GUIDELINES and RESOURCES

FOR CENTERS RELATED TO

SOLIHTEN INSTITUTE ACCREDITATION

Solihten Institute
7887 East Belleview Avenue, Suite 1100
Denver, CO 80111
Phone (303) 691-0144
info@solihten.org

© December 2021

TABLE OF CONTENTS

I. Introduction 2

II. Accreditation Process Timeline 3

III. Phases of the Accreditation Process 4

IV. Guidelines for Assessing Center Compliance with Standards 7

V. Appendices

A. *Resources for Center Leaders*

1. Checklist of Documentation Materials to be Compiled and Sent by the Center 32
2. Board President (or Board Member) Self Study 35
3. Executive Director (or Lead Staff) Self Study 36
4. Supplemental Procedures in Lieu of Independent Accounting Services 37
5. Center Financial Governance and Accountability Report 38
6. Guidelines for Scheduling the Site-Visitor's Time 39

B. *General Resources*

1. Site-Visit Arrangements and Expenses 41
2. A History of Solihten Institute Accreditation 42
3. Cooperative Accreditation Agreements 45

I. INTRODUCTION

The Solihten Ministry is an interfaith network of open and developing Solihten Counseling Centers and Solihten Institute. With over 300 offices in the United States, Solihten Centers provide approximately 600,000 hours of counseling, education and consultation each year. Each Center designs services and programs to meet the needs of the particular communities it serves. All Solihten Centers are expected to achieve Full Accreditation with Solihten Institute by complying with all ***applicable*** accreditation standards or to meet this criterion for affiliation through accreditation with one of three recognized national behavioral health accrediting bodies (CARF, COA, or The Joint Commission), and a set of additional criteria established by Solihten Institute.

The Purpose of Solihten Institute Accreditation Process is to help ensure that affiliated Solihten Centers maintain sound organizational structures, efficient management and administration, high-quality clinical processes, appropriate personnel and financial practices, and professional accountability.

Approval of Full Accreditation does not guarantee that a Center is in full compliance, nor does Solihten Institute accreditation in any way imply an assurance that a Center has or will maintain continuous compliance with the standards during the accreditation period. Rather Solihten Institute accreditation indicates that in the best judgment of the visitor and Solihten Institute Accreditation Committee, based on the evidence presented at the time of the review, the Center met all the standards in ways that the committee judged to be acceptable.

The Value of Accreditation for Centers: For Center leaders, the accreditation process is an opportunity to examine Center life in dialogue with an outside consultant. The process requires the examination and enhancement of aspects of organizational life and functioning that are important, but frequently not matters of either urgency or top priority. When successfully completed, Full Accreditation status indicates that the Center has been assessed in relation to a wide range of quality standards that are recognized nationally by managed care companies, denominations, and colleagues in the field. In particular, the most recent benchmark of Solihten Institute standards included comparisons to the Joint Commission and CARF behavioral health quality standards.

Centers are encouraged to maximize the leverage that Solihten Accreditation can have locally through utilization of the marketing materials from Solihten Institute. Solihten Accreditation is often helpful with local funders and in foundation grant applications to demonstrate that a Center meets nationally recognized quality standards. In addition, in some instances third party payers, and state regulatory agencies have recognized the value of Centers compliance with Solihten Institute Accreditation standards.

II. ACCREDITATION PROCESS TIMELINE

Six to nine months before the visit is due:

- Institute contacts Center to initiate accreditation process
- Accreditation guidelines sent to Center
- Site-visit dates set, site-visitor selected, and travel plans initiated
- Executive Director and Board President Self-Studies initiated

Four weeks prior to the visit:

- Completed materials and proposed site-visit schedule sent to site-visitor and Institute Coordinator
- Visitor confirms travel arrangements with Center director

Two weeks prior to the visit:

- Institute Coordinator and site-visitor confer about visit and materials

Within two weeks after visit:

- The site-visitor sends the Institute a draft of the site-visit report and documentation of expenses for the visit
- The Institute pays the visitor's honorarium and expenses and bills the Center for the expenses

Within four weeks after visit:

- The Institute sends copies of the report to the Center Director, Center Board President, and site-visitor

At least three weeks prior to the next accreditation committee meeting:

- The Center Director and Board President send a response to the report to the Institute Accreditation Coordinator

Following the accreditation committee meeting:

- The Institute and/or the committee chair notify the Center Director and site-visitor of the committee's action
- The Institute sends an accreditation certificate and sample news release to Centers approved for full accreditation.

III. PHASES OF THE ACCREDITATION PROCESS

PREPARING FOR THE SITE-VISIT

There are four phases in the accreditation process:

1. **In the Preparation Phase,** Center leaders' complete self-studies, compile extensive documentation of Center policies and practices, a site visitor is identified, and a site-visit schedule is planned with the guidance of Solihten Institute Accreditation Coordinator.

2. **In the Site-Visit Phase,** the site-visitor carries out a 1½ - 2 day site visit to the Center, working with Center leaders to assess the Center's compliance with the accreditation standards by reviewing materials, conducting interviews, observing meetings, and spot-checking various clinical and administrative records. Center functions are assessed in relationship to a set of 38 standards related to the Center's organization, board of directors, personnel, services, finances, facilities, administration, program accountability, and services for clergy and congregations.

3. **In the Reporting Phase,** the visitor gives an oral report to Center leaders at the end of the visit. Then, the visitor prepares a written report that is sent to Center leaders after review by Solihten Institute Accreditation Coordinator. Center leaders prepare a written response to the report and send it along with any further documentation to the Institute Coordinator.

4. **In the Decision-Making Phase,** the Accreditation Committee of Solihten Institute board of directors acts on a recommendation from the Institute coordinator along with a summary of the site-visit report and Center response. The committee's determination of a Center's accreditation status is reported to Center leaders and to the Institute board of directors.

A Center, that in the view of the committee has achieved acceptable compliance with all standards, is approved for **Full Accreditation** for a period of up to four years.

Centers that achieve one of the three nationally recognized behavioral health accreditations and meet the additional criteria established by Solihten Institute will be approved for **Full Accreditation** for the period of time determined by the relevant accrediting body.

Centers that are judged to meet most, but not all of the standards at the time of review, may be approved for **Provisional Accreditation** for a period of six months to one year.

The committee may place determination of a Center's accreditation status on **hold**, pending further information or action.

On rare occasions, the committee may recommend to the board that Solihten Institute **disaffiliate** with a Center based on the findings of the accreditation review.

The committee may authorize **extending** the length of the current accreditation period in response to a request from Center leaders or other concern. When an extension occurs, the next period of accreditation is shortened to reflect the period of extension, so that the four-year cycle is routinely maintained.

Preparation for a site-review is a combined effort by board and staff members of the Center, the site-visitor, and Solihten Institute Accreditation Coordinator.

Timing: Solihten Centers are reviewed for accreditation on a four-year cycle. For a newly developed or newly-affiliated Center, an accreditation review is planned approximately one year after opening or affiliating, with significant allowances for variations based on the circumstances of an individual Center. For Centers due for re-accreditation, the site-visit review is usually scheduled three to six months prior to the end of the current accreditation period.

Scheduling Considerations: Developing an effective schedule for an accreditation site-visit is a cooperative effort. The average review requires a site-visit of 12 to 16 contact hours over a period of one and one-half to two days with additional time for the visitor's travel, initial review of the materials, and preparation of the written report (see Appendix A-5 Guidelines for Scheduling the Site Visitor's Time). It is usually helpful for the executive director to clear some, but not all, of his or her time during the visit to be available to participate in the scheduled meetings and to discuss the visitor's findings and impressions as they develop.

Preparation by Center Leaders with the Institute Coordinator

1. The Institute Accreditation Coordinator contacts Center leaders well before the visit and provides this accreditation packet electronically.

2. The Institute Coordinator and Center director confer regarding the most suitable site-visit dates, the current issues facing the Center, and the site-visitor(s). Normally visits are scheduled to coincide with regularly scheduled board and staff meetings.

3. The Center then submits both the Executive Director and Board President Self-Studies, materials which document the Center's compliance with the accreditation standards, and a site-visit schedule. Not less than four weeks prior to the scheduled visit, the Center sends a copy of the schedule, self-study materials and documentation to the Institute. Center leaders should also maintain a full set of materials at the Center.

4. Well before the visit, the site-visitor contacts the Center executive to make arrangements for travel and lodging and to discuss other scheduling considerations.

REPORTING ON THE SITE-VISIT

The reporting phase has four elements:

1. **Exit review:** At the end of the site-visit, the reviewer presents Center leaders with a verbal report of his or her view of the Center's level of compliance with the standards. The exit interview usually includes the executive director and board president and may also include other staff, board leaders, and stakeholders of their choosing.

2. **Site-visitor's report:** The visitor prepares a written report draft of his/her findings and sends it to the Institute Coordinator for review.

3. **Final report:** The Institute Coordinator reviews the draft report and, in consultation with the visitor, makes any revisions needed to reflect that discussion and the standard patterns of Solihten Institute accreditation. Copies of the site-visit report with any necessary revisions are sent from the Institute Coordinator to the Center director, the board president, and the visitor.

4. **The Center's written response:** Center leaders review the report and send a written response to the Institute Coordinator. In the response, Center leaders should indicate their receipt and review of the report, identify any errors in the report or disagreements with the conclusions, document any actions the Center has taken to address any standards which were ***Not Yet Met*** at the time of the visit, and describe how the Center plans to meet any unmet standards. The response should reach the Institute Coordinator at least two weeks prior the Accreditation Committee meeting at which it will be considered.

COMMITTEE DECISION-MAKING

1. **Summary and recommendation for committee action:** The Institute Coordinator presents a summary of the site-visitor's report and the Center response along with supplementary materials and a recommendation to Solihten Institute Accreditation Committee for action at a quarterly meeting.

2. **Committee action:** A Center in basic compliance with all standards at an acceptable level receives Full Accreditation for a period of up to four years. Provisional Accreditation is granted when a Center meets most, but not all, of the standards. A change from Provisional to Full Accreditation may be approved at any committee meeting. The usual four-year period of Full Accreditation is reduced by the period of Provisional Accreditation. In some circumstances a Center's accreditation status may be placed on hold, pending further information or action. In rare instances, the process of disaffiliation of a Center from the Solihten Ministry may be initiated through the accreditation process.

Solihten Institute accreditation is an assessment of a Center's compliance with the standards at the time of the accreditation review. Committee approval of full or provisional accreditation expresses the committee's judgment that a Center has been in acceptable compliance with the standards during the accreditation visit or came into compliance between the time of the visit and the time of the committee's action. **While Centers are expected to maintain the standards between visits, the Institute does not assert any claim that it can assure that a Center is maintaining compliance during the full accreditation period.**

IV. GUIDELINES FOR ASSESSING COMPLIANCE WITH THE SOLIHTEN INSTITUTE ACCREDITATION STANDARDS

In the following discussion of accreditation standards, you will find commentary that expands on the meaning and intent of the particular standard.

SOLIHTEN INSTITUTE ACCREDITATION STANDARDS WITH COMMENTARY

Each Solihten Center shall demonstrate at least minimal compliance with each accreditation standard.
A Center may petition the Accreditation Committee to make an exception or accept an equivalent method for fulfilling a requirement. This request should be described in detail in a letter to Solihten Institute and submitted with the accreditation materials listed in the appendix.

*For each standard, the visitor makes a finding about whether the Center has **Met** or **Not Yet Met** the standard. For standards with more than one element, the visitor may state an overall finding or indicate a finding for each element.*

ORGANIZATIONAL STRUCTURE

At the beginning of this section of the report, the visitor should provide a brief narrative indicating any relevant general information regarding the Center's organizational structure.

1. **The Center shall:**
    - A. **demonstrate its state as a nonprofit corporation**
    - B. **operate under a board of directors**
    - C. **demonstrate it is recognized as tax exempt by the Internal Revenue Service**
    - D. **define a primary service area and/or constituency.**

    To document compliance with this standard, the Center should have appropriate articles of incorporation and bylaws, an initial and if applicable a permanent letter on tax exemption from the IRS.

    If the Center is not separately incorporated, please identify how it is organized.

    Definition of a primary service area and/or constituency:
    What is the Center's definition of its service area?

Usually this is a listing of counties and/or geographic boundaries such as rivers or highways.

For some Centers the description of a particular constituency may be more important than a geographical area, e.g. a Presbyterian Center may focus primarily on Presbyterians and Presbyterian congregations throughout a large metropolitan area while still providing services to persons of other or no religious affiliations.

The purpose of this provision is for Center leaders to know who and where they are intending to serve as a guide to their marketing, fund raising, provision for access through the placement of offices, etc. It is also helpful for Solihten Institute's efforts to establish new Centers along as serving as a guide for neighboring Centers in working cooperatively.

If the Center is in close proximity to another Solihten Center, there should be some inquiry during the visit with mention in the report about the relationship of the Centers. Please keep in mind that overlapping boundaries are not prohibited by either the accreditation standards or the agreement of affiliation between Solihten Institute and affiliated Centers. Centers with adjoining or overlapping service areas or constituencies are expected to work cooperatively and be in active communication with one another and not assume needless duplication of services. If Centers find they are in conflict over their service areas, Solihten Institute urges Center leaders at the staff and board level to actively discuss their differences in order to reach a working agreement.

2. **The Center shall have an organizational chart and accompanying narrative that reflects the leadership structure, responsibility, control, and accountability consistent with its bylaws, job descriptions, and current practices.**

   Does the Center have such a chart with accompanying descriptions of the Center's structure, and are they consistent with other documents and with Center practice?

3. **The bylaws shall include:**
   - **A. a rationale identifying "mind-body-spirit-community integrated services" as the basis for the Center's ministry**

     Where is this rationale stated in the bylaws? While the Solihten Ministry is broadly interfaith, Centers may be more narrowly defined in their organizational grounding in a single congregation or denomination, in traditionally mainline Protestant congregations, in the ecumenical Christian community, or in sponsorship from a broader range of denominations or religious traditions. The particular identity of a Center should be a key element in shaping its mission, programs, marketing, locations, funding, etc.

   - **B. provision for the election, removal, and replacement of board members**

     The bylaws should define how members are nominated and elected to the board, how a member can be removed, and how vacancies are filled when a member does not fulfill their full term because of removal, resignation, death, etc.

C. **the responsibilities of the board, board members, and board officers and committees.**

   The bylaws should include a basic statement of these responsibilities and identify any standing committees.

   For many Centers more specific responsibilities are identified on an annual basis as part of the planning process that indicates goals and activities for board leaders, committees, and task forces.

4. **The Center shall attest that the programs and services of the Center and the activities of the board of directors, officers, and staff follow its Articles of Incorporation and their Bylaws.**

   The documentation that is sent related to current programs and services, and board membership and structure is reviewed against the articles of incorporation and bylaws for agreement. At times Centers will need to update their articles of incorporation or bylaws to reflect current practices or be asked to work toward compliance with them as they are currently written.

BOARD OF DIRECTORS

The visitor is asked to begin this section with general comments on board composition and basic functioning activities. Does the board structure and activity fit the Center's size, age, style, and complexity? How is board work done – in committees or as a committee of the whole? Is there a strong executive committee? Are advisory boards or task forces used?

5. **The board of directors shall:**

   A. **meet at least four times each year**

   Many boards meet monthly or bi-monthly, but are required to meet at least quarterly. Frequency of board meetings should be determined by efficiency of operations. Consideration should be being given to the meaningful use of committees and short-term task groups. The board operating as "a committee of the whole," making decisions of minor importance in full board meetings, should be avoided whenever possible.

   B. **consist of at least six members**

   The intent of the requirement for time-limited classes is for board members not to serve in perpetuity without any provision for review of membership. While many Centers have a provision that normally a board member will not serve more than two consecutive terms without being off the board for a period of time, the standards do not require such mandatory retirement. In some Centers, board members may serve an unlimited number of consecutive time-limited terms??

C. **conduct an orientation for new members**

To enhance the ability of new board members to serve in Center leadership ethically and responsibly, it is imperative for them to receive orientation to the following aspects of the Center: mission, vision, core values, current strategic plan, goals for quality and performance improvement, organizational structure and decision making process, the annual budget, funding structure and interpretation of financial statements, information regarding those served, as well

D. **develop a strategic plan and update at least annually**

Centers are encouraged to develop a strategic plan annually, with focused strategic initiatives that the board and staff engage with and update throughout the year.

E. **conduct a board self-assessment annually.**

A range of board self-assessment tools are available in not for profit organizational best practices literature. Solihten Institute can assist boards in selecting an appropriate tool. Boards are encouraged to establish a baseline of factors on which they measure themselves from year to year, and to be open to using a range of tools over time to cover a spectrum of key variables for effective board leadership.

6. **The board of directors shall include representatives of the medical, business, financial, legal, religious communities, behavioral health consumer(s), and/or family member(s) of current or former consumer(s).**

The representative quality of board members has many dimensions. At its most basic, a representative board contributes to more balanced decision-making and enhances the quality of the trusteeship for which boards are constituted. Body, mind, spirit, and community should be as well-reflected on the board as in the Center's internal practices. Decisions by the board are enhanced where there is input from board members who represent diverse community perspectives.

Generally, there is an expectation that the medical representative is a physician and the legal representative is an attorney. If a Center believes this type of representation can be fulfilled by other persons, e.g. by having a hospital administrator or a nurse as the medical representative, the rationale should be included in the materials.

The purposeful inclusion of consumers or family members of consumers of behavioral health is a key component of current nationally recognized quality standards. The consumer(s) may or may not have received services from your Center, but their voice and/or that of their family members is an imperative aspect of a representative board.

There are critical marketing elements involved in board representation. Board members from differing segments of the community often play a key role in making and sustaining connections with their colleague. For example, physicians are more likely to refer to a Center in which a recognized colleague serves. An attorney on the board may have as part of his or her regular responsibilities, introducing the Center staff and services to new attorneys in the community.

A Physician on the board may take responsibility for arranging talks by staff members at the local medical society. Similarly, board members are often key links in sustaining the Center's relationship with supporting congregations, and other key community stakeholders.

7. **The board of directors shall annually evaluate the Center's performance documenting in board minutes or otherwise their review and approval of Center practices in the areas of:**
   A. **counseling and non-counseling services offered**
   B. **board development**
   C. **financial management**
   D. **fund-raising**
   E. **marketing**
   F. **establishing compensation**
   G. **community collaborations**
   H. **program evaluation**
   I. **client satisfaction data**
   J. **client/program outcomes.**

   The focus of this standard is to ensure that the board is aware of the Center practices in these areas and exercises oversight. To fulfill the standard, the Center should have a written description of its practices in these areas and the board minutes should reflect the fact of the board's review and approval of them at least annually. For many Centers, this review and approval takes place as part of the Center's ongoing planning processes and/or is part of the executive committee's work.

   The descriptions indicated here are not the same as the Center's policies and procedures in these areas. These are designed to be relatively simple statements which describe how the Center goes about work in these areas with special attention to the role of the board. For example, what steps are taken to recruit, elect, orient, and evaluate new board members?

   What is the overall pattern of financial management in the Center indicating the roles and responsibilities of the bookkeeper, the Center director, the board treasurer, and the board as a body? How does the Center go about fund-raising, and what are the roles, responsibilities, and timelines involved? Statements on some areas may be embedded in larger documents, e.g. information on establishing compensation may be found in the Center's personnel policies and procedures.

   Program evaluation may include a range of objective and subjective forms or reporting. Client satisfaction data should report on the specific responses given by clients to a client satisfaction survey. Client/Program outcomes should reflect one or more forms of empirical clinical outcomes data.

   These descriptions form the core of the "corporate memory" for the Center board and staff. They are especially useful in orienting new board and staff members to Center operations. As new decisions or changes are made, they would be added to this document so that the Center has an ongoing statement of how it functions in essential areas.

Center leaders would use these descriptions as a starting point for the activities of various committees and task forces reviewing and renewing them regularly on at least an annual basis. Usually, the initial descriptions would be developed through a board/staff partnership, drawing on consultation from others with particular expertise at critical points. Then, they would be approved by the board in final form.

It is most helpful if the summary descriptions of these practices are gathered together in one document for the accreditation site visit; this information could also be used as part of a board member orientation notebook.

PERSONNEL

The visitor is asked to make general comments about the staff, including comments on the cohesion, efficiency, teamwork, morale, growth, and stability of both clinical and administrative staff.

8. The Center shall have written personnel policies and procedures that include provisions for:

   A. position descriptions and qualifications for counseling and non-counseling personnel
   B. hiring and terminating staff members and consultants
   C. anti-discrimination policies
   D. sexual and anti-harassment policies
   E. staff compensation and benefits
   F. processing staff grievances
   G. investigating ethical complaints
   H. a conflict of interest policy
   I. a confidential information policy
   J. a whistleblower policy
   K. a social media policy
   L. staff orientation, performance appraisal and continuing education
   M. eliciting employee suggestions for clinical and organizational improvement.

The personnel policies and procedures of most Centers involve more than these elements. The visitor will review them to be sure that these elements are adequately included.

Most Centers operate with at-will employment practices that are standard in most states and utilize an employee handbook similar to the sample included in the Personnel Resources *section of Solihten Institute Resource Library. If this is the case, the visitor should assess whether the Center's personnel related materials are consistent with an at-will position and with the information in the employee handbook.*

Some Centers claim a bona-fide occupational qualification (BFOQ) in the areas of religion as applicable to some or all positions. In this case, it should be clearly stated in Center materials.

Since most Centers include persons with a variety of credentials, certifications or licenses, and professional affiliations, Centers normally indicate that they will follow the guidelines for investigating ethical complaints mandated by the relevant credentialing group. Even so, the Center should have a written policy and procedure for carrying out its own internal investigation, which includes specific provisions for the staff member (where the Executive Director is usually involved) and for the Executive Director (where the Board President, personnel chair, and/or other board representative are usually involved).

9. **The Center staff shall be multi-disciplinary and include a state-credentialed mental health service provider, a state-credentialed medical professional, and a clergyperson or religious professional as a staff member or consultant.**

   This provision reflects the basic team approach of Solihten Centers.

   In some Centers, the physician and/or the clergyperson may be a consultant rather than a staff member. In such a case, there should be evidence that the consultant is actively involved in the life of the Center by attending clinical staffing meetings, reviewing client care, etc.

   This standard includes the necessity that at least one of the Center's program staff members have a state license or state certification as a mental health service provider, while recognizing that such licensure or certification may have many different professional terms, e.g. licensed psychologist or psychiatrist, social worker, professional counselor, marriage and family therapist, certified fee based pastoral counselor, etc.

   While most Centers rely on a psychiatric and/or non-psychiatric physician to fulfill the role of the "state credentialed medical professional," the term is designed to open up the possibility that, for some Centers, the role might be fulfilled by a nurse prescriber, nurse-practitioner, or other qualified medical person whom can bring a medical perspective and medical resources to the Center's clinical practice.

   The requirement for a clergyperson or religious professional is designed to include on the multi-disciplinary team, a person who is trained as a professional in utilizing religious resources and reflecting theologically and spiritually in relation to the matters presented in the case conference.

10. **The board of directors shall appoint an executive who is accountable to the board for Center operations.**

    The visitor will note if the director is "interim" or "acting" or is selected in some way other than by board appointment. It will also be noted if the director's responsibilities do not include accountability for all Center operations, or if the Center divides the primary executive role among two or more persons.

11. **All persons who provide professional clinical services for the Center shall obtain licensure or certification from the state in which they practice or be in candidacy with the state.**

Under this standard, if a person providing clinical services can be licensed or certified by the state for the work they practice, they must secure such credentialing. For example, a former member of AAPC (now APCE) who provides marital and family therapy and has previously been practicing as an AAPC member and member of the clergy but could be state credentialed as a licensed marriage and family therapist, needs to hold that credential or be in an officially sanctioned process of securing it.
If a staff member is in training or has associate or intern status as they move toward full licensure or certification, the documentation of this status must be noted.

12. **The Center shall document its standards for the employment, supervision, continuing education, and evaluation of all professional persons, including trainees, who are providing services not requiring a state credential. Professional persons without state credentials shall have training appropriate to the services provided and hold membership or credentialing in an appropriate professional organization, abiding by its requirements for consultation or supervision, ethical practice, and continuing education.**

    Solihten Centers now employ an increasing number of persons who provide important services for which there are no state credentialing processes, licenses, or certifications. In most states, these would include spiritual directors, clergy and congregation care consultants, coaches, Clinical Pastoral Education Supervisors, and others. For persons who provide professional services and not eligible for state credentials, the Center should describe and document the Center's criteria for determining their competency to provide such service. These criteria might include general standards which are applied across the board and specific standards applicable to persons with particular functions. The criteria might include credentials from other organizations, completion of specialized training, designation by an authorizing body, supervisory relationships, etc. The Center should also document how these individuals are supervised and evaluated. These standards may be consistent with criteria specified by the major professional organization related to the particular service.

13. **The Center executive director and board president will attest in writing that all persons providing services for the Center are to their knowledge in good standing professionally and practicing within:**
    - **A. the scope of their competency as marked by appropriate state licensure, training, and supervision**
    - **B. the boundaries and ethical standards of their credentialing and training**
    - **C. the scope of their competency as marked by appropriate professional membership(s) or credentialing for those providing services not requiring a state credential.**

    As part of their preparation for the accreditation site-review, Center leaders are responsible for conducting a due diligence review of staff providing professional services.

This includes the professional good standing of staff and affirmation that they are practicing within the boundaries and ethical standards of their credentialing and training. The review would include confirming that they are in good standing with any credentialing body or board, reviewing the scope of practice for the employee's case load, and affirming that all staff members do not have any current ethical complaints lodged against them. Normally, Center leaders should secure this assurance at least annually.

Such information can usually be secured by visiting the state website governing the clinician's licensure/certification or other credential and documented in the personnel files.

A written statement should be drafted and signed by the Executive Director and Board President that such due diligence has been completed and to their knowledge the standard has been met.

If there is an official complaint in process, the fact will be noted in the report without identifying the staff member, the complainant, or the nature of the complaint to honor the strict confidentiality of ethical issues. For example, the report might state: "Board and staff leaders are responding to an ethical complaint lodged against one of the Center clinicians by a professional organization."

For those providing services not requiring a state credential, it will be imperative for the Center to determine criteria for the necessary training, boundaries, ethical standards and scope of competency. These criteria may be consistent with the standards of the major professional organization related to the particular service.

14. The Center shall:

A. employ or have a written agreement with one or more physicians and/or health care organizations to provide medical and psychiatric consultation and services

B. document annually the good standing of the provider(s) through the appropriate State or Federal regulatory bodies.

The purposes of this standard include assuring that the Center has an active working arrangement with one or more physicians or health care organizations, and that arrangements have been worked out for them to provide or secure medical and psychiatric consultation and services as needed for client care and staff development.

The intent of the standard is to ensure that there is an established access to such consultant and services so that it does not have to be initiated at the point of client need.

The consultation and/or services can be provided by a single provider or combination of providers qualified to do so – a single physician or psychiatrist, one or more of each, a clinic, a residency program, etc. In many Centers, the written agreement is in the form of a letter. The arrangement may or may not involve payment to the provider. A copy of the letter of agreement, along with an explanation of the current level of involvement of the consultant at the Center, will verify compliance with provision A of this standard.

For an individual psychiatric, medical provider, or consultant, good standing status can usually be secured by visiting the state website governing the clinician's licensure/certification or other credential and documenting the personnel file. If an agreement is with a medical facility, a copy of the current state or federal licensure/ certification of the facility will suffice.

15. **The Center shall maintain personnel files for each staff member and consultant that includes:**
   - **A. an initial application or resume**
   - **B. a position description**
   - **C. record of a background check**
   - **D. an employment agreement**

15D has several important aspects. In most Centers following at-will employment practices, the agreement is most often in the form of an initial letter of agreement welcoming the person to the staff, noting their position, indicating what they will be paid, and referring to the Center's personnel policies and procedures for other matters. In this way, the Center does not inadvertently imply a contractual relationship.

Some Centers do not follow at-will practices and utilize more traditional and usually more lengthy and complex legal employment contracts.

A few Centers engage staff members or consultants as independent contractors rather than employees. Solihten Institute has cautioned Centers that, except in unusual circumstances or situations in which the person provides very limited services, this practice may be in conflict with achieving compliance with other accreditation standards regarding staff meetings, records, and maintaining common policies may require separate professional liability coverage and may place the Center in some jeopardy for an adverse IRS ruling that could be costly to both the individual and the Center. The IRS has very clear, strict guidelines distinguishing between independent contractors and employees. A few Centers have devised processes for hiring staff members as independent contractors and meeting accreditation standards through their voluntary fulfillment of the Center's needs for various kinds of record-keeping, clinical staff meeting participation, etc. These Centers have relied on the opinions received from sources such as state employment audits or retired IRS reviewers as the basis for affirming their practice as appropriate.

- **E. an acknowledgement of receipt of the Center's Employee Handbook**
- **F. documentation of professional good standing <u>annually</u> through State licensing bureau or in the case of professionals providing services not requiring a state credential, through appropriate professional membership or credentialing**

15F is an increasingly important feature for companies issuing liability insurance and third-party payers, as well as to lessen the Center's exposure to legal liability claims. For licensed clinicians, documentation of professional good standing should take place annually through the appropriate State licensing bureau. In most states, this can be done by having someone other than that staff member contact the credentialing body online or by telephone, confirm the standing of the staff members, and then document

that verification in the personnel file, signed and dated by the verifying person. There are also independent verification organizations that carry out this service for a fee.

In the case of professionals providing services not requiring a state credential, good standing should be verified through appropriate professional membership or credentialing verified from the original source.

To fully comply with this requirement, the Center, or its agent, should document an independent verification of the essential credential of the staff members providing professional services. For example upon hiring, the Center should have the applicant request the degree granting institution to send official copies of transcripts directly to the Center.

For those without state recognized credentials providing services not requiring them, the Center shall clarify criteria for good standing in its policies and verify on an annual basis compliance with said policy.

While this process requires extra work on the part of Center leaders, it has two primary benefits. (1) It provides assurance to clients, boards, the general public, and third party payers that those who provide care are properly licensed or credentialed. (2) It may enable the Center to be approved by major third-party payers without having to expend the considerable time and money needed to undergo direct review(s) by each such third-party payer or managed care organization.

Full compliance with 15F would be demonstrated by the inclusion in the personnel file of a signed and dated written summary of the employee's performance review conducted on an annual basis. To protect the confidentiality of the performance review process, no reviews are to be included with the accreditation application materials. The site-visitor reviews these materials on site.

G. record of ongoing annual performance reviews

15G: The usual pattern for performance reviews is for the executive or management staff to review those they supervise and for the board or a board committee to review the executive. The most effective reviews are generally dialogical and focused on performance, that is, the accomplishment of goals and plans identified at the beginning of the evaluation period, rather than judgmental and presented as qualitative assessments. For example, it is more helpful to state "John increased his case load by an average of 5 hours per week with most of the increase attributable to a 20% increase in speaking engagements" than to say "John was more productive and did a better job of marketing than in the previous year."

H. records of any disciplinary action or commendations

I. legally required materials such as I-9 and W-4 forms or housing allowance requests (kept in a separate file from other personnel materials due to federal regulation and/or privacy concerns).

15I: It is imperative for any employee who qualifies for clergy status with the IRS, and who claims a housing allowance, to have the housing allowance amount claimed from Center income approved annually by the Board of Directors.

Standard 15 Overall:

To comply with current personnel law and human resource practices, Centers should keep complete, up-to-date, and precise personnel records.

Usually they should include the items listed in these standards and no other materials, unless otherwise required by Center policy or state law.

Site visitors normally review all files in a small Center and a random selection representing various Center roles in larger Centers.

To protect the privacy of individuals, personnel materials are <u>not</u> to be sent as part of the advance review materials; they are to be reviewed on site. The reviewer will note if anything is missing from one or more files.

SERVICES

The visitor is asked to provide general comments about the Center's services, both significant current strengths and challenges.

16. **The Center shall offer mental health services by state-credentialed providers; education programs for the public, clergy, congregations, and/or professional groups; and consultation services.**

    Centers shall submit a brief description of their areas of service and highlight any unusual or extensive services, or point site visitor to appropriate sections of the Center website.

17. **The Center shall have written clinical policies and procedures, describing the Center's standards governing:**
    - **A. case management including client intake, therapy process, and discharge**
    - **B. continuity and coordination of care (including communicating with referring professionals, making referrals, and coordinating treatment with primary health or psychiatric provider)**
    - **C. providing necessary disclosures to clients (including client rights, privacy practices and informed consent)**
    - **D. records and record-keeping**
    - **E. fee setting and collecting**
    - **F. maintaining physical and electronic confidentiality, (including releases of information, and business associate agreements)**
    - **G. safety planning (including managing emergencies and critical incidents)**
    - **H. conducting client satisfaction surveys**
    - **I. responding to legal and other requests for information**
    - **J. meeting ethical and professional standards**
    - **K. infection control and prevention**

L. medication management procedures, if providing psychiatric services.

The Center's policy and procedures statements should include clear written statements on each of these areas. If any area is not adequately covered, that omission will be noted by the site visitor. When policies and procedures are particularly strong or useful, this will be noted as well.

18. The Center's standard case management procedures and clinical records shall define and document:

A. An intake process that includes:

1. **the client's completion of a comprehensive intake form including medical and behavioral health history with current medications noted**
2. **a signed and dated service agreement, including informed consent and notice of the Center's privacy practices**
3. **the therapist's preparation of an initial assessment and treatment plan, including an initial risk assessment**
4. **team review as indicated.**

18A. What is in each file? Does each file contain the items specified in the accreditation standard, in the Center's statement of procedures or protocols, and in generally accepted professional standards? Are the records legible, orderly, complete, dated, and signed as needed? When clinical forms are used, are items left blank otherwise noted with an N/A?

B. A therapy process that includes:

1. **signed and dated progress notes for each session**
2. **treatment plan updates**
3. **response to critical incidents**
4. **use of consultation and staff review**
5. **contacts with referring professionals**
6. **consideration of the client's medical records and medications with a physician or other qualified medical professional**
7. **consideration of the client's religious or spiritual orientation and practices in the clinical process**
8. **use of empirically supported treatment modalities.**

18B. To what extent does the written record present a coherent picture of the client's needs, the plan for treatment with appropriate updates as treatment progresses, the network of persons involved with the client (referral source, therapist(s), consultants, other staff), and the progress of the therapeutic process? Does reading the record accurately portray what is going on in the therapy?

C. A discharge summary that includes:

1. **the number of sessions completed**
2. **counseling outcomes**
3. **reasons for discharge**
4. **recommendations.**

18C. Does the documentation reflect appropriate attention to meeting the needs of the client, responding to referral sources, using clinical staffing and consultation, addressing critical incidents, and attending to liability concerns? For example, is contact with the referral source noted? Is there record that the client has been presented in clinical staffing or consultation?

If issues of suicide, homicide, abuse, or threats are present, have they been noted in any way; have these been fully addressed and the response documented?
Given that Center records may be called into court; do the records reflect awareness of this possibility?

D. A documented quality assurance process, which includes at least quarterly monitoring of record keeping compliance.

18D. This provision requires the Center to monitor the extent to which its open and closed clinical files conform to the elements in both standards 17 and 18. This can be done by a formal peer review process with clinicians checking one another's files, or by a designated quality assurance person taking the responsibility for monitoring all open and closed files.

Standard 18 Overall:

In addition to stating intentions, Center materials should document the consistent implementation of these processes. While much of this documentation will be found in the clinical records for each client, some will need to be found in other places. The visitor may want to spend time with the Executive Director or Clinical Director going through the list and asking them to identify and show where each element is documented.

In order to assess compliance with standard 18, the visitor will review approximately 20-25 randomly chosen files, 3/4 of them current and 1/4 terminated, representing all of the clinicians on staff. Each file will be reviewed on at least three levels:

19. Clinical staff members will review their clinical cases and other work at least every two weeks through clinical staffing, supervision, consultation, and/or peer review.

The expectation embodied in this standard is that every clinician providing professional services will take part in some type of professional review of those services with one or more other clinicians at least every two weeks. The format in which such review takes place may vary from Center to Center and clinician to clinician.

20. All clinical staff members shall participate, at least monthly, in a clinical staff meeting that includes a state-credentialed mental health service provider, a state-credentialed medical professional, and a clergyperson or religious professional.

The intent of this standard is to ensure that every clinician takes part at least monthly in some type of clinical staff meeting that involves the input and perspectives of persons with medical, theological, and psychotherapeutic experience. The content of these meetings may vary between Centers, from one meeting to the next; it may also involve review of each recent intake, cases involving particular medical or psychiatric issues, case selected for

review by each clinician, one or more intensive case studies, or some combination. As discussed earlier for standard 9, the medical input may come from a psychiatrist, a non-psychiatric physician or another medical professional such as a nurse prescriber or nurse practitioner, the theological perspective from a clergyperson or other religious professional who has been ordained or set apart by a religious body on the basis of their training and education.

21. **All clinical staff members shall receive clinical supervision or consultation appropriate to their levels of experience and certification or licensure.**

Each state licensing and certifying agency or professional organization has its own expectations of the extent to which those they credential should be involved in supervision or consultation on their own work. The intent of this standard is to confirm that the clinical staff members are complying with these expectations. Since persons may have several credentials with differing levels of expectation, the key to the standard is compliance with the most rigorous applicable requirements for each individual.

*In this standard**, supervision** means a setting in which the focus is on the person and behavior of the therapist with a client or clients.*
It implies that the supervisor is more experienced or knowledgeable in the field or more highly credentialed in relation to the particular issues.

Most often the supervisor is responsible for quality control and is legally responsible for the treatment. The variation of peer supervision suggests two therapists of relatively equal experience and knowledge who often present to one another in turn. In peer supervision, there is usually no expectation that the peer supervisor has any direct responsibility for quality control.

***Consultation** tends to refer to a setting in which the therapist presents issues with clients when the focus is on the client's issues and the activity of the therapist in addressing client needs and less attention is given to the person and behavior of the therapist. Most often the consultant does not have responsibility for quality control.*

The overall intent of the standard is to ensure that persons are not functioning in isolation without active engagement of their peers and experts in reviewing and enhancing their work. In general, supervision/consultation is not the same as clinical staffing in which the focus is on managing or reviewing client treatment in a group.

22. **Non-counseling services offered by the Center that are not reviewed under standards 19-21 (above) will be reviewed in periodic case consultation as appropriate to the service and caseload.**

The Center will state its expectations for consultation and a procedure for how it is carried out.

23. **The services offered by the Center shall be covered by professional liability insurance.**

In responding to this standard, the Center should verify whether coverage is provided by a single policy for the Center or through individual coverage for each therapist. What company provides the coverage? What is the amount of coverage per occurrence and overall? The general standard is $1 million per occurrence and $3 million aggregate. If the coverage is for individuals, the Center should be named in each policy so that the Center gets notice of lapsed or cancelled coverage.

The most complete coverage is a Center policy that covers the organization, the Board of Directors and Officers, administrative and clinical staff, consultants, and volunteers. Some Centers also name their host congregations as additionally insured parties.

Professional liability insurance is not the same as Directors' and Officers' coverage.

24. **For programs and services other than professional clinical practice, the Center shall define and implement policies and practices which reflect appropriate administration, risk management, record-keeping, and service evaluation.**
    - **A. Centers offering coaching, spiritual direction, or prevention/wellness services shall have records that at a minimum include signed agreements demarcating the difference between counseling and the service being offered and defining the responsibilities of each party.**
    - **B. Centers offering formal consultation or mediation shall have records that at a minimum include a written contract for services defining the responsibilities of each party and following any and all state regulations for mediation.**

    This standard addresses the fact that Solihten Centers are involved increasingly in a diversification of their programs and services. Traditional clinical services are well covered in other standards. This standard calls on Centers to define the policies and practices they rely upon to ensure that programs other than professional clinical practice have appropriate administration, risk management, record-keeping, and evaluation.

    To comply with this standard, the Center should have a written document which describes how such programs are administered and managed, what risk management processes are employed, what records are kept, and how the program or service is evaluated. This type of definition may, in some instances be quite simple—e.g. for an accredited CPE program, the Center could simply indicate it complies with the accreditation standards and processes of the CPE accrediting body and include a copy of those standards with its documentation.

    For a state certified Foster Care program, the reference would be the state standards for this service. In other areas such as coaching, spiritual direction, or congregational consultation for which there are not broadly accepted standards, the Center will need to articulate its own policies and procedures for this standard. These policies should then be reflected in active practice, such as in the record-keeping for coaching or spiritual direction. A range of resources are available in current professional literature related to various preventative/wellness services.

25. The Center shall have written policies and procedures regarding its "mind-body-spirit-community" integrated services including descriptions of the:

A. Center philosophy of integration regarding mind-body-spirit care

B. include approach to integrated care setting(s) of behavioral health & primary care (if applicable)

C. "community" focus to include emphasis on cultural competency and diversity in providing services for populations served

D. staff orientation to and continuing education in integration

E. application(s) in services offered and in the work of the staff and board (e.g. staff meetings, clinical consultations, board meetings, etc.)

F. outcome evaluation process

G. congruence of the approach to integration with the Center's mission

H. Center's informed consent statement as it relates to the philosophy of integration.

Centers in the Solihten Ministry are committed to the integration of mind, body, and spirit in the therapeutic, educational, and consultative services offered in addition to an emphasis on the vital role of community in our lives and in the healing process. The emphasis on "spirit" is most frequently described through one or more of the following terms: faith/spiritual/theological integration.

While the methodology in these integrative efforts is not prescribed, foundational aspects of integration for Solihten affiliated Centers include a bio-psycho-socio-spiritual view of human nature with respect for the client's religious or spiritual beliefs and practices resulting in a non-proselytizing approach to services offered. With this perspective in mind, staff training typically focuses on specific strategies for intentionally gathering information on client religious and spiritual beliefs and practices and incorporating those beliefs and practices into treatment planning and service delivery based on the needs and wishes of the client.

Incorporating these core components of a professional model of services, each Center will be evaluated in the light of its own integration philosophy, model, goals, objectives, and evaluative methods in keeping with the Center's stated mission.
This accreditation standard is specifically intended to allow a Center to have broad latitude in defining its philosophy or model of integration. The Center is encouraged to determine its principles, goals, objectives, desired outcomes, and methods consistent with its integration philosophy. There is no one "right" or "approved" approach to this integrative component.

In addition, Solihten Institute affiliated Centers have long emphasized the need for physical health and collaborative efforts with primary care providers. This renewed emphasis in this standard applies in particular to co-located or integrated care services. Furthermore, part of the "community" component of this standard is an increased sensitivity to cultural competency and diversity of the multiple populations served by Centers.

A Center should have a clear, coherent, and well-articulated description of the principles underlying its philosophy or model of integration, as well as a clear description of its orientation/training of staff (i.e., goals and objectives), and the resources, methods, and processes by which it applies this approach and how it proposes to attain and evaluate its desired outcomes in the services offered and in the work of the staff and board.
The Center's "philosophy of integration" should additionally address the congruence of this philosophy with the Center's stated mission, and it should be addressed in the Center's statement of informed consent. A template for this standard is available from Solihten Institute.

FINANCES

The visitor is asked to provide general comments about the Center's financial conditions and management.

In 2021, the Solihten Institute Board of Directors approved substantial changes to the Finances Standards, and in order to provide more information, Laurie Pechie, Executive Vice President and Accreditation Coordinator sat down with Randy Rhoade, CPA, President/CEO of the Samaritan Center in Elkhart, Indiana and former Solihten Institute Board Treasurer.

That conversation is available for viewing here: https://vimeo.com/685614570/4d9c4ea333

26. The board of directors shall:

A. approve the Center's annual budget

B. establish and monitor compliance with the Center's written policies for financial management

C. review and approve financial reports as evident in board minutes

D. provide for independent accounting services annually[1] OR establish documentation of board monitored and approved internal financial procedures[2] helping to ensure financial reporting integrity and appropriate evaluation of cost benefit and risk of known internal control weaknesses.

[1]Independent public accounting services (Recommended for Annual Operating revenue averages for the 3 preceding years, exceeding):

- *Audit ($ 1,400,000 professional fees or $ 2,000,000 total)*
- *Review ($ 700,000 professional fees or $ 1,000,000 total)*
- *Full Disclosure Compilation ($ 350,000 professional fees or $ 500,000 total)*

Please note: Many states have specific requirements for 501(c)3 non-profit organizations that may be lower than these recommended thresholds. If such a case exists, the Center would need to comply with state guidelines.

*[2]Documented internal procedures in lieu of independent accounting services. See supplemental procedures and documentation recommendations (**Appendix 4**)*

E. provide for a Center Financial Governance and Accountability Report to be

submitted with the Accreditation review materials. Such report must be submitted and signed by identified Center leadership.

In addition to meeting the particular elements in this standard of an approved budget, financial oversight, and an audit or review, the key element here is whether the board is actively responsible for the overall financial condition of the Center. Do they approve a reasonable budget that they are then active in fulfilling? Is the board or a board committee involved in paying attention to how month-to-month finances are meeting or diverging from budget projections?
Does the board take an active role in ensuring that the Center has sufficient financial, facility, personnel, and material resources?

*The purpose of the **"Center Financial Governance and Accountability Report** is to give assurance that the board has analyzed and made a judgement regarding the Center's financial management and sustainability. In addition, it will also call for a plan to increase the Center's financial sustainability and vitality. This report will become a valuable foundation for a proactive consultative relationship with the Center during the years between Accreditation site visits.*

27. The Center shall:

A. Document annual review and approval of budget

Deficit budgets should show appropriate evaluation of existing unrestricted cash reserves or identify planned activities supporting deficits that help ensure sustainability.

B. Have established operating reserves and the accompanying policies and procedures that help ensure organizational sustainability for at least one year. If this level of operating reserves is not met, a documented plan that identifies and addresses the steps required to strengthen the organization's financial condition.

C. Centers shall have written fee policies and practices that include provisions for serving persons who cannot afford the full cost of service.

This standard is based on the premise that a healthy Center operates with at least as much income as expenses and with sufficient reserves that month-to-month fluctuations in cash flow do not create crises requiring that checks be held, or money borrowed on an emergency basis.

If such Centers decide to spend beyond their immediate income, they do so carefully with advance planning for meeting such an expenditure, e.g. a Center invests in bringing on a new staff member with a plan for repaying that expenditure as the staff member achieves a full case load.

Centers that maintain a balanced budget and a three-month operating reserve meet this standard. A Center may identify the reserves from various sources – as specified operating reserves, as restricted reserves which can be used for emergencies or special needs, as income from endowment, etc. The major point is to have sufficient available monies to meet unexpected needs.

Some Centers may not be currently maintaining a balanced budget and/or may not have a one-year operating reserve. If they present a written plan that indicates a timeline and methods for achieving that condition, the Center may be affirmed as meeting this standard.

The site visitor will encourage the board to own responsibility for fulfilling the plan and achieving the goals therein.

A Center with a major endowment may simply plan to meet provision C by investing existing funds wisely and using the interest to support other financial needs.

For Centers without a full endowment, a plan should be implemented for securing the necessary funds.

There are many levels of strength and security that may be found in such plans. Other than an endowment, the strongest approach to fee assistance would be to have a reliable source or sources for funding fee assistance. For example, some Centers have an annual fund-raising event or activity through which they regularly raise the full amount they anticipate using for client assistance in the next year. Similarly some Centers have a long history of being able to secure grants from foundations for new program developments or capital improvements.

If a Center does not have adequate resources on hand to meet these needs, full compliance with this standard could also be documented with a written financial or business plan which shows the amount of funding needed for each category and the means by which those funds will be secured, along with a report on the year to date and/or previous year results.

28. The Center shall implement written fee policies and practices that include provisions for serving persons who cannot afford the full cost of service.
There are two elements in this standard. First, each Center needs to have a written statement of their policies governing the setting and collecting of fees. These may address issues such as the standard fee and minimum fee, the use of client assistance funds to supplement what clients can pay out of pocket or secure from other sources, normal procedures regarding the use of third party payments, practices for collection of overdue accounts, etc. Second, each Center needs as part of its policies and practices, carefully thought out ways to deal financially with provision of services to persons who cannot afford the full cost of services.

To fully address this issue, the Center not only needs policies and practices for the use of funds to support clients who cannot pay the full fee, they also need policies and practices related to securing the funds that make such service possible; and in the reality of today's mental health environment, most Centers also need a written statement about their limits and how they respond to clients whose needs are beyond their capacity to help because of financial limitations.

FACILITIES

The visitor is asked to make general comments regarding the facilities, citing particular strengths and any particular challenges regarding the current Center facilities.

29. The Center shall provide facilities which are:

A. accessible within the service area

B. accommodating for persons with disabilities

C. available during some evening or weekend hours

D. clearly identified, electronically, as a *Solihten Center* location

29D: While Centers may use another name as their primary identification, they should be clearly identified with notice on the website that state with a live link that the Center is, "A Solihten Center," or "A Solihten Institute Affiliate," or "Accredited by Solihten Institute," or some similar statement.

E. reflective of the Center's religious identity

29E: If a Center is not located in a religious facility, there should be some way in which the Center is identified as carrying out a religious mission. For example, some Centers have a plaque situated prominently in the waiting area or entryway that states that the Center is an interfaith ministry and lists the various supporting congregations.

F. adequate in size, furnishings, and equipment for the provision of professional services

29F: Inasmuch as the facilities and furnishings form a primary public "face" for the Center and its services, they should reflect a level of professional quality compatible with the Center's mission.

G. secured through a written agreement

H. tobacco and smoke free.

29H: Centers need to have a specific policy statement indicating that the facility is both tobacco and smoke free.

Standard 29 Overall
This standard calls for an overall evaluation of Center facilities. Are they accessible, professional, clearly identified, and appropriately furnished and equipped? It will be helpful for the site-visitor to comment on any areas of particular strength or need.

ADMINISTRATION

The visitor is asked to comment on the overall administrative functions of the Center and may want to mention the persons who do the administration work.

30. The Center shall develop an Information Management Plan, along with related policies, and review annually. This plan should address the following:

A. electronic health record (or a specific plan to adopt one)

B. website

C. **e-mail**
D. **text messaging**
E. **health information data**
F. **data back-up**
G. **emergency shut down procedures**
H. **patient portal(s) (if applicable)**
I. **telehealth services (if applicable)**
J. **social media (if applicable)**

To stay relevant and viable, Centers need to engage in clear, ethical use of technology. Adopting related policies and procedures is also what allows staff to stay compliant with appropriate professional and legal standards of the provision of high quality, client-centered behavioral healthcare services.

30. The Center shall document current administrative procedures. To include such activities as client scheduling, fee collection, billing, accounts receivable, credentialing, accounting, donor records, processing mail, separation of duties, etc.

The administrative procedures for many Centers could be summarized in a few words such as "Mary or John does whatever is needed." So long as "John or Mary" is there and never out for a day, this method can work fairly well. However, when "Mary or John" takes a new job or is out for a vacation or an emergency, it may be very difficult for anyone else to accomplish necessary administrative tasks.

This standard requires that Centers put on paper the basic administrative operating procedures.

A good manual could guide a new person, who is familiar with office procedures but unfamiliar with the Center, in running the office and carrying essential functions on short notice.

The process of periodically updating such documentation is helpful to Centers in reflecting on their administrative practices. The written materials required by this standard should be very practical statements of basic procedures and information related to each of the activities named in this standard, in addition to any other administrative procedures integral to the operation of the Center.

31. Staff meetings with an administrative focus shall be held at least monthly.

The frequency of administrative meetings and who is usually present should be reported.

Questions to consider include: does the process seem to adequately meet the needs of the Center for resolving administrative issues and communicating administrative information? In many Centers, the administrative meeting is held monthly in conjunction with the regular clinical meetings.

32. The Center executive shall ensure that all staff members receive administrative

supervision and/or consultation.

Administrative supervision involves all of the work of administrative staff members and those aspects of clinical and program staff members' jobs having to do with their participation in Center business, such as marketing, fee-setting, collections, and sharing in the activities other than counseling. The test is whether or not the current level of supervision or consultation is adequate to ensure the quality of the Center's administrative practices.
For example, is adequate attention given to ensuring that clinical files are current, billing is timely, funding requests are sent as needed, etc. Do clinical staff members have productivity expectations or participate in marketing events?

PROGRAM ACCOUNTABILITY

The site visitor comments on the forms of accountability that the Center has maintained, i.e. with local congregations, other local stakeholders, Solihten Institute, the applicable state regulatory body and any other accrediting bodies.

33. The Center shall prepare and distribute an annual report summarizing the Center's programs, finances, and statistics.

An annual report is a primary means by which a Center communicates with various persons and groups who entrust it with support and utilize its services. For most Centers, the annual report is a one to four page document, often distributed as or in an issue of the Center newsletter, providing information on the activities of the previous year for the Center community and the general public.

34. The Center shall maintain the provisions of its affiliation agreement with Solihten Institute including:
A. submitting BOD minutes and financial reports at least quarterly
B. contributing requested annual statistical data.

Compliance with this standard is usually assessed after consultation with Solihten Institute. To be fully met, the Center should be current in payment of its affiliation fees or be fulfilling a mutually agreed upon payment plan, send Board of Directors minutes and financial reports to the Institute at least quarterly, as well as the required annual statistical information, publicly identify with the Solihten Ministry, and participate actively in the Solihten network. The visitor will identify any particular strengths or weaknesses in this regard.

35. The Center shall develop a Quality and Performance Improvement Program that includes:
A. a written description of the QI/PI program
B. compilation and analysis of data regarding at least one clinical and at least one administrative function annually
C. documentation of accountability to the Center board of directors

D. at least annual public reporting of QI/PI results.

The Center shall have a written description of a quality and performance improvement program whose elements typically include the establishment of a QI/PI Committee, the development of an annual plan, and a description of Center resources devoted to quality improvement efforts, and the means for evaluating and publicly reporting these efforts.

37. **The Center shall develop a Compliance Plan/Program addressing and attesting to the following:**
    A. **implementing written policies, procedures and standards of conduct**
    B. **annual update of the Plan and annual review and approval by the Center board of directors**
    C. **designating compliance and privacy officer(s) and a compliance committee**
    D. **the compliance officer should have a key role in assisting the Center to abide by all applicable legal and ethical standards. This includes federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA), FTC Red Flag Rules, Health Information Technology for Economic and Clinical Health Act (HITECH), Labor Laws, State Licensing Regulations, additional State Privacy Regulations (if applicable), etc.**
    E. **conducting effective training and education**
    F. **developing effective lines of communication**
    G. **enforcing standards through well-publicized disciplinary guidelines;**
    H. **conducting internal monitoring and auditing (risk management); and**
    I. **responding promptly to detected offenses and developing corrective action.**

    Compliance with legal and regulatory standards is increasingly imperative for Centers. The development of a formal Compliance Plan/Program is required for behavioral health organizations that receive federal funding, including the provisions listed in this standard.

    Solihten Institute has always emphasized compliance with all applicable laws and works to provide Centers with resources with which to assure this compliance.
    A template of a Compliance Plan is available for Centers, along with relevant policy and procedure templates.

CLERGY AND CONGREGATION CARE

The visitor comments on the current development of this program area in the life of the Center.

38. **Centers with programs for clergy and congregations shall include:**
    A. **a designated program leader accountable to the executive director**
    B. **an advisory team or board committee to assist with program planning, evaluation, and marketing**
    C. **a plan for initiating and maintaining relationships with local clergy, congregations, and as appropriate, judicatories and seminaries**
    D. **provision in the Center's organizational chart, strategic plan, and financial plan.**

    For Centers with programmatic emphasis on Clergy and Congregation Care, these provisions provide the means to integrate the program into the Center culture and its accountability structures. The site visitor will be considering how the CCC program fits within the Center.

    Does the program lead staff member report on a regular basis to the executive director, and are the board and staff aware and supportive of the CCC program?

How often does the CCC team meet with other staff and/or present to the board? How are staff and board members involved with the CCC program? What is the CCC program plan and does it have the staff, Center administrative and financial support to be successful? The site visitor may comment on these aspects of the CCC program, as well as particularly effective service offerings and program strengths.

APPENDIX A-1

DOCUMENTATION MATERIALS TO BE COMPILED AND SENT BY THE CENTER

Four or more weeks prior to the scheduled visit, the following materials should be compiled, in order, and sent to the site-visitor and to Solihten Institute Accreditation Coordinator. The usual method is to upload the required documentation to the cloud-based storage that is provided by the Institute. The Institute staff encourages you to see this as a checklist to ensure that all materials are uploaded for review by the site visitor.

GENERAL

- ☐ Proposed Site-visit Schedule
- ☐ Board President & Executive Director Self-Studies
- ☐ Historical sketch of Center to date
- ☐ A HIPAA/Red Flag Business Associates Agreement filled out in the accreditation visitor's name to be signed by the visitor and returned to the Center

ORGANIZATION

- ☐ Copy of original incorporation papers with any subsequent revisions
- ☐ Copy of initial and permanent IRS letters affirming 501(c)3 exemption status
- ☐ Written definition of Center's primary service area and/or constituency
- ☐ Organizational chart with narrative discussion showing leadership structure and responsibility
- ☐ Copy of Center's bylaws with date of latest revision

BOARD OF DIRECTORS

- ☐ List of board members with name, address, phone numbers, board office and/or committee, congregational affiliation, occupation, geographical, professional area or constituency they represent and term of service
- ☐ Copies of board minutes and reports for past twelve months
- ☐ A written description of the Center's new board member orientation process
- ☐ Copy of the Center's current strategic plan
- ☐ Copy of the Center's current board self-assessment
- ☐ A written description of the Center's practices in the areas of board development, financial management, fund-raising, marketing, establishing compensation, community collaborations, and program evaluation
- ☐ A summary of the Center's client satisfaction and client/program outcome data for the past full year

PERSONNEL

- ☐ A copy of the Center's personnel policies
- ☐ An up-to-date listing of the Center's staff members and consultants showing their names, job titles, professional affiliations, licensures or certifications, and full or part-time work status

PERSONNEL *continued*

- ☐ Statement and documentation of the Center’s standards for the employment, supervision, and evaluation of all persons, including trainees, who are providing services not requiring a state credential
- ☐ Signed statement from executive director and board president confirming that all persons providing services for the Center are to their knowledge in good standing professionally and practicing within the boundaries and ethical standards of their credentialing and training
- ☐ Written agreement(s) with physician(s) and/or healthcare organization(s), and documentation of provider and/or organizational professional good standing
- ☐ List of staff members by name with date of most recent annual review, name of supervisor or consultant, and frequency of supervision/consultation contact

SERVICES

- ☐ A descriptive listing of the Center’s current counseling and non-counseling services and programs
- ☐ A copy of the Center’s clinical policies and procedures and case management procedures
- ☐ Copies of the forms used in the Center's clinical practice
- ☐ A brief description of the pattern of staff gatherings (clinical, administrative, non-counseling services case consultation, other) and a listing of the dates and attendees for these staff meetings during the past year
- ☐ A copy of the endorsement page(s) for the Center’s professional liability coverage
- ☐ For Center programs other than professional clinical practice include the quality assurance policies and practices for administration, risk management, record-keeping, and service evaluation
- ☐ A copy of the Center’s integrated services policies and procedures

FINANCES

- ☐ Copy of current budget with date adopted by board and year-to-date financial reports
- ☐ Copy of most recent audit, financial review, or documentation of completion of the supplemental procedures in lieu of independent accounting services
- ☐ Center Financial Governance and Accountability Report
- ☐ Copy of plan(s) for Center financial development
- ☐ Copy of Center fee policy and, if applicable, scale for financial assistance

FACILITIES

- ☐ List of current service locations noting cost, hours of use, and hours of counseling, and non-counseling services provided in past twelve months
- ☐ Copies of current facility agreements, signed and dated

ADMINISTRATION

- ☐ Copy of Center Information Management Plan
- ☐ Copy of office administration procedures
- ☐ Copies of current materials for marketing and fund raising including brochures, newsletters, program announcements, bulletin inserts, solicitation letters, etc.

PROGRAM ACCOUNTABILITY

- ☐ Copy of most recent annual report
- ☐ Description of Center quality and performance improvement plan and results.
- ☐ Copy of Center Compliance Plan/Program
- ☐ CCC job description, advisory team or committee minutes, program plan (if applicable).
- ☐ Listing of current official Center relations, e.g., with employee assistance programs, state agencies, seminaries for training, businesses for contracted service, third party payers for approved payment, endorsing congregations or judicatories, provider panels on which staff members are included, etc.
- ☐ Copy of most recent report from any other accrediting or certifying body, e.g. ACPE, The Joint Commission, CARF, Council on Accreditation, state mental health board, etc.

APPENDIX A-2

BOARD PRESIDENT AND/OR BOARD MEMBER(S) SELF-STUDY

These questions are intended for the Board President. We encourage you to involve other board members in responding. Response to these questions will help the Institute Coordinator work with you in preparing for the site-visit and assist the site-visitor in understanding the Center. Please respond on separate paper; include the name and position of the person(s) responding and send your responses with the application materials.

1. What is the Center's uniqueness? What sets it apart from other area services?

2. How well do you think the Center is fulfilling its mission through its programs and services?

3. Name three Center strengths. What are reasons for them?

4. Name three Center weaknesses. What is needed to address them?

5. What did the Center accomplish in the last twelve months that was particularly noteworthy? What were the keys to these accomplishments?

6. What opportunities or challenges face the Center in the immediate future in areas such as Center services, staffing, board development, funding, marketing, and community relations?

7. Have any major issues or problems needing special attention surfaced recently? Through what means are Center leaders dealing with these issues?

8. A Center is a developing/changing organization. At what developmental point is the Center? If the Center is in transition, describe where it has been and where it is going.

9. Imagine the Center in three to five years. Will it look the same or be different in significant ways? Describe the big picture.

10. What challenges you most as Board President (as board members)?

11. What are your greatest satisfactions as Board President (as board members)?

12. What is most valuable to your Center about participation with Solihten Institute and other Solihten Centers? What would enhance this relationship?

Please provide any other comments that will help the site-visitor understand the Center.

APPENDIX A-3

EXECUTIVE DIRECTOR OR LEAD STAFF MEMBER(S) SELF-STUDY

These questions are intended for the Executive Director. We encourage you to involve other staff persons in responding. Your responses to these questions will help the Institute Coordinator staff work with you in preparing for the site-visit and assist the site-visitor in understanding the Center. Please respond on separate paper: include the name and position of the person(s) responding and send your responses with the application materials.

1. What is the Center's uniqueness? What sets it apart from other area services?
2. How well do you think the Center is fulfilling its mission through its programs and services?
3. Name three Center strengths. What are reasons for them?
4. Name three Center weaknesses. What is needed to address them?
5. What did the Center accomplish in the last twelve months that was particularly noteworthy? What were the keys to these accomplishments?
6. What opportunities or challenges face the Center in the immediate future in areas such as Center services, staffing, board development, funding, marketing, and community relations?
7. Have any major issues or problems needing special attention surfaced recently? Through what means are Center leaders dealing with these issues?
8. A Center is a developing/changing organization. At what developmental point is the Center? If the Center is in transition, describe where it has been and where it is going.
9. Imagine the Center in three to five years. Will it look the same or be different in significant ways? Describe the big picture.
10. What challenges you most as executive director (as staff members)?
11. What are your greatest satisfactions as executive director (as staff members)?
12. What is most valuable to your Center about participation with Solihten Institute and other Solihten Centers? What would enhance this relationship?

Please provide any other comments that will help the site-visitor understand the Center.

APPENDIX A-4

SUPPLEMENTAL PROCEDURES IN LIEU OF INDEPENDENT ACCOUNTING SERVICES

A. Engaged Board of Directors defined by:

1. a Board or Committee delegate with at least three members, one of which having appropriate accounting degree, experience, or professional designation to support electing not to engage public accounting services
2. documentation of annual review and timely filed 990 tax return
3. documented annual review of known internal control weaknesses and organization assessment of risk and cost benefit analysis for corrections or elections not to correct. Must be timely reported to the entire board of directors as show in the minutes
4. documented annual personnel review of highest-ranking accounting staff personnel
5. documented annual review of compensation reports (W-2's or equivalent reporting) and reconciliation with annual financial report and 990 tax return
6. documented periodic review of transactions for appropriate authorization, compliance, and organizational propriety (i.e. independent selection of transactions from bank statement direct online access of bank account for random selection of transactions to be traced to supporting documentation establishing business purpose and authorization and accurate account recording in general ledger); *a minimum of 30 transactions should be reviewed annually*
7. documented periodic review of account reconciliations and reporting (i.e. review to ensure timely completed bank reconciliations and support for account balances used for financial reports).

B. Qualified Staff and Accounting Procedures

1. Center accounting position with appropriate accounting degree, experience, or professional designation to support electing not to engage public accounting services.
2. Provide consistent timely financial reports at least quarterly to the board that reflect:
   a. Current Accounting Period
   b. Budget for Accounting Period
   c. Prior Year Accounting Period
   d. YTD Accounting Period
   e. YTD Budget for Accounting Period
   f. YTD Prior Year Accounting Period
3. consistent compliance and established audit trail that includes:
   a. accounting period end close procedure checklists and documentation of completion
   b. accounting adjustments with memos and explanations of adjustment
   c. Trial Balance and General Ledger review noted at least quarterly or consistent with board approved procedure
   d. documented donations and (applicable) restrictions and appropriate financial reporting.

APPENDIX A-5

Center Financial Governance and Accountability Report

To be completed by Board Treasurer and/or Chair of the Board Finance/Audit Committee and submitted with Accreditation review materials prior to site visit.

1. For each of the last four years has your Center engaged independent public accounting services (audit, review, or full-disclosure compilation) as recommended by ACC 26D?

2. If not, have the alternative documented internal procedures been completed, reviewed, and approved by the Board of Directors (with documentation in the minutes)?

3. Have independent accounting services identified any internal control weaknesses? If so, have the board evaluated and implemented corrections?

4. Is the board or Center staff aware of any internal control weaknesses not identified with accounting services or not previously reported or evaluated by the board? If so, please note, with organizational plans to evaluate and address and expected date of completion.

5. Has the Center staff and board evaluated the organization's sustainability?
   a. Does the Center have unrestricted positive equity? If so, what percent of the annual budget does it represent?
   b. Does the Center have temporarily restricted positive equity that can provide significant resources to help sustain operations? If so, what percent of the annual budget will be supported by utilizing (meeting restrictions to be able to support current operations) temporarily restricted equity?
   c. Has the Center accurately identified costs to operate? By program?
   d. What is the average cost per clinical hour to provide mental health services? How does this compare to other Network Centers of similar size as reported in the *Solihten Centers' Annual Statistical Report?*
   e. What percentage of the Center's annual revenue is comprised of donations and fundraising? *For the most recent completed year and the current year budget.*
   f. Are the fundraising and donation revenues supporting mission consistent with the board's vision to serve the community including economically disadvantaged community members?
   g. Do you consider your Center's business model to be a sustainable operation for at least the next year or more? If not, how is the organization working toward a sustainable business model?

____________________	____________________	____________________
Board Treasurer and/or Chair of the F/A Committee	Board President/Chair	Center Executive Director

Three Signatures are Preferred, one Board member and the Center Director are Required

APPENDIX A-6

GUIDELINES FOR SCHEDULING THE SITE-VISITOR'S TIME

In preparing for the site-visit, Center leaders should work with the site-visitor and Accreditation Coordinator to organize a schedule that includes the elements listed below. The entry and exit interviews are first and last. If possible, place the board meeting toward the end of the visit. There is no set order for the other meetings. Some meetings may be combined for efficiency, e.g., with management team, consultants, host pastors, etc. The times listed are for general guidance. A draft of the proposed schedule should be sent to the site-visitor and the Institute Coordinator with the site-visit materials. At least two weeks prior to the visit, the visitor and Center director will need to work together to fine-tune the amount of time spent on each activity for the final schedule.

1. **Entry interview with executive director** (1-2 hours). Other staff and board members may be included at the discretion of the director.

2. **Staff interviews** (15-30 minutes each if done individually, 60 minutes for group). **Leadership or Management Team** (if applicable), including a meeting with the **Clinical Director and/or CCC Program Leader** (30 minutes each). The visitor should meet individually with staff leaders such as clinical, training or CCC directors in larger Centers or all staff in small Centers. Frequently it is most efficient to schedule group meetings with clinical and administrative staff members.

3. **Administrative or office manager** (30-45 minutes). Other office staff may be included at the discretion of the executive director and/or manager.

4. **Board President** (30-45 minutes). Some Centers prefer a more extensive time with the executive committee of the board in lieu of the individual meeting with the board president.

5. **Host pastors/facilities** (30 minutes each). Centers with one or two locations may schedule a host pastor visit and facility review at each site. Centers with many locations may show one or two offices and invite host pastors to a gathering.

6. **Consultants** (10-30 minutes each). These may be in person individually, in a group, or by phone.

7. **Clinical case conference**. The visitor observes the Center's normal case review process usually with a medical/psychiatric consultant and/or a theological/pastoral consultant participating.

8. **Staff gathering.** Meeting with the full administrative and clinical staff provides an opportunity for the visitor to discuss related issues.

9. **Review of records, materials, and procedures** (2 hours or more).

The visitor will need time, which may be interspersed between meetings, to review clinical, personnel, administrative, and financial records and procedures. These materials are examined on-site.

10. **Board meeting.** If the regularly scheduled board meeting occurs toward the end of the site-visit, it provides an opportunity for the visitor to give an overall report on the Center's accreditation compliance as well as engage in dialogue regarding Center life and development, board functioning, and participation in the Solihten network. Center leaders are asked to allow at least thirty minutes during the early part of the meeting for this purpose.

11. **Exit interview** (1 to 1 1/2 hours). The final activity of the visit is an exit interview in which the visitor reports on his/her findings to the Executive Director and any other persons the director wishes to include, such as the Board President, executive committee, management team, etc. The Center should make copies of the standards available to participants for reference during this meeting.

It is usually helpful for the Executive Director to clear some, but not all, of his or her time during the visit to be available to participate in the scheduled meetings and to discuss the visitor's findings and impressions as they develop. If time allows and the visitor agrees, Center leaders are welcome to schedule time for the site-visitor with other individuals or groups, e.g., committee chairpersons, board members, key supporters, or area pastors, etc.

The visitor will need time during the visit to prepare notes for the exit interview presentation. If feasible, it is helpful for the visitor to have a desk at which they can work and access to a phone.

APPENDIX B-1

ACCREDITATION SITE-VISIT ARRANGEMENTS AND EXPENSES

Each Center is responsible for paying the out-of-pocket expenses associated with the accreditation site-visit. These normally include air and/or automobile travel, transportation during the visit, lodging, meals, and incidental expenses. The cost for expenses is usually between $750 and $1,250.

If they wish, Centers may pay hotels, meals, etc. directly and/or reimburse the site-visitor at the time of the visit. Otherwise, the visitor is asked to keep track of expenses and submit them with documentation for reimbursement by Solihten Institute. The Institute Coordinator arranges for the visitor to be reimbursed and the Center invoiced for the visit expenses.

It is the usual practice on site-visits for the visitor to stay in a hotel, motel, bed and breakfast, or other commercial facility. Some Center leaders have been able to secure such comfortable accommodations without charge or at a reduced rate as an in kind contribution to the Center. If a Center wishes to offer accommodations in a private home, the visitor should be assured of a quiet room including a private bath and adequate workspace. It may be, however, that the visitor prefers a commercial lodging, and in all cases, this desire should be honored.

In the conducting of a site-visit, a site-visitor who is not an Institute staff member is considered an agent of Solihten Institute and is covered by the Institute's liability insurance coverage.

APPENDIX B-2

A HISTORY OF SOLIHTEN INSTITUTE ACCREDITATION

Origins. The first Solihten Center opened in the First Presbyterian Church in Elkhart, Indiana in September 1972. This Center was inspired by the vision of Burton Kintner, M.D., a family physician in the congregation. Initially called The Solihten Health and Living Center, this part-time program extended the congregation's ministry with expanded counseling and educational services, which drew on the talents of physicians, counselors, and ministers in a team approach to helping people under stress. The Rev. R.J. Ross, an Associate Pastor of the congregation, with training in pastoral care and a degree in management, served as the Center director as part of his responsibilities at First Presbyterian Church. In 1976, when the Center had grown to need a full-time executive director, he accepted that position.

Over the next few years, The Rev. Ross and other congregational leaders supported the development of several similar Solihten Centers in neighboring communities in northern Indiana and southern Michigan. By 1978, six Centers had joined together in the Solihten Association in order to respond to several significant developments:

- Congregations and communities in southern Michigan and northern Indiana expressed interest in establishing similar Centers to serve their communities.

- A Commission on Mental Health appointed by President Jimmy Carter highlighted Solihten Centers as filling gaps in the community mental health system initiated in the 1960's to provide a national mental health safety net. Their report encouraged development of Solihten Counseling Centers in other communities.

- The Martin Foundation committed $700,000 to the development of the Solihten Ministry as an alternative to tax supported community mental health services and more costly private practice services. Solihten Institute was also established with The Rev. Ross as executive director with a mission to expand nationally with at least forty additional Centers.

- The Rev. Ross conducted a study of the major pastoral counseling centers throughout the country as well as other programs that linked religion and health care, such as the Holistic Health Centers initiated by Dr. Granger Westberg.

Hallmarks. The national study, the experiences of the initial Centers, and the counsel of the early Solihten leaders helped identify certain characteristics that came to be core organizational elements in Solihten Centers. These are:

- Belief in the close relationship of body, mind, spirit, and community, and the importance of all four components in health and wholeness
- Establishment as not-for-profit, tax exempt organizations governed by a board of directors composed of local leaders

- A collaborative approach to counseling that includes the medical, psychological, and theological disciplines
- Commitment to excellent care through attention to quality assurance and effective allocation of resources to meet community needs
- Counseling services accessible to clients geographically, physically, and economically
- A ministry that extends and complements the mission and work of local congregations with offices frequently located in religious facilities
- Professional staff members who are accountable through licensure and certification to state agencies and professional organizations
- Management grounded in sound, proven business and organizational practices

While Solihten Centers are diverse in their sponsorship, organizational structures, and range of services, these features have remained the common hallmarks of the Solihten ministry.

Accreditation. As part of the formation of Solihten Institute, the executive directors and board presidents of the Solihten Centers then in operation agreed to meet together during 1978-79 in order to translate the values and commitments essential to the identity of a Solihten Center into concrete accreditation standards. They worked with a consultant associated with the accreditation processes of the Joint Commission on Accreditation of Health Organizations (JCAHO) - Mental Health Division to clarify the Solihten standards.

The standards were designed to articulate a common core of values and practices, establish a system of organizational quality control, identify the key marks of Solihten affiliation, and guide the development of similar Centers embodying the same commitments.

When the initial standards were defined and reviewed in relation to the Solihten Centers then in operation, it became clear to the Center leaders who formulated them that none of the original Centers fully met all of the standards. In keeping with their commitment to quality and to the integrity of the accreditation process, Center leaders affirmed the standards and went to work making the changes necessary in their Centers to come into full compliance.

In 1980, Institute staff member Elaine Keiser Black visited each of the ten affiliated Centers and conducted a site-review to assess compliance with the standards. Working with a committee composed of Solihten Institute board members including area Center directors, she identified areas for development. By 1981, the ten programs had successfully met the standards and were confirmed as accredited Solihten Centers.

In 1983 Solihten Institute moved from Elkhart, Indiana to Denver, Colorado. Since that time there have been seven revisions of the standards in 1985, 1989, 1994, 2001, 2006, 2012, and 2016.

Dr. Jim Laurie served as Accreditation Coordinator from 1983 to 2008, and Dr. Paul Bretz assumed this role upon Dr. Laurie's retirement, serving in this capacity until 2014. At present, Solihten Institute Vice President Fonda Latham, LCSW, ACSW serves as Accreditation Coordinator.

The most recent (December 2020) revision of Solihten Institute Accreditation standards included updates that resulted from a benchmark against both The Joint Commission and CARF Behavioral Health Quality Standards. In addition, standards have been developed related to diversified services, including preventative/wellness services. Standards for services to clergy and congregations have been developed because of funding by the Lilly Endowment, Inc. Approximately 15-20 site-visits are now conducted annually by Solihten Institute staff members.

APPENDIX B-3

COOPERATIVE ACCREDITATION AGREEMENTS

Solihten Institute seeks to work cooperatively with other Accrediting Organizations. When a Solihten Center has achieved or is seeking accreditation by an organization other than Solihten Institute that has similar standards, Solihten Institute will consider whether there are appropriate ways to combine elements of the accreditation processes for greater efficiency and cost savings. In particular, Solihten Institute recognizes The Joint Commission, CARF, and COA Behavioral Health Accreditation as nationally recognized standards of quality. Centers may choose to pursue one of these accreditations and will be required to meet a select number of quality standards unique to the identity and services of Solihten Institute affiliated Centers.