SERVICE GUIDELINES

FOR PEOPLE IN SUPPORTED LIVING HOMES

JANUARY 2005

Northwest Territories Health and Social Services

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1. INTRODUCTION

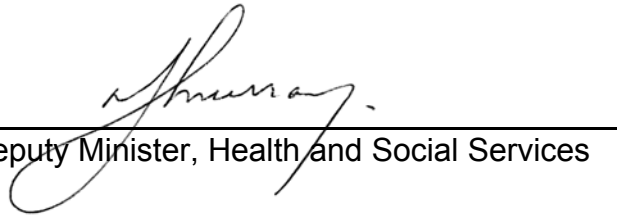
The Department of Health and Social Services is pleased to support the vision of providing a range of housing supports to enable persons with disabilities to reside in a safe and secure living environment that promotes independence and is conducive to the achievement of personal goals.

The former "Program Standards for Children and Adult Group Homes for the Northwest Territories" (2000) provided standards for children and adults who required supported care to live in community group homes. In 1998 and 2002, the Department evaluated community psychiatric services in Yellowknife and noted the need for standards for psychiatric group homes and other forms of supported living. The department proceeded to work with a contractor and consultation group to develop standards and a costing model for supported housing for adults with psychiatric needs. By the final draft, it was recommended that the scope be extended beyond adults with psychiatric disabilities: in fact, the standards were a useful model for all types of supported living in the Northwest Territories.

Service Guidelines for People in Supported Living Homes (2004) are written for Health and Social Services Authorities and service providers who work with adults who need support to live independently in the community. Adults may require assistance as a result of psychiatric, physical and/or mental disabilities. This document describes the background, the best practices literature, the philosophical approach and the certification process for service providers who provide a range of housing supports. The **Service Guidelines** contain forms to help potential supported housing service providers prepare for the pre-certification process. The companion document, ***Service Standards for People in Supported Living Homes*** (2004), outlines organizational, quality of care, and quality of life standards that guide Authorities in reviewing service providers for certification. These two documents replace "Program Standards for Adult Group Homes" (2000).

For more information on the Service Guidelines or Service Standards, contact the Mental Health Consultant at (867) 873-7926.

Approved by:



Deputy Minister, Health and Social Services

2. BACKGROUND

In May of 2001 the Premier of the Northwest Territories (NWT) asked a broad partnership of government representatives, non-governmental organizations (NGOs) and Aboriginal groups to develop a service framework to guide the development of effective services and to promote the full inclusion of persons with disabilities throughout the NWT.

Named the *Disability Steering Committee Partnership,* the group consulted extensively, identified needs, agreed on vision, values and principles, and over the course of eight months, distilled the concerns into five "core building blocks."

The Disability Framework was guided by a vision of *full citizenship*, values of *equality, inclusion, accessibility and participation,* and principles of *cultural appropriateness, building community capacity, self-determination, autonomy, dignity, respect, participation and independence*.

The "core building blocks" included *education, employment, income, disability supports and housing.* The building blocks were considered interrelated and together formed a comprehensive view of programs and services for the disabled in the Territories. Notwithstanding the interrelationship of each dimension, discreet goals and objectives were identified for each building block. In the area of housing, the goal was to ensure that persons with disabilities would be provided with "a range of housing options that are affordable, accessible, and that maximize independence."

Since 1992, preceding and parallel to the development of the Disability Framework, the NWT Department of Health and Social Services (DHSS) commissioned nine studies relating to improving health and social service delivery to the people of the NWT. Three of those reports called for the development of new policies and protocols relating to supported housing for people with various forms of mental disability.

This policy document, titled *Service Guidelines for People in Supported Living Homes*, provides a framework for the provision of housing options to people with disabilities in the NWT.

3. DEFINITIONS

Disability: The loss or reduction of functional ability and activity due to any disturbance of, or interference with, the normal structure and functioning of the body, including the systems of mental function.

Psychiatric Illness: Health conditions characterized by alterations in thinking, mood and behaviour (or some combination thereof), and associated with distress and/or impaired function.

Acquired Brain Injury: Impairment of brain function caused by trauma, toxicity or disease and associated with impaired function.

Developmental Disability: Developmental brain condition characterized by limitations in intellectual function and adaptive behaviors as expressed in conceptual, social and adaptive skills.

4. HOUSING NEEDS

Housing and health are inextricably linked. At a basic level, housing is meant to provide us with a secure environment with respect to safety, light, temperature, sanitation, a place to put possessions, to sleep, to eat and to satisfy basic body needs. But a home is much more. It is a base for daily routines; it gives us access to shopping, jobs, education, friends and family, church, social and health services and more. And homes are important sites for meaning in life. We decorate to reflect our identity and to remind us of the people who are important to us (pictures). Homes communicate to the world something about us – an expression of our status. They also provide opportunities for social relationships, for friendship, for intimacy and for refuge.

Suitable, adequate and affordable housing are important to all people, including those who are disabled. Homes help the disabled to maintain treatment or rehabilitation, establish and maintain relationships, create a secure and meaningful environment, access services, seek refuge, develop relationships and belong to a community.

Adequate housing is particularly critical in the sometimes harsh climate of the north, and housing problems are often acute. Please see Appendix A for a current profile of housing statistics in the NWT.

5. CONCEPTUAL FRAMEWORK

Housing has always played a critical role in the evolution of human service systems. In the early 19th century persons considered "insane," "retarded" or "dumb" were locked in jails or poorhouses or held without care in their own homes. An era of institutionalization followed where large isolated buildings were constructed, originally intended to be short-term and treatment-oriented. Unfortunately, the model quickly deteriorated and became aversive and custodial, often becoming one's "home," meeting basic needs but creating institutionalization (a syndrome characterized by loss of function and a mechanized existence).

By the 1970s, the human service systems developed the **"continuum"** model of residential care that remained the dominant form for twenty years. In its simplest form, the continuum contains several settings that provide different levels of service and supervision along with different levels of restrictiveness, with the most intense treatment in the most restrictive services. The patient or client is matched to a setting based on his or her level of functioning and need for restriction, moving along the continuum, from the most to least restrictive alternative. The clients are to represent a relatively homogenous group, essentially functioning at the same level and requiring the same level of service. In each setting the client is to learn new skills and adaptations and then graduates to the next more "normal" and less restrictive setting – or experiences a decline in function and returns to a setting that requires more intensive programming. Typically, staff members have the power to determine the clients' activities and lifestyle; defining appropriate behaviour even to small details such as when a television is off, what to eat, how a bed is made, whether alcohol is permitted and whether a light stays on.

While the continuum housing models varied across the country, typically they included a halfway house, family foster care, supervised apartments and independent living. Research in the late 1980s identified a model program, or "best practices," as including crisis residences, group homes, supervised residences, development residences, supportive residences, supervised apartments, supportive apartments and open community living, with respite programs for people who lost their place in the continuum.

In spite of a general acceptance of the continuum, it has failed to foster the development of options that adequately meet the needs of many persons with disabilities, including psychiatric illnesses, acquired brain injury and/or developmental disabilities. The reality of many disabilities, and in particular psychiatric disability, is that the model of progressive movement does not fit reality very well. People with these disabilities rarely change in a linear fashion, nor do they change at a predetermined rate. Residential moves place enormous stress on individuals; they often lose their network of supportive relationships

through a move, and people must prepare for the next setting while trying to adjust to the current one.

In addition, the experience in many sectors showed that people with severe impairments in function could live in usual housing if adequate supports and services were available. Examples include (a) community treatment teams, case management and mobile crisis services (Stein and Test); (b) models of normalization (Wolfensberger); (c) independent living movement for those with physical disabilities; and, (d) the assisted living model for elderly persons.

This shift in concept reflects the need for stable “normal” housing options (a home) and a place in the community, decoupled from, yet connected to, the formal service system.

In recent years, the supported model of housing has emerged to reflect this philosophy, decoupling the services from the home and linking them to the client as an individual. As the client’s needs change, the services and supports can be introduced or withdrawn from the environment. The client does not move as his or her needs change, but remains in stable housing as the services change. Supported housing also seeks to draw resources from the community, rather than develop a specialized environment that provides standard services. The supported housing model also requires a shift in the attitudes of housing staff in order to accommodate the shifting of some of the control from staff to clients. Staff will help clients to structure time and develop positive daily activities, but clients choose to conduct themselves as they wish in their homes. Access to the client’s home is by permission and the client may keep his or her housing even if they refuse therapeutic service.

In summary, the most important element of the supported housing model is the development of a permanent, secure home in the community - one that reflects, to the extent possible, the individual’s own ideas concerning an appropriate home. The home is then supplemented by the development of skills associated with “normal” living, participation in the life of the community, the provision of a personalized set of support services and where necessary, medical and therapeutic services based on the needs of the individual.

The contrast between:

SUPPORTED HOUSING	**CONTINUUM HOUSING**
A home	A residence
Choice	Placement
Citizen role	Client/patient role
Client control	Staff control
Social integration	Grouped by disability
Permanent setting	Transitional setting
Individualized supports	Standardized supports
Facilitative environment	Least restrictive environment

6. BEST PRACTICE

Best practices research on housing throughout North America (Goering, Carling, Trainor, Suwala), has consistently reported the following general criteria relating to the most successful programs:

- Decoupling homes from services
- Individualized supports
- Client/consumer choice
- Permanency.

While a wide range of housing options may be needed throughout the North West Territories, best practice research suggests there should be a shift in resources and an emphasis on the supported housing model. In summary, the model promotes the use of generic or "normal" housing widely dispersed in the community, individualized supports which vary in intensity with regard to need, consumer choice from a range of options, and open-ended tenure. Ideally, all supported housing strategies should be combined with service coordination often referred to as case management and assertive community treatment initiatives.

In the supported living model, the resident should be able to expect:

- Confidentiality
- Freedom from mental or physical abuse
- Respect and dignity
- Privacy
- A process for informed consent
- A grievance and appeal process
- Freedom of choice
- Freedom to pursue lawful political, religious and sexual activity
- Control over personal possessions.

The current emphasis on supported housing models has been fuelled by their contribution to both improved health outcomes (Baker, F. and Douglas, C. (1990); Brown, M.A Ridgeway, P., Anthony, W.A. and Rogers, E.S. (1991); Eberle, M. Kraus, D., serge L. and Hulchauski, D. (1999); Hurlburt, M.S., Wood, P.A and Hough, R.I. (1996); Goering (1997); Nelson, G., and Smith Fowler, H. (1987); Nelson, G., Brent Hall, G. and Walsh-Bowers, R. (1995 and 1997) and by client preference (Elliot, Massey, McCarthy, Ogilvie, Tanzman). Improved health outcomes include:

- Fewer symptoms of illness
- Fewer days in hospital
- Reduced use of crisis service
- Fewer contacts with police
- Improved quality of life

- Reduced stigma
- Reduced deviant behaviour.

These improved health outcomes were directly related to the clients' satisfaction with their homes. Client preference for supported housing was consistently reported within the context of safety, privacy, comfort, independence and opportunities to socialize. A review of 26 separate studies of client preference in housing found little variation in preference, with most preferring independent living in a house or apartment followed by a boarding home or with a family. Institutional living was the least preferred, with congregate (group) living the second least preferred. In fact, homelessness was frequently selected over institutional care. While this might lead to the conclusion that people with disabilities want to be left alone, those same studies confirmed a desire for support, with most clients wanting 24-hour "access" to staff as a top priority, the availability of home visits as required as a second priority, and assistance with budgeting a third choice.

In summary, the studies concluded that people with disabilities:

- Prefer living independently but realize that independence is facilitated by supports
- Want staff and professional supports on an as-needed basis rather than constantly
- Most consistently identify the need for income, housing subsidies, transportation and telephone.

While the supported housing needs and preferences of persons with psychiatric, brain injury and developmental disabilities are highly similar, there are differences. In general, persons with **psychiatric disabilities** may present a greater range of motivational and behavioral difficulties, including alcohol- and drug-related issues, while persons with **developmental disabilities** may present lower tolerance for stimuli and a greater need for structure, training and activity. Caution must be exercised in placing persons with **acquired brain injury,** as they frequently have greater security and medical needs. The most significant consideration in the appropriate placement of individuals from either "grouping," is the training, attitudes and skill of staff members.

7. SUPPORT ELEMENTS

Persons with disabilities who live in supported housing arrangements typically require assistance with several of the following support elements:

1	Safety and security	Physical environment Competence assessment
2	Personal care	Grooming Hygiene Self-care skills
3	Household management	Laundry Cleaning
4	Nutrition	Food preparation Menu planning including cultural options Shopping
5	Liaison/advocacy	Liaison and advocacy to fully utilize community, employment, health and social services
6	Money management	Budgeting Banking Spending
7	Housing support	Suite identification/administration Liaison/support to landlord
8	Personal effectiveness	Problem solving Decision making Goal setting Communication skills
9	Community integration	Accompanying to social/recreational activities Use of public services – transit Group work – build social contacts (peer support/self-help)
10	Personal Support	Encouragement/confidence-building/security Building family relationships Encourage maintenance of medical, counseling and therapeutic contacts
11	Medication monitoring	Medication delivery and storage Encouraging and monitoring medication compliance
12	Crisis management	Emergency availability Crisis intervention/management
13	Employment	Job coaching Job search Motivation and support
14	Respite	A break from the rigors of living Opportunities for staff
15	Service coordination	Coordinate medical psych-social and rehab services Staff training and support

8. HOUSING OPTIONS

Despite more than two decades of experience with the **continuum** and **supported** models of community residential services, a common language or nomenclature has failed to materialize and there is no consensus on the most appropriate description of the component parts of various models. Indeed, the literature describes more than 160 terms to label programs (Ridgway and Carling), with some individual models describing up to 20 options in a range of services.

Despite this lack of conceptual clarity, there are a few descriptors, which are dominant in the current literature, and best reflect the housing options most relevant to the reality of the Northwest Territories.

Family Living Homes
Private homes that provide a family atmosphere and personal supports for a fee paid by the individual or by a funding agency. No municipal licensing is required and placement is not considered transitional. Ideally one to three guests reside in the Family Living Homes. Support elements are provided by families and a Service Coordinator (Case Manager).

Group Living Homes
Homes managed by for-profit or not-for-profit organizations that provide transitional or continuing accommodation and supports for up to five persons, for a fee paid by the resident and/or a granting agency. Municipal licensing is required. Live-in staff and a Service Coordinator usually provide support elements.

Supported Living Homes
Homes, generally apartments, either rented by individuals or managed by for-profit or not-for-profit organizations that provide continuing accommodation ideally for one to two persons to a maximum of three persons (individual bedrooms are essential). Fees are paid by the resident and/or a granting agency and municipal licensing is not required. Service elements are provided by on-site staff and a Service Coordinator.

Independent Living Homes
Homes, generally apartments, rented independently by residents or by for-profit or not-for-profit organizations that ideally provide continuing accommodation for one or two persons. Costs are paid by the resident and/or a granting agency and municipal licensing is not required. Service elements, generally minimal, are provided by off-site staff and/or a Service Coordinator.

Temporary Shelter Homes
Short-term accommodation in a home or apartment managed by a for-profit or not-for-profit organization in order to provide urgently-needed housing or respite care ideally for one to three persons. Costs are paid by a granting agency on a standby basis and service elements are not individualized for funding purposes. Intensive service is available with highly qualified staff. Municipal licensing may be required.

9. STANDARDS

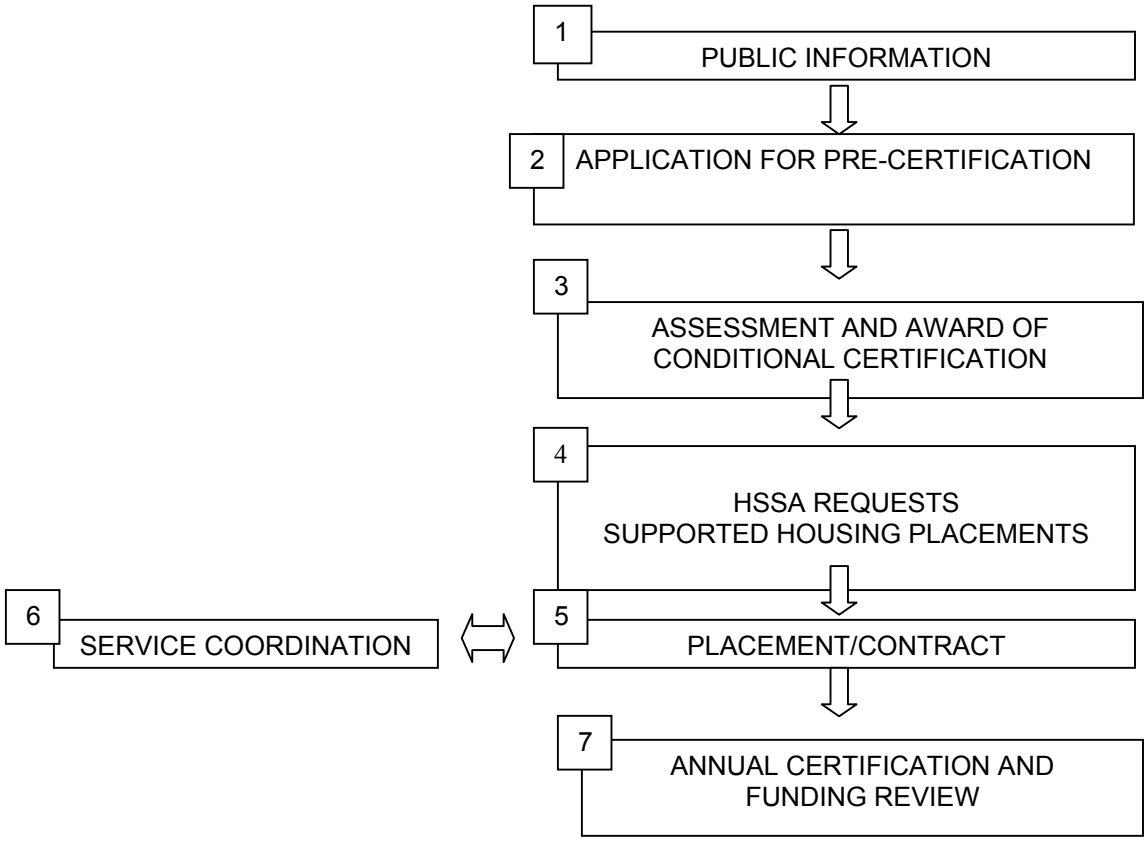
The purpose for residential standards is to ensure consistent high quality services for people with disabilities who live in residential programs supported by the government of the Northwest Territories. Standards (entitled ***Service Standards for People in Supported Living Homes),*** are detailed in a companion document.

The standards are mandatory for all service providers and measure how individual caregivers and organizations support individuals to achieve the best quality of life possible.

10. CERTIFICATION

Consistent with best practices in housing, the Department of Health and Social Services will emphasize supported housing options that encourage a range of providers to provide flexible, individualized, continuing and normalized home environments. If a housing service provider wishes to be considered for funding from the Government of the Northwest Territories for the purposes of providing supportive housing services to persons with disabilities, they must first be "pre-certified." The approval of an Application for Pre-Certification will authorize potential providers to respond to a Health and Social Services Authority (HSSA) invitation to provide future service to specific clients. Client placements and funding allocations will be individualized. Following placement, providers will be required to meet all Departmental service "standards." Within six months of the initial placement in a supported housing facility provided by a **new** service provider, the Authority will undertake a survey of the program. A successful outcome of that survey will lead to certification of the residential service. Certification denotes compliance with the Department's service standards. Further reviews and certification will occur annually.

The following flow chart illustrates the process.



1. A Health and Social Services (HSS) Authority provides public information regarding opportunities for individual citizens and organizations to provide supported housing options to people with psychiatric, brain injury and/or developmental disabilities.

2. Interested parties complete an "Application for Pre-Certification" (Appendix B), provided by the Authority. The application details responsibilities, service requirements, standards to be met, funding levels and contractual requirements.

3. Following an assessment by the Authority, pre-certification will be awarded or denied. Details regarding appeals and repeat applications will be provided.

4. Representatives of the Authority, who may be individually assigned staff or staff representatives of an Adult Assessment and Placement Committee, will contact pre-certified individuals and/or organizations to determine their interest in providing service to individual clients. The Authority's representative will then select the most appropriate placement based on the client's needs and preferences, and on the individual or organization's ability/desire to provide the range of "service elements" deemed necessary. Funding will be based on the current funding levels, adjusted from time to time (see Funding Framework companion document).

5. A "Contract for Placement" will be entered into between the Authority and the pre-certified body. The contract will confirm the requirements detailed during the process and outline an individual service plan, accountability measures and fees.

   In communities with Service Coordinators, providers will work closely with them to achieve the goals of the individual service plans in relation to the service elements agreed upon. Other Authority staff may be assigned the coordination responsibility in communities where Service Coordinators do not exist, or the service provider may be contracted to deliver the service themselves.

6. Six months following the initial placement and each year thereafter, the HSSA will undertake a service review to determine compliance with program standards. Compliance will result in the issuance or renewal of certification status. The review will also reassess the necessary service elements. Appendix C details the certification process and Appendix D details responsibilities in table form.

Pre-Certification
Applicants for pre-certification will be assessed against the following criteria adapted from the Service Standards. Full compliance with Service Standards must occur within six months of pre-certification.

Criteria

- Motivation to provide supportive housing
- Potential for a quality service
- Financial management capabilities
- Knowledge of regulations
- Staff credentials
- Adequacy of facility
- Value system.

See Appendix C for application form and process.

Certification
The certification (compliance with service standards) process will consist of a site visit(s) by Authority staff, which will review the supported housing program within the context of the Service Standards. Each standard will be rated “M” Met, “NM” Not Met, “UK” Unknown or “NA” Not Applicable. A maximum of two standards may be rated as unmet in order for certification to be granted. In the event of failure, the reviewer *may* stipulate a time frame during which the housing provider must remedy the deficiencies. Failure to do so will result in the termination of the supportive housing contract. Following a review where certification is denied, the housing provider may appeal the decision *if* the provider has concerns with the reviewer’s objectivity (for a more detailed guide to the certification process, see Appendix C and Appendix D).

11. FUNDING LEVELS

The research on best practices in supportive housing recognizes that a full range of housing and support options are necessary in order to address the needs of a diverse population. Funding levels usually reflect the individuals' need for specific services within a range of support elements (see section 6). Costs for supportive housing programs vary dramatically across North America, but even the highest-cost programs compare favorably with the institutional/facility-based system, where psychiatric units, psychiatric hospitals, extended care centers and correctional facilities cost on average 20% to 200% more. Funding levels for supported housing will be determined by HSS Authorities based on local conditions and circumstances. They will be adjusted when and as required, in consultation with the Department of Health and Social Services.

APPENDIX A

HOUSING STATISTICS IN THE NORTHWEST TERRITORIES

- 51% of all housing is rented.
- 18% of all dwellings are public housing units.
- Vacancy rates have fallen from 9% in 1998 to 1% in 2001 and are expected to drop even lower.
- 30 % of all dwellings have a problem with suitability, adequacy or affordability, nearly twice the national rate.
- 8% of households are occupied by six or more persons, although this has dropped from 14% 20 years ago.
- An estimated 13% of residents have a disability, often coupled with loneliness, high unemployment, poor education, low income and poor housing arrangements.
- 67% of adult persons with disabilities are single, divorced or separated.
- 84% of adult persons with disabilities are unemployed.
- 44% of adults with disabilities have less than grade nine education.
- 80% of disabled people have annual incomes of less than $20,000.
- 22% of all households have less than $50,000 annual income, with 40% of them having corresponding problems with suitability, adequacy or affordability in their housing.
- While 10% of disabled people have a psychiatric disability, brain-related disabilities are often not understood, accepted or acknowledged and the estimated prevalence may be underreported.
- An estimated 580 persons with disabilities were unable to obtain appropriate housing in 2000, and that number is expected to grow to 751 by 2009.

References

NWT Housing Corporation (2000). NWT Housing Needs Survey.

RBC Capital Markets (July 2002). Northern Properties REIT.

Little, L., Auchterlonie, S. and Stephen, B., Lutra Associates Ltd., on behalf of the partnership of: NWT Council for Disabled Persons; GNWT Health and Social Services; Yellowknife Assoc. for Community Living; GNWT Education, Culture and Employment (College and Careers Div.); YWCA of Yellowknife; Human Resources Development Canada; and MaryAnne Duchesne (2000). Living with Disability . . . Living with Dignity. Needs assessment of persons with disabilities in the NWT; Summary Report.

APPENDIX B

APPLICATION FOR PRE-CERTIFICATION

Citizens who are interested in providing supported housing services should complete and return the enclosed "Application Form" to the nearest Health and Social Services Authority. It is strongly recommended that the full contents of this report, ***Service Guidelines***, and the companion report, ***Service Standards for People in Supported Living Homes*** be read carefully prior to the submission of this application. All applicants will be contacted by a representative of the Authority.

APPLICATION FOR PRE-CERTIFICATION

Supported Housing Programs
GNWT Department of Health and Social Services

Name _____

Address _____

Phone_____ Fax_____ E-mail_____

1. Proposed Housing: FSH ☐ GLH ☐ SLH ☐ TSH ☐
2. Proposed # of individuals to be served _____
3. Proposed population(s) to be served:
    a. Psychiatric Illness ☐
    b. Acquired Brain Injury ☐
    c. Developmental Disabilities ☐
4. Location of proposed service _____
5. Proposer is:
    a. Individual ☐
    b. Non-Profit Society ☐
    c. Corporation ☐
    d. Other ☐
6. Why do you wish to provide supported housing?_____

_____

_____

_____

_____

Family Living Homes (FLH); Group Living Homes (GLH); Supported Living Homes (SLH); Temporary Shelter Homes (TSH)

7. Describe your family or organization:

8. Describe how you have managed finances in the past (accounting package, personal skills, contract out, etc.)

9. Describe the Federal, Territorial and Municipal regulations you have met or will need to meet and how you will do so (zoning, licensing, etc.

10. Describe your current or proposed staff and summarize their credentials (education and experience). Please attach a resume, copy of educational diplomas and RCMP criminal records check for the senior employee.

11. Describe your facility (house, apartment, etc.), including living space, provisions for privacy, sanitation, food preparation, safety, storage, access to outdoors, laundry and transportation, and the policies relating to pets, smoking, use of alcohol, etc.

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12. How do your personal/organizational values match our conflict with the documents?
Service Guidelines and/or ***Service Standards***?

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13. Are there any other issues, comments or recommendations you might wish to make?

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Signature

_____

Witness

Date_____

(Use the reverse of paper if additional space is required)

APPENDIX C

CERTIFICATION PROCESS

Participation in a survey for **Certification** is a requirement of the **"Service Guidelines"** policies six months following the placement of the first individual in a home and then annually thereafter.

While service providers are expected to continuously review their services and seek to improve them through a Quality Assurance program, an external review serves to objectively substantiate the quality of the service and provide assurances regarding the service and care which individuals are receiving.

Preparation

- The Authority assigns certification review responsibility to one or more staff members, appoints a **Certification Team** to review the results of the review and determines an appeal process.
- A representative of the Authority contacts the service provider in order to arrange a time for the certification review.
- The service provider reviews the **Service Guidelines** and **Service Standards (**the Authorities representatives will be available to review the documents with staff upon request).
- The service provider advises individuals of the review and informs them that they will be asked to participate.
- The service provider assembles the necessary support documentation.

On-Site Survey

- The representative(s) of the Authority ("reviewers") first meet with the senior service provider for the purpose of introductions and orientation.
- The service provider will provide all necessary documentation.
- The reviewer or reviewers then interview staff using the Service Standards document as a guide.
- The reviewers will then interview individuals using the standards as a guide.
- Finally, the reviewers will examine the facilities and documents.
- The interviewers will then rate each **indicator** through a process of observation, conversation and document review. The ratings will denote that the indicators have been **MET, NOT MET, UNKNOWN** or **NOT APPLICABLE.**
- Based on the review, the reviewers *may* identify further information and/or documentation that requires examination. A second site visit may be required.
- When the site visits are complete, the reviewer(s) will meet with the service provider and describe the post-survey process and time frame. Ratings can be discussed on a general basis; however, certification decisions will be made by the Certification Team.

Measuring Standards

- 80% of the component parts of each indicator must be met in order for the indicator to be rated as "MET," e.g.. Standard 4.3 requires a Strategic Plan. A minimum six of the seven identified components of the plan must exist.
- 80% of participant interviews must be rated as "MET" for the indicator to be "MET," e.g. if five participants are interviewed, four must report the indicator has been met.
- All indicators must be rated as "MET" for a standard to be rated as "MET."
- A maximum of two Standards may be rated as NOT MET for certification to be granted.

Post-Survey

- The Certification Team reviews the survey results and makes a determination if certification is to be granted.
- The service provider is advised in writing that certification has been granted **OR** the service provider is advised that the certification has not been granted.
- The survey results are reviewed with service providers, and both the strengths and deficiencies are identified. If the review was failed, remedies and a time frame for a supplementary review are agreed upon. In extreme circumstances a notification of contract termination can be provided.
- If remedies cannot be agreed upon, and the service provider has judged the review to lack objectivity or to have made errors in fact, that service provider may appeal the review in writing through the Authority's predetermined appeal process.

The decision of the Appeals body is final and will determine future action.

APPENDIX D

CERTIFICATION RESPONSIBILITES

Preparation	
The Authority will: ❑ Assign certification review responsibility to one or more staff members ❑ Appoint a **Certification Team** to review the results of the review ❑ Determine an appeal process ❑ Contact the service provider in order to arrange a time for the certification review ❑ Provide the **Service Guidelines** and **Service Standards** and be available to meet with the service provider to review documents upon request	The Service Provider will: ❑ Review the **Service Guidelines** and **Service Standards** ❑ Advise individuals of the review and inform them that they will be asked to participate ❑ Assemble the necessary support documentation
On-Site Survey	
The Authority (review team) will: ❑ Meet with the senior service provider for the purpose of introductions and orientation ❑ Interview staff using the Service Standards document as a guide ❑ Interview individuals using the standards as a guide ❑ Examine the facilities and documents ❑ Rate each **indicator** through a process of observation, conversation and document review. Ratings will denote that the indicators have been **MET**, **NOT MET**, **UNKNOWN**, or **NOT APPLICABLE**. ❑ May identify further information and/or documentation that requires examination.	The Service Provider will: ❑ Provide all the necessary documentation

Survey Completion

When the site visits are complete, the review team and the service provider meet to:

- Discuss the post-survey process and time frame
- Discuss the ratings on a general basis

Measuring Standards

- 80% of the component parts of each indicator must be met in order for the indicator to be rated as "MET", e.g. Standard 4.3 requires a Strategic Plan. A minimum six of the seven identified components of the plan must exist.
- 80% of participant interviews must be rated as "MET" for the indicator to be "MET", e.g. if five participants are interviewed, four must report the indicator has been "MET".
-

Post-Survey

The Authority will:	The Service Provider will:
❑ Review the survey results and make a determination if certification is to be granted ❑ Advise the service provider in writing that certification has been granted **OR** that certification has not been granted ❑ Review the survey results with service provider: identify both the strengths and deficiencies.	❑ Review the survey results with Certification Team ❑ Identify and agree upon remedies and a time frame for supplementary review (if the review was failed). ❑ Appeal the review in writing, through the HSSA pre-determined appeal process (if the review was judged to be erroneous of lacked objectivity)

APPENDIX E

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