CARF
Behavioral Health

Ohio Update

2013

OUR NAME

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Commission on Accreditation of Rehabilitation Facilities

CARF's Mission is …

To promote the quality, value and optimal outcomes of services, through a consultative accreditation process, that centers on enhancing the lives of the persons served.

Overview

- Minimal Changes to Sections 1 & 2
- Appendix C - Required Training (p. 383)
- BH
  - Health Home (added mid 2012)
  - Integrated Behavioral Health/ Primary Care
  - Eating Disorders

Section 1

ASPIRE® to Excellence

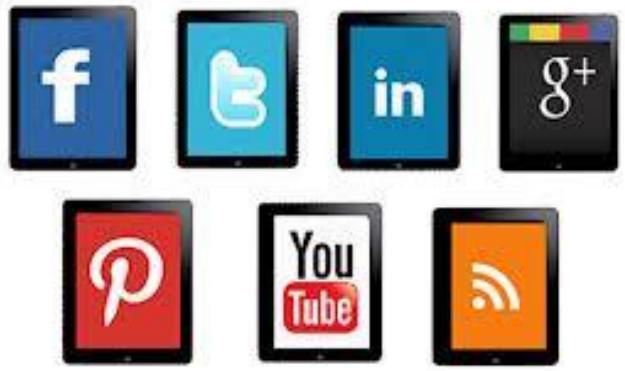
ASPIRE to Excellence®

NO NEW OR REVISED:

A. Leadership	B. Governance	C. Strategic Plan	D. Input
E. Legal Req.	F. Financial	J. Technology	L. Accessibility

G. Risk Management

3. The program implements written procedures regarding communications that address:
   a. Media relations.
   b. <u>Social media.</u>



H. Health and Safety

4. Personnel receive ***documented*** competency-based training….

5. Evacuation routes ~~***signage***~~ that are: accessible, understandable….

H. Health and Safety

6. Unannounced tests of all emergency procedures:
   c. Are analyzed for performance that addresses:

(1) *Areas needing improvement.*
(2) *Actions to be taken.*
(3) *Results of performance improvement plans.*
(4) *Education and training of personnel.*

8. The organization has written procedures regarding critical incidents that include:
   c. Documentation.

I. Human Resources

**2.a.(2) Clarified verification of HS Ed*

5. The organization provides ***documented*** personnel training:

8. The organization implements personnel policies that:

   b. Address at a minimum:

      (1) Employee relations, including:

(b) Disciplinary action.

(c) Termination

      (2) Employee selection, including:

(b) Promotions.

(c) Job postings.

Moved from standard 6 and now required in policy not just "guidelines"

K. Rights of Persons Served

Revise!

3. The program/service demonstrates:
   a. Knowledge of the ***decision making authority*** of the person served.

Legal Status

4. The organization:
c. Documents formal complaints received.

NEW

5. A ***written analysis*** of formal complaints:

MODIFY

Review

M. Performance Measurement & Management

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.***

M. Performance Measurement & Management

3. The data collected by the organization:

   d. Are used to set:

      (1) Written business function:

         (a) Objectives.
         (b) Performance indicators.
         (c) Performance targets.

      (2) Written service delivery:

         (a) Objectives.
         (b) Performance indicators.
         (c) Performance targets.

3.d. was moved from standard 6. and expanded

M. Performance Measurement & Management

7. For each service delivery performance indicator, the organization determines:

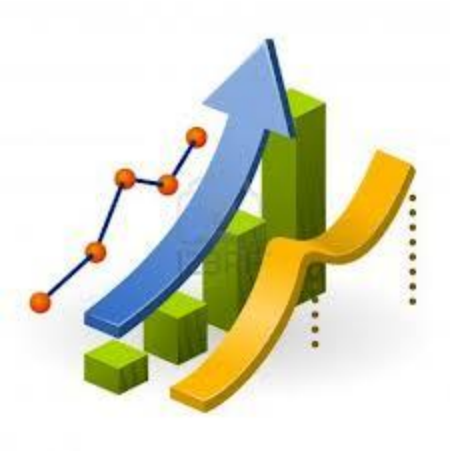
   d. A performance ***target**** based on an industry benchmark, the organization's performance history, or established by the organization or other stakeholder.

**** Target changed from goal.***

N. Performance Improvement

1. A written analysis is completed:

   b. That analyzes performance indicators in relation to performance ***targets*,*** including:



**** Targets changed from goals.***

Section 2

New & Revised

Behavioral Health
General Program Standards

2013

Applicability Table

BH – No modifications made to the applicability table.

Program/Service Structure

2.A.10 When the program is identified as a treatment program, it identifies:

a. Treatment modalities.

b. The credentials of staff qualified to provide treatment.

Program/Service Structure

24. Revision: Note that some language was moved to the intent and the example expanded to define tobacco products*.

* including: chewing tobacco, green cigarettes, etc.

Screening and Access to Services

14.m. *“Living situation”* added to the information collected as part of the assessment process.

Medication Use

1. The organization has a policy that identifies:

   b. The process for persons served to obtain medications needed to promote recovery and/or desired treatment/services outcomes, including whether or not it directly provides:

   (1) <u>Medication control.</u>

Nonviolent Practices

2.e (example)

The addition of the reference link for eCPR.

"Organizations may consider training in eCPR, a holistic empowering approach to assisting persons served to cope with emotional crisis. Information on this approach can be found at www.emotional-cpr.org

Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis by three simple steps:

C = Connecting
P = emPowering, and
R = Revitalizing.

Section 3

BH

Core Program Standards

New and Revised

FIELD CATEGORY

Comprehensive Care

This field category is designed to provide any combination of behavioral health services related to mental illness, addictions or intellectual/developmental disabilities, and management of or coordination with the healthcare needs of the person served.

It applies only to Health Home or Integrated Behavioral Health/Primary Care programs.

D. Community Housing

Slight change to definition of “transitional living” – includes apartments or homes, and no longer time defined.

9. In congregate housing, provisions are made to address the need for:

d. Separate sleeping areas based on:

(1) Age.

(2) Gender.

(3) Developmental need.

N. Health Home

1. The written program description clearly defines the following:
   a. Population served.
   b. How primary care and other healthcare services will be:
      (1) Provided.
      (2) Accessed.
      (3) Coordinated.
   c. Referral procedures for external services needed by persons served.
   d. The process for providing care coordination and disease management supports for the persons served:
      (1) Internally.
      (2) To external service providers.
2. The program is organized and delivered in a manner that ensures:
   a. An integrated team approach.
   b. Inclusion of complementary disciplines needed by the persons served.

Health Home

3. When primary care or other healthcare services are provided directly by the health home, support for these services includes:
   a. Co-location with appropriate physical space.
   b. Implemented written procedures regarding:
      (1) Access to primary care or other medical services.
      (2) Sharing of information
      (3) Coordination of care.
   c. Cross training for the most common chronic medical and behavioral illnesses prevalent in the population served.

Health Home

4. **The program:**
   a. **Identifies hours when healthcare services are available.**
   b. **Ensures the availability of the following:**
      (1) Psychiatrist or psychologist.
      (2) Primary care provider.
      (3) When needed, other professional legally authorized to prescribe.
      (4) Care coordinator.
      (5) Other QBHP, based on the needs of the persons served.

Health Home

5. **When neither a psychiatrist nor primary care physician is a member of the health home team, a psychiatrist or primary care physician is available for consultation and/or program oversight during hours of operation.**

6. **When not provided directly by the health home, off-site treating psychiatrists or primary care providers are offered care coordination and disease management supports to facilitate and enhance treatment for the persons served in the health home.**

Health Home

7. The health home team ensures that the following services are provided, as needed, to all persons served:
   a. Health promotion, including education.
   b. Care management, including:
      (1) Outreach
      (2) Engagement
   c. Comprehensive care management and care coordination, including, but not limited to:
      (1) Triage based on acuity.
      (2) Assessment of service needs.
      (3) Identification of gaps in treatment.
      (4) Development of an integrated person-centered plan.
      (5) Implementation of the person-centered plan.
      (6) Assignment of health team roles and responsibilities.
      (7) Arranging for and ensuring access to primary care and other needed healthcare services.
      (8) Appointment scheduling.
      (9) Monitoring of critical chronic disease indicators.

Health Home

7. d. Comprehensive transitional care, including:

(1) Ensuring that healthcare and treatment information is appropriately shared with all providers involved in the care of the person served, including:

(a) Treatment history.

(b) Current medications.

(c) Identified treatment needs/gaps.

(d) Support needed for successful transition between treatment settings.

(2) Providing follow up and medication reconciliation upon discharge from hospitalization.

Health Home

7. e. Individual and family support services, including:

(1) Education regarding concerns applicable to the person served.

(2) Education or training in self-management of chronic diseases.

(3) When possible and allowed, interaction with family members and/or significant others to:

(a) Identify any potential impact(s) of disease(s) of the person served on the family unit.

(b) Offer education or training in response to identified concerns.

f. Referral to needed community and social supports.

Health Home

8. **Care coordination includes sharing information:**
   a. **As follows:**
      (1) **Treatment history.**
      (2) **Assessed needs.**
      (3) **Current medications.**
      (4) **Identified goals.**
      (5) **Identified treatment gaps, when applicable.**

Health Home

8. Care coordination includes sharing information (continued):
   b. To the following providers involved in the care of the person served, as applicable:
      (1) Primary care.
      (2) Behavioral health.
      (3) Hospital.
      (4) Medical specialty.
      (5) Others, when applicable.
   c. During transitions between:
      (1) Inpatient and outpatient care.
      (2) Levels of care.
      (3) Outpatient care providers.
   d. In accordance with applicable laws and authorizations.

Health Home

9. **The health home enhances access through the following:**
   a. **Flexible scheduling.**
   b. **Capacity for same or next day visits, excluding weekends or holidays.**
   c. **Staff response to phone calls on the day of receipt.**
   d. **After hour's access through coverage that:**
      (1) **Shares necessary data on the person served.**
      (2) **Provides a contact summary to the health home.**
      (3) **Includes a warmline and/or recovery supports.**

Health Home

10. **Adequacy of staffing includes:**
    a. **Access to a variety of disciplines to respond to the needs of persons served.**
    b. **Coverage that allows for a warm handoff.**
    c. **Identified backup for planned absences.**

11. **The program assesses and responds to the needs of the majority of the targeted population served by providing services:**
    a. **In locations that meet their needs.**
    b. **At times to meet their needs.**

Health Home

12.The program offers education that:

a. Is understandable to the person served.

b. Includes family members or significant others, as permitted or legally allowed.

c. Includes:

(1) Health promotion, including:

(a) Healthy diet.

(b) Exercise.

(2) Wellness.

(3) Resilience and recovery.

(4) The interaction between mental and physical health.

Health Home

12. The program offers education that: (continued)
    c. Includes:
        (5) Prevention/intervention activities, based on the needs of the person served, including:
            (a) Smoking cessation.
            (b) Substance abuse.
            (c) Increased physical activity.
            (d) Obesity education.
            (e) Chronic disease education as it may relate to:
                (i) Heart disease.
                (ii) Diabetes.
                (iii) Other chronic medical conditions highly prevalent among the population served by the health home.
        (6) Self-management of identified:
            (1) Medical conditions.
            (2) Behavioral health concerns.
            (3) Other life issues as identified by the person served.
        (7) Medication use.

Health Home

13. Policies regarding initial consent for treatment identify:
    a. How information will be internally shared.
    b. How information is shared by collaborating agencies.
    c. The ability of the person served to decline health home services.
    d. The procedures to be followed if health home services are declined.

14. Written screening procedures clearly identify when additional information will be sought in response to the presenting condition of the person served:
    a. Including necessary:
        (1) Tests.
        (2) External assessments.
    b. To ensure the identification of underlying health problems or medical conditions.
    c. To provide appropriate response to emergency or crisis needs.

Health Home

15. Health assessment screening:
    a. Includes at a minimum:
        (1) Suicide risk.
        (2) Depression.
        (3) Metabolic syndrome screen.
        (4) Substance use.
        (5) Tobacco use.
        (6) Chronic health conditions highly prevalent among the population served by the program.
        (7) Chronic disease status, including at least the following:
            (a) Diabetes.
            (b) Hypertension.
            (c) Cardiovascular disease.
            (d) Asthma/COPD.
        (8) Chronic pain.
        (9) Perception of needs from the perspective of the person served.

Health Home

15. Health assessment screening: (continued)
    b. Is conducted or reviewed by a nurse, nurse practitioner or other equivalent medical personnel.
    c. Is completed for all persons enrolled in the health home:
        (1) For new enrollees subsequent to contacting the person served and introducing them to healthcare home services.
        (2) At the time of the annual assessment.

Health Home

16. The person-centered plan is an individualized, integrated plan that:

a. Includes:

(1) Medical needs.

(2) Behavioral health needs.

b. Is developed with collaboration of:

(1) The person served.

(2) Other stakeholders, when permitted or legally authorized.

c. Is developed with or reviewed by all staff necessary to carry out the plan.

Health Home

17. **Written procedures define a follow-through process in response to the initial assessment that includes:**
    a. **Reassessment when appropriate.**
    b. **Documented active linkage and/or referral in response to identified concerns.**
    c. **Identification of staff member(s) responsible for care coordination.**
    d. **Identification of care coordination responsibilities that include contacts for:**
        (1) **Self management planning.**
        (2) **Determining availability of needed supports.**
        (3) **Medication adherence.**
        (4) **Treatment adherence.**

Health Home

18. **Written procedures guide ongoing:**
    a. **Communication among interdisciplinary team members.**
    b. **Collaboration with external service providers.**
    c. **Communication with the person served and family members, when identified and allowed.**
    d. **Response to limitations on communication when identified by the person served**
    e. **Need for documentation of the results of communication and collaboration.**
    f. **Coordination of individual health care for the person served.**

Health Home

19. The program uses patient registries and/or electronic health records:

- **a. For data:**
  - **(1) Collection.**
  - **(2) Analysis.**
- **b. To proactively manage the health home population through tracking of the following about the person served:**
  - **(1) Contacts.**
  - **(2) Education.**
  - **(3) Disease status.**
  - **(4) Risk status.**
- **c. To support a process of:**
  - **(1) Identifying potentially dangerous medication practices.**
  - **(2) Remediating practices identified.**

Health Home

20. Performance measurement indicators address how service delivery responds to the needs of the persons served in an integrated/holistic manner, and include:

- **a. Process measures.**
- **b. Outcome measures for the persons served that consider:**
  - **(1) Medical status.**
  - **(2) Behavioral status.**
- **c. Real life functional outcomes for the person served.**
- **d. Perception of care from the perspective of the person served.**

Integrated BH/PC

1. **The written program description clearly defines the following:**
   - **a. Population served.**
   - **b. Integrated services that can be provided:**
     - **(1) Internally.**
     - **(2) Through contracts or other agreements.**
   - **c. Referral procedures for other services needed by persons served.**

Integrated BH/PC

2. **Integration of identified disciplines is supported by:**

    a. **Colocation and physical space arrangements.**
    b. **Implemented written procedures for:**
        (1) **Colocation.**
        (2) **Coordination.**
    c. **Applicable cross training.**

Integrated BH/PC

3. When colocation is not possible, the program is organized and delivered in a manner that ensures an integrated team approach that includes all the complementary disciplines.
4. The program:
    a. Identifies hours when medical services are available.
    b. Ensures that one or more of the following medical staff, legally able to independently provide the services offered, is on site during hours in which medical services are offered:
        (1) Physician.
        (2) Physician's assistant.
        (3) Nurse practitioner.

Integrated BH/PC

5. **A psychiatrist or psychologist is available for consultation during hours of operation.**

6. **Behavioral health providers are available on site during identified hours of integrated service operation.**

Integrated BH/PC

7. **Adequacy of staffing includes:**
    - **a. A variety of disciplines to respond to the needs of persons served.**
    - **b. Staff specifically trained and knowledgeable about the unique aspects of an integrated setting.**
    - **c. On-site coverage to allow for face-to-face linkage to appropriately trained staff.**
    - **d. Identified backup for planned absences.**

Integrated BH/PC

8. **The program assesses and responds to the needs of the majority of its targeted service population by providing services:**
    a. **In locations that meet its needs.**
    b. **At times that meet its needs.**

Integrated BH/PC

9. The program offers education that includes:

a. Wellness.

b. Resilience and recovery.

c. The interaction between mental and physical health.

d. Self-management of identified:

(1) Medical conditions.

(2) Behavioral health concerns.

Integrated BH/PC

10. **Policies regarding initial consent for treatment identify:**
    a. **How information will be internally shared.**
    b. **The ability of the person served to decline integrated services.**
    c. **The procedures to be followed if integrated services are declined.**
11. **Written screening procedures identify additional requirements based on the:**
    a. **Specific needs of the population served.**
    b. **Presenting conditions of persons served.**

Integrated BH/PC

12. Written procedures provide for an intake assessment to determine:

a. An initial level of care.

b. The need for:

(1) Integrated services.

(2) Immediate referral to specific:

(a) Internal services.

(b) External providers.

Integrated BH/PC

13. **An individualized integrated plan regarding medical and behavioral health needs is developed with collaboration of:**
    a. **The person served.**
    b. **All staff necessary to carry out the plan.**

Integrated BH/PC

14. Written procedures define a follow-through process in response to the initial assessment that includes:

    a. Reassessment when appropriate.

    b. Documented active linkage and/or referral in response to identified concerns.

    c. Identification of staff member(s) responsible for care coordination.

    d. Identification of care coordination responsibilities that include contacts for:

    (1) Self management planning.

    (2) Determining availability of needed supports.

    (3) Medication adherence.

    (4) Treatment adherence.

Integrated BH/PC

15. **Written procedures guide ongoing:**
    - **a. Communication among interdisciplinary team members.**
    - **b. Collaboration with external service providers.**
    - **c. Communication with the person served and family members, when identified.**
    - **d. Need for documentation of the results of communication and collaboration.**

Integrated BH/PC

16. **Performance measurement includes indicators addressing how services delivery responds to the needs of the persons served in an integrated/holistic manner.**

R. Intensive Outpatient Treatment

Revised to reflect varying contact hours based on age.

1. In intensive outpatient treatment, at least one of the following occurs, depending on the age of the person served:
   a. An adult and/or family members are provided with at least nine direct contact hours per week.
   b. A child or adolescent and/or family members are provided with at least six direct contact hours per week.

U. Partial Hospitalization

8. ***When applicable, based on the needs of the persons served,*** **a psychiatrist is available 24 hours a day, 7 days a week.**

11. **An *initial* assessment of the person served:**

*** changed from ‘primary’ assessment**

W. Residential Treatment

2. Based on the needs of the persons served, services are provided by a coordinated *treatment* team that includes, at a minimum, the following professionals:

Section 4

BH

Specific Population Designation

New and Revised

G. Eating Disorders

A thorough review is recommended.

Can only be used with Residential Treatment and Inpatient standards.

Child & Adolescent standards must also be applied if the program serves them.

Section 5

Community & Employment Services

New and Revised

Overview

Section J. Home and Community Services has been deleted

Section O. Employment Skills Training is new

A. Program/Service Structure

12. If behavioral change approaches are used, *positive behavior interventions*:
    b. Continue to be used in conjunction with any restrictive procedures.

13. Personnel are trained in the use of positive interventions:
    a. Initially.
    b. Annually.

14. d. If restrictions are placed on the rights of a person served:
    (2) *Monitors the effectiveness of these methods to reduce rights restrictions.*

J. Personnel Supports Services

The program description and the standards in the Personal Supports Services portion of this section have been revised based on input from the field. A thorough review is suggested.

Changes include:

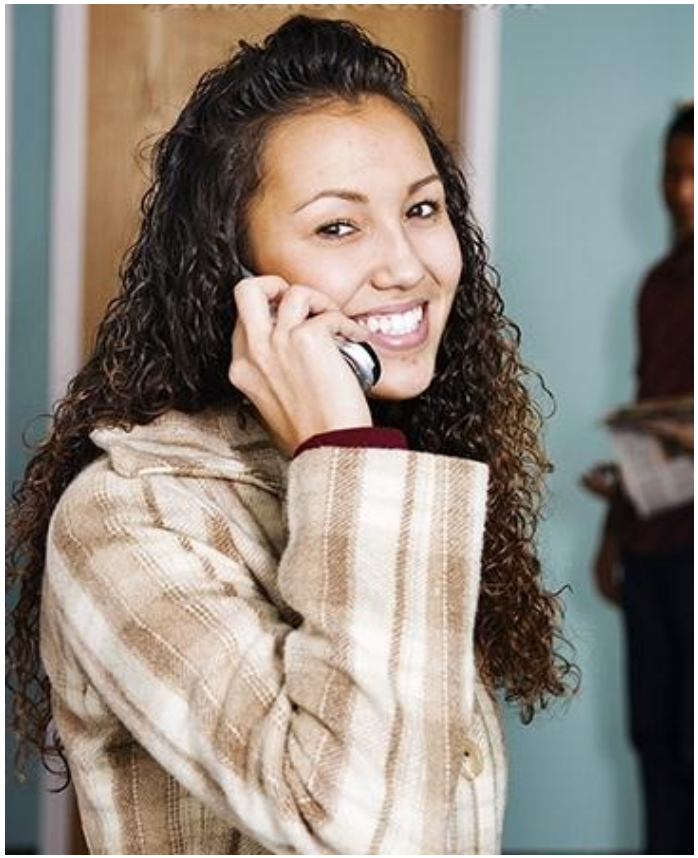
- ✓ Standard 1. is new.
- ✓ Standard 2. was previously Standard 1. and it has been modified.
- ✓ Previous Standard 2. has been combined with and incorporated into what was previously Standard 1.
- ✓ Standard 3. has been modified and restructured.
- ✓ Standards 4. and 5. were not changed.
- ✓ Previous Standard 6. has been deleted.
- ✓ Standards 6. and 7. are new.

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

Resource Specialist

- Resource Specialists are your:
  - Guides
  - Experts in interpretation of the standards and CARF process
- Resource Specialists help with:
  - Selection of appropriate field categories (BH) and programs.
  - Time lines for submission of pre-survey documentation and fees.
- Resource Specialists will set you up in Customer Connect.

CARF Contact for Ohio



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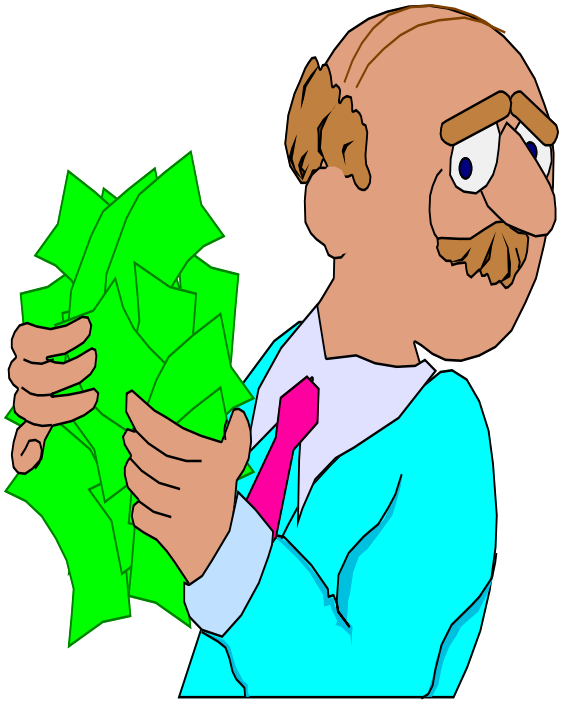
“What’s the Cost?”



- 2013 Standards Manual - $167
- 2013 Intent to Survey (application) fee - $995
- 2013 Survey fee - $1525 per surveyor per day

Questions