Service Standards

Case Management

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

Definition

Case Management services provide continuity of care through a collaborative process of assessment, care planning, service referral, case monitoring, and advocacy to secure and coordinate appropriate resources and meet the needs of individuals and families served.

Note: *COA Accreditation's Case Management (CM) standards apply to stand-alone case management programs. Organizations that provide case management services as part of more comprehensive direct services such as clinical counseling, substance use treatment, housing assistance, therapeutic or child welfare services for children or youth, or other services are not accredited under Case Management (CM).*

Note: *Please see CM Reference List for a list of resources that informed the development of these standards.*

Table of Evidence

Self Study Evidence

No Self Study Evidence

Case Management

CM 1: Person-Centered Logic Model

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

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

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

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

Logic models have been implemented for all programs and the organization has identified at least two outcomes for all its programs.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Logic models need improvement or clarification; or
- Logic models are still under development for some of its programs, but are completed for all high-risk programs such as protective services, foster care, residential treatment, etc.; or
- At least one desired outcome has been identified for all of its programs.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Logic models need significant improvement; or
- Logic models are still under development for a majority of programs; or
- A logic model has not been developed for one or more high-risk programs; or
- Outcomes have not been identified for one or more programs.

4

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

- Logic models have not been developed or implemented; or
- Outcomes have not been identified for any programs.

Table of Evidence

Self Study Evidence

*	• Program logic model that includes a list of outcomes being measured	
	• See program description completed during intake	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

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

CM 1.01

A program logic model, or equivalent framework, identifies:

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

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

Examples: *Information that may be used to inform the development of the program logic model includes, but is not limited to: (a) characteristics of the service population, (b) needs assessments and periodic reassessments, and (c) the best available evidence of service effectiveness.*

CM 1.02

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

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

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

Case Management

CM 2: Personnel

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

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

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

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- With some exceptions, staff (direct service providers, supervisors, and program managers) possess the required qualifications, but the integrity of the service is not compromised; or
- Supervisors provide additional support and oversight, as needed, to the few staff without the listed qualifications; or
- Most staff who do not meet educational requirements are seeking to obtain them; or
- With few exceptions, staff have received required training, including applicable specialized training; or
- Training curricula are not fully developed or lack depth; or
- Training documentation is consistently maintained and kept up-to-date with some exceptions; or
- A substantial number of supervisors meet the requirements of the standard, and the organization provides training and/or consultation to improve competencies when needed; or
- With few exceptions, caseload sizes are consistently maintained as required by the standards or as required by internal policy when caseload has not been set by a standard; or
- Workloads are such that staff can effectively accomplish their assigned tasks and provide quality services and are adjusted as necessary; or
- Specialized services are obtained as required by the standards.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

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

- Specialized services are infrequently obtained as required by the standards.

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

Table of Evidence

Self Study Evidence

*	• Table of contents of training curricula	
*	• Procedures or other documentation relevant to continuity of care and case assignment	
*	• List of program personnel that includes: 1. Title 2. Name 3. Employee, volunteer, or independent contractor 4. Degree or other qualifications 5. Time in current position • See organizational chart submitted during application	

Site Visit Evidence

*	• Sample job descriptions from across relevant job categories • Documentation tracking staff completion of required trainings and/or competencies • Training curricula • Caseload size requirements set by policy, regulation, or contract, when applicable • Documentation of current caseload size per worker

On-Site Activities

*	• Interviews may include: 1. Program director 2. Relevant personnel • Review personnel files

CM 2.01

Case managers are qualified by:

a. a bachelor's degree in a human service field;
b. a bachelor's degree in a field other than a human service, with appropriate experience; or
c. appropriate licensure or certification.

Interpretation: *Appropriate experience, including lived experience, and specialized training can compensate for a lack of a bachelor's degree depending on the type of case management services being provided.*

Examples: *Regarding element (c), appropriate licensing and certifications may vary depending on the program model and populations served but may include Certified Case Manager (CCM), Accredited Case Manager (ACM), Certified Social Work*

Case Manager (C-SWCM), Case Management Nurse – Board Certified (CMGT-BC), or other recognition from a national certification body.

CM 2.02

Supervisors of case managers are qualified by:

a. an advanced degree in a human service field and a minimum of two years' experience in direct services or case management;
b. a bachelor's degree in a human service field and four years' experience in direct services or case management; and/or
c. licensure or certification in case management and four years' experience in direct services or case management.

Interpretation: *Years of experience providing services, in addition to formal trainings, certifications, and/or leadership experience can compensate for a lack of degree depending on the type of case management services being offered.*

CM 2.03

Case managers receive training on, or demonstrate competency in:

a. the principles and practices of person-centered care;
b. skills and strategies for engaging, partnering with, and supporting family members, when appropriate;
c. coordinating services as part of a team; and
d. linking service recipients with, or making referrals to, community services.

CM 2.04

When staff with lived experience provide services to individuals and families, the organization:

a. clearly defines their roles and responsibilities;
b. includes them as equal partners on the team;
c. helps other program personnel understand the position and its purpose at the program;
d. establishes guidelines for recruitment and selection;
e. ensures they are trained to perform their roles and responsibilities;
f. provides ongoing support and supervision to address any issues that occur, including helping them manage personal triggers that may arise on the job;
g. facilitates opportunities to connect and consult with others performing similar roles; and
h. ensures they are offered opportunities for professional development and career advancement.

NA: The organization does not have lived experience positions.

Examples: *Staff with lived experience can play an important role in welcoming, engaging, empowering, supporting, and advocating for individuals and families. These workers may experience challenges in their employment including stigma from co-workers, inappropriate expectations from other staff, role confusion, triggers from past trauma, and lack of opportunities for support and advancement. When they are viewed and included as full partners who have input into program decisions and given appropriate support, staff with lived experience can help organizations ensure their culture and practices prioritize the experience and involvement of persons served and their families.*

Examples: *Organizations may use other terms to describe staff with lived experience including staff with lived expertise, peer support workers, peer support specialists, peer/family/youth partners, peer/family/youth advocates, peer recovery coaches, family mentors, and/or family liaisons.*

CM 2.05

The organization promotes stability and service continuity by:

a. assigning a worker at intake or early in the contact, when appropriate; and
b. minimizing the number of workers assigned to the individual or family during their contact with the organization.

CM 2.06

The organization determines and adjusts caseload sizes to support the achievement of desired outcomes, paying attention to:

a. the identified needs of individuals and families;
b. the goals and desired outcomes of persons served; and
c. the frequency of contact.

Examples: *Additional factors that can be considered when determining employee workloads include but are not limited to: (a) the qualifications, competencies, and experience of the worker, including the level of supervision needed, (b) the work and time required to accomplish assigned tasks and job responsibilities, and (c) service volume.*

Case Management

CM 3: Intake and Assessment

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

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

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- In a few rare instances, urgent needs were not prioritized; or
- For the most part, established timeframes are met; or
- Culturally responsive assessments are the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Urgent needs are often not prioritized; or
- Services are frequently not initiated in a timely manner; or
- Applicants are not receiving referrals, as appropriate; or
- Assessment and reassessment timeframes are often missed; or
- Assessments are sometimes not sufficiently individualized;
- Culturally responsive assessments are not the norm, and this is not being addressed in supervision or training; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent; or
- Intake or assessment is done by another organization or referral source and no documentation and/or summary of required information is present in case record.

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

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

Table of Evidence

Self Study Evidence

*	• Screening and intake procedures	
*	• Assessment and re-assessment procedures	
*	• Copy of assessment tool(s)	
*	• Procedures for referring individuals to services	

Site Visit Evidence

*	• Community resource and referral list

On-Site Activities

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

CM 3.01

Individuals and families are screened and informed about:

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

NA: Another organization is responsible for screening, as defined in a contract.

CM 3.02 (FP)

Prompt, responsive intake practices:

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

CM 3.03

Individuals and families participate in an individualized, trauma-informed, culturally and linguistically responsive assessment that is:

a. conducted in a place of the individual's or family's choice, when possible;
b. completed within established timeframes;
c. appropriately tailored to meet the age, developmental level, and preferences of persons served;
d. inclusive of information, screenings, and assessments provided by partnering or referring providers, when appropriate; and
e. focused on information pertinent for meeting service requests and objectives.

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

CM 3.04

The organization provides or arranges for specialized assessments when indicated.

Examples: *Specialized assessments vary based on the program model and populations served but may include assessments related to: (a) physical health, (b) substance use or mental health, (c) domestic violence, (d) speech and language, (e) occupational therapy, or (f) ABA therapy.*

CM 3.05

Reassessments are conducted as needed according to the needs and preferences of the individual or family and inform revisions to the service plan when indicated.

Interpretation: *Situations that may necessitate a reassessment include, but are not limited to, changes in the individual or family's status or circumstances, a new physical or mental health diagnosis, or imminent discharge from a hospital or institution.*

Case Management

CM 4: Service Planning and Monitoring

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

Each individual or family participates in the development and ongoing review of a service plan that is the basis for coordinating and delivering appropriate services and support.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- With few exceptions, staff work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc.; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Timeframes are often missed; or
- Case reviews are not being done consistently; or
- Level of care for some people is clearly inappropriate; or
- Service planning is often done without the full participation of persons served; or
- Appropriate family involvement is not documented; or
- Documentation is routinely incomplete and/or missing; or
- Individual staff members work with persons served, when appropriate, to help them receive needed support, access services, mediate barriers, etc., but this is the exception.

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

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

Table of Evidence

Self Study Evidence

* • Service planning and monitoring procedures	

Site Visit Evidence

No Site Visit Evidence

On-Site Activities

*

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

CM 4.01

An assessment-based service plan is developed in a timely manner with the full participation of individuals and families and includes:

a. agreed upon goals, desired outcomes, and timeframes for achieving them;
b. services and supports to be provided, and by whom;
c. possibilities for maintaining and strengthening family relationships and other informal social networks;
d. procedures for expedited service planning when crisis or urgent need is identified; and
e. documentation of the individual's or family's participation in service planning.

Interpretation: *Although personnel should help identify available services and their potential risks and benefits and participate in evaluating options, individuals and families should be the primary planners of their goals and objectives and have the right to decide what services and supports will be provided.*

Examples: *Personnel can help to engage and motivate individuals and families in the service planning process by demonstrating: (a) sensitivity to their needs and personal goals, (b) a non-judgmental manner, (c) respect for their autonomy, confidentiality, sociocultural values, identity, lifestyle choices, and complex family interactions, (d) flexibility, and (e) appropriate boundaries.*

CM 4.02

The organization partners with the individual or family to regularly review their case at a frequency that meets their needs and:

a. assesses service plan implementation;
b. reviews progress toward achieving goals and desired outcomes;
c. determines the continuing appropriateness of agreed-upon service goals; and
d. makes adjustments to the service plan when indicated.

Case Management

CM 5: Service Elements

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

The organization collaborates with individuals, families, and other service providers to facilitate the coordinated delivery of needed supports and services.

Rating Indicators:

1

All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- For the most part, established timeframes are met; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- Active participation of persons served occurs to a considerable extent.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

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

4

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

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

Table of Evidence

Self Study Evidence

*	• Service coordination procedures	
*	• Procedures for keeping the community resource documentation system up-to-date	
*	• Crisis response procedures	

Site Visit Evidence

*	• Community resource and referral list

On-Site Activities

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

CM 5.01

The organization works in active partnership with individuals and families to:

a. locate, arrange, and coordinate identified services;
b. identify and connect them to informal community resources and social networks, as appropriate;
c. ensure that they receive appropriate advocacy support;
d. assist with access to the full array of services to which they are eligible; and
e. anticipate, identify, and mediate barriers to services within the service delivery system.

Examples: *Services may include but are not limited to: (a) 24-hour crisis intervention, (b) psychiatric services, (c) housing services, (d) medical and dental services, (e) substance use treatment, (f) public assistance and income maintenance, (g) family support services, (h) vocational training and job placements, and (i) transportation.*

Examples: *In regard to element (c), ways in which case managers may advocate on behalf of persons served include but are not limited to ensuring individuals are informed of their rights and applicable benefits, appealing denials of services, and representing the best interests of the individual when appropriate and desired by the person. Case managers may also advocate for service populations at the community or national level by participating in advocacy groups or getting involved in public policy and political activism.*

CM 5.02

The organization provides continued evaluation of services, including:

a. confirming, usually within one or two working days, that a service has been initiated in accordance with the individual's preferences;
b. verifying, usually within 15 working days, that the service is appropriate and satisfactory;
c. following up with persons served routinely as specified by program design; and
d. responding promptly to any complaints or problems that develop in the delivery of services or with the individual or family.

Interpretation: *The organization should tailor the type and frequency of service evaluation according to the needs of individuals and families, frequency and intensity of service provided, and frequency of contact with informal caregivers and cooperating providers.*

CM 5.03

The organization maintains or has access to a comprehensive, up-to-date documentation system of community programs and services that includes:

a. name, location, and telephone number;
b. contact person or referral system;
c. services offered;
d. languages offered;
e. fee structure; and
f. eligibility requirements.

Interpretation: *The organization ensures the community resource documentation system remains up-to-date by evaluating resources on an ongoing basis to assess the safety, quality, and availability of services provided.*

CM 5.04 (FP)

Written procedures address how to respond in crisis situations, including:

a. providing intervention and stabilization;
b. connecting the individual to more intensive services; and/or
c. contacting emergency responders as appropriate.

Examples: *Crisis situations can include those involving a risk of imminent harm, including suicide, medical crises, substance overdoses or withdrawals, violence, child endangerment, and other emergency situations. Examples of what may be outlined in crisis response procedures can include but are not limited to: (a) protective measures or special precautions related to individuals involved in cases of domestic violence or other endangerment situations, (b) protocols on how to connect individuals and families to appropriate formal crisis intervention services or emergency responders, and (c) guidance on mandatory reporting and the disclosure of suspected abuse or other criminal behavior.*

Case Management

CM 6: Case Closing and Aftercare

Purpose

Case Management services help individuals and families access needed resources and supports that build on their strengths, promote their independence and stability, improve their quality of life, and meet their individualized service goals.

The organization works with individuals and families to plan for case closing and, when possible, to develop aftercare plans.

Rating Indicators:

1 All elements or requirements outlined in the standard are evident in practice, as indicated by full implementation of the practices outlined in the Practice Standards.

2

Practices are basically sound but there is room for improvement, as noted in the ratings for the Practice Standards; e.g.,

- Minor inconsistencies and not yet fully developed practices are noted; however, these do not significantly impact service quality; or
- Procedures need strengthening; or
- With few exceptions, procedures are understood by staff and are being used; or
- Proper documentation is the norm and any issues with individual staff members are being addressed through performance evaluations and training; or
- In a few instances, the organization terminated services inappropriately; or
- Active participation of persons served occurs to a considerable extent; or
- A formal case closing evaluation is not consistently provided to the public authority per the requirements of the standard.

3

Practice requires significant improvement, as noted in the ratings for the Practice Standards. Service quality or program functioning may be compromised; e.g.,

- Procedures and/or case record documentation need significant strengthening; or
- Procedures are not well-understood or used appropriately; or
- Services are frequently terminated inappropriately; or
- Aftercare planning is not initiated early enough to ensure orderly transitions; or
- A formal case closing summary and assessment is seldom provided to the public authority per the requirements of the standard; or
- Several case records are missing important information; or
- Participation of persons served is inconsistent.

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

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

Table of Evidence

Self Study Evidence

*	• Case closing procedures	
*	• Aftercare planning and follow-up procedures	

Site Visit Evidence

*

- Relevant portions of contract with public authority, as applicable

On-Site Activities

*

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

CM 6.01

Planning for case closing:

a. is a clearly defined process that includes assignment of staff responsibility;
b. begins at intake; and
c. involves the worker, persons served, and others as appropriate to the needs and wishes of the individual or family.

CM 6.02

Upon case closing, the organization notifies any collaborating service providers, as appropriate.

CM 6.03

If an individual or family has to leave the program unexpectedly, the organization makes every effort to identify other service options and link them with appropriate services.

Interpretation: *The organization must determine on a case-by-case basis its responsibility to continue providing services to persons whose third-party benefits are denied or have ended and who are in critical situations.*

CM 6.04

When appropriate, the organization works with persons served and their family to:

a. develop an aftercare plan, sufficiently in advance of case closing, that identifies short- and long-term needs and facilitates the initiation or continuation of needed supports and services; or
b. conduct a formal case closing evaluation, including an assessment of unmet need, when the organization has a contract with a public authority that does not include aftercare planning or follow-up.

CM 6.05

The organization follows up on the aftercare plan, as appropriate, when possible, and with the permission of the individual or family.
NA: The organization has a contract with a public authority that prohibits or does not include aftercare planning or follow-up.

Examples: *Reasons why follow-up may not be appropriate include, but are not limited to, cases where individuals are transferred to long-term care settings or a higher level of care, or where there may be a safety risk such as in cases of domestic violence.*