devices; and feminine hygiene.

Personal representative: An individual who is designated by a person served or, if appropriate, by a parent or guardian to advocate for the needs, wants, and rights of the person served.

Personnel: Individuals employed full time or part time or on a contract.

Personnel: (Behavioral Health, Child and Youth Services, Opioid Treatment Program) Individuals who provide services in a program on a part- or full-time basis as staff members, independent contractors, volunteers, students, trainees, or interns.

Persons with severe and persistent mental illness: (Behavioral Health) Adults with a primary diagnosis of schizophrenia, psychiatric disorders, major affective disorders (such as treatment resistant major depression and bipolar disorder), or other major mental illness according to the current *Diagnostic and Statistical Manual of Mental Disorders,* which may also include a secondary diagnosis.

Pharmacotherapy: Any treatment of the persons served with prescription medications, including methadone or methadone-like drugs.

Plan: Written direction that is action oriented and related to a specific project or defined goal, either present and/or future oriented. A plan may include the steps to be taken to achieve stated goals, a timeline, priorities, the resources needed and/or available for achieving the plan, and the positions or persons responsible for implementing the identified steps.

Plan of care: The document that contains the program that has been designed to meet the needs of the person served. This document is prepared with input from the team, including the person served. The plan is modified and revised, as needed, depending upon the needs of the person served.

Policy: Written course of action or guidelines adopted by leadership and reflected in actual practice.

Polypharmacy: (Behavioral Health, Child and Youth Services, and Opioid Treatment Program) The use of multiple medications to treat different conditions.

Predicted outcomes: The outcomes established by the team at the time of the completion of the initial assessment.

Preferred practice patterns: Statements developed as a guideline for blind rehabilitation specialists that specify procedures, clinical indications for performing the procedures, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes.

Prevailing wage: A wage paid to experienced workers in the vicinity who do not have disabilities that impede them in doing the work to be performed. An experienced worker is one who has become proficient in performing a job and is not receiving entry-level wages. Prevailing wage rates must be based on work done using similar methods and equipment. The information to be recorded in documenting prevailing wage rates includes:

- The date of contact with the firm.

- The name, address, and phone number of the firm.
- The individual contacted within the firm.
- The title of the individual contacted.
- The wage range provided.
- A brief description of the work for which information is provided.
- The basis for the conclusion that the wage rate is not based on an entry-level position.

Primary care: Active, organized, structured treatment for a presenting illness.

Private homes: An apartment, duplex, house, or condominium owned or leased by a person served.

If a person served and the organization co-sign a lease for the person served for an apartment, duplex, or townhouse, this living arrangement will be considered a private home. The organization will not technically be considered a lessor of this private home for the person served, but will be considered a financial guarantor for the person served who is leasing his or her own private home.

Procedure: A "how to" description of actions to be taken. Not required to be written unless specified.

Prognosis: The process of projecting:

- The likelihood of a person achieving stated goals.
- The length of time necessary for the person to achieve his or her rehabilitation goals.
- The degree of independence the person is likely to achieve.
- The likelihood of the person maintaining outcomes achieved.

Program: A system of activities performed for the benefit of persons served.

Program sponsor: (Opioid Treatment Program) The person named in the application for certification as responsible for the opioid treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any medication units.

Proprietary organization: An organization that is operated for profit.

Publicly operated organization: An organization that is operated by a governmental entity.

Qualified behavioral health practitioner: (Behavioral Health, Child and Youth Services, Opioid Treatment Program) A person certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide mental health or alcohol and other drug services. Persons other than a physician who are designated by a program to order seclusion or restraints must be permitted to do so by federal, state, provincial, or other regulations.

Qualified practitioner: (Child and Youth Services) A person who is certified, licensed, registered, or credentialed by a governmental entity or professional association as meeting the educational, experiential, or competency requirements necessary to provide human services.

Reasonable accommodations: Modifications or adjustments, which are not unduly burdensome, that assist the persons served or staff members to access benefits and privileges that are equal to those enjoyed by others. Examples taken from the Americans with Disabilities Act include making existing facilities readily accessible to and usable by persons with disabilities; restructuring jobs; modifying work schedules; reassigning persons to vacant positions; acquiring or modifying equipment or assistive devices; adjusting or modifying examinations, training materials, policies, and procedures; and providing qualified readers or interpreters.

Regular: Occurring at fixed, uniform intervals of time determined by the organization. The organization assesses and uses information about and input from the persons served and other stakeholders to determine the frequency necessary.

Rehabilitation: The process of providing those comprehensive services deemed appropriate

to the needs of persons with disabilities in a coordinated manner in a program or service designed to achieve objectives of improved health, welfare, and realization of the person's maximum physical, social, psychological, and vocational potential for useful and productive activity. Rehabilitation services are necessary when a person with a disability is in need of assistance and it is beyond the person's personal capacities and resources to achieve his or her maximum potential for personal, social, and economic adjustment and beyond the capabilities of the services available in the person's usual daily experience. Such assistance continues as long as the person makes significant and observable improvement.

Rehabilitation nursing services: The formalized organizational structure that delineates the appropriate accountability, staff mix, and competencies and provides a process for establishing, implementing, and maintaining patient care standards and nursing policies that are specific to rehabilitation nursing. The nursing staff includes members who provide direct care and those who provide supervision and perform support functions. This staff usually includes clinical nurse specialists, registered nurses, licensed practical (vocational) nurses, nursing assistants, and unit clerical support. Nursing services are provided under the direct supervision of a registered nurse unless supervision is otherwise defined by applicable state practice acts or provincial legislation for nursing.

Rehabilitative treatment environment: A rehabilitation setting that provides for:

- The provision of a range of choices, with personal preference and self-determination receiving full respect and consideration.
- A variety of social interactions that promote community integration.
- Treatment of a sufficient volume of persons served to ensure that there is an environment of peer support and mentorship.
- Treatment of a sufficient volume of persons served to support professional team involvement and competence.
- A physical environment conducive to enhancing the functional abilities of the persons served.

Reliability: The process of obtaining data in a consistent or reproducible manner.

Representative sample/sampling: A group of randomly selected individuals determined through a procedure such that each person has an equal probability of inclusion in the sample. If sampling is used, the sample should reflect the population to which the results are generalized. Although no specific percentage of persons served is required to be included in the sample, general principles of data analysis state that the larger the sample, the less the error that is expected in comparing the sample to the entire population of persons served. The number of persons sampled within each program area or subgroup should be sufficient to give confidence that the characteristics of the sample reflect the distribution of the entire population of persons served.

Residence: (Employment and Community Services) The actual building or structure in which a person lives.

Residential settings: (Employment and Community Services) The individual model of services delivered—Supported Living, Independent Living, Group Home, Intermediate Care Facility (ICF), etc.

Restraint: The use of physical, mechanical, or other means to temporarily subdue an individual or otherwise limit a person's freedom of movement. Restraint is used only when other less restrictive measures have been found to be ineffective to protect the person served or others from injury or serious harm.

Risk: Exposure to the chance of injury or loss. The risk can be external, such as a natural disaster, injury that occurs on the property of a program, or fire. The risk can be internal to the organization and include things such as back injuries while performing job duties, it can involve liability issues such as the sharing of information about a person served without consent, or it can jeopardize the health of those internal or external to the organization due to

such things as poor or nonexistent infection control practices.

Risk factors: (Behavioral Health) Certain conditions and situations that precede and may predict the later development of behavioral health problems. Examples of risk factors may include poverty, family instability, or poor academic performance. Examples of protective factors may include an internal locus of control, a positive adult role model, and a positive outlook.

Risk factors: Aspect of personal behavior or lifestyle, environmental exposure, or variable or condition that increases the likelihood of an adverse outcome.

Screening: A face-to-face, computer-assisted, or telephone interview with a person served to determine his or her eligibility for services and/or proper referral for services.

Seclusion: The separation of an individual from normal program participation in an involuntary manner. The person served is in seclusion if freedom to leave the segregated room or area is denied. Voluntary time-out is not considered seclusion.

Sentinel events: An unexpected occurrence within a CARF-accredited program involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called sentinel because they signal the need for immediate investigation and response.

Service: Activities performed for the benefit of persons served.

Service access: The organization's capacity to provide services to those who desire or are in need of receiving it.

Service referral: The practice of arranging for a person to receive the services provided by a given professional service unit of the organization or through some other appropriate agent. This arrangement, which is usually made by the individual responsible for the program of the person served, should be documented by notation in the person's permanent record.

Short-term detoxification treatment: (Opioid Treatment Program) Detoxification treatment for no more than 30 days.

Should: Inasmuch as CARF is a standards-setting and consultative resource rather than a regulatory or enforcement agency, the term *should* is used synonymously with the term *shall*. CARF's intent is that each applicable standard and each policy within this document will be addressed and met by organizations seeking to become accredited or maintain current accreditation.

Skilled healthcare provider: Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist).

Skilled healthcare provider: (Behavioral Health, Child and Youth Services) Licensed, certified, or registered healthcare provider (e.g., nurse, physician, or respiratory therapist). Can also include specifically trained natural or foster family member knowledgeable in the care of the specific individual.

Staff member: A person who is directly employed by an organization on either a full- or part-time basis.

Stakeholders: Individuals or groups who have an interest in the activities and outcomes of an organization and its programs and services. They include, but are not limited to, the persons served, families, governance or designated authority, purchasers, regulators, referral sources, personnel, employers, advocacy groups, contributors, supporters, landlords, business interests, and the community.

Strategic planning: An organization's directional framework, developed and integrated from a variety of sources, including but not limited to financial planning, environmental scans, and organizational competencies and opportunities.

Supervisor: The lead person who is responsible for an employee's job performance. A supervisor may be a manager or a person with another title.

Supports: Individuals significant to a person served and/or activities, materials, equipment,

or other services designed and implemented to assist the person served. Examples include instruction, training, assistive technology, and/or removal of architectural barriers.

Team: At a minimum, the person served and the primary personnel directly involved in the participatory process of defining, refining, and meeting the person's goals. The team may also include other significant persons such as employers, family members, and/or peers at the option of the person served and the organization.

Team integration: The process of bringing individuals together or incorporating them into a collaborative team. The entire team becomes the dominant culture and decision-making body for the rehabilitation process. There is recognition of and respect for the value of information provided by an individual team member, with a focus on the interdependence and coordination of all team members. Through coordinated communication, there is accountability by the team 24 hours per day, 7 days per week for all decisions made.

Transition *(from school)*: (Employment and Community Services) The process of moving from education services to adult services, including living and working in the community.

Transition: The process of moving from one level of care or service/support to another, changing from child/adolescent service systems to adult systems, or leaving care or services/supports.

Transition plan: (Aging Services, Behavioral Health, Child and Youth Services, Opioid Treatment Program) A document developed with the full participation of the person served that (a) focuses on a successful transfer/transition between program or service phases/levels/steps or (b) focuses on a successful transition to a community living situation. The plan could be part of the individual plan and details how the person served will maintain the gains made during services and support ongoing recovery and/or continued well-being at the next phase/level/step.

Treatment: A professionally recognized approach that applies accepted theories, principles, and techniques designed to achieve recovery and rehabilitative outcomes for the persons served.

Unrelated (board representation): The absence of an affiliation between a governing board member and any person or entity that benefits from any organizational transaction. For purposes of the foregoing, *affiliation* generally means a relationship that is:

- Familial;
- Characterized by control of at least a 35 percent voting, profits, or beneficial interest by the member; or
- Substantially influenced by the member.

Validity: Refers to the appropriateness, meaningfulness, and usefulness of a measure and the inferences made from it. Commonly regarded as the extent to which a test measures what it is intended to measure.

Value: The relationship between quality and cost.

Visit: Episode of service delivery to one person served on one day by one service or discipline.

Visual skills: The instructional area that addresses the needs of persons with partial vision to gain a better understanding of their eye problems through patient education and teaches them how to utilize their remaining vision effectively through the use of low vision techniques. It also includes assessment and training with special optical aids and devices designed to meet the various needs of the persons served. These needs may include reading, activities of daily living, orientation, mobility, and home repairs.

Wellness education: Learning activities that are intended to improve the patient's health status. These include but are not limited to healthcare education, self-management of medication(s), nutritional instruction, exercise programs, and training in the proper use of exercise equipment.

Youth: The time a person is young—generally referring to the time between childhood and adulthood.

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How well did the CARF *2018 Medical Rehabilitation Standards Manual* meet your needs?

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