Capacity Building Initiative

Central Community Support Services Network

Developing Service Delivery Best Practice Guidelines

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Background

In August 2007, Ontario's Minister of Health and Long-Term Care announced *Aging at Home*, a three year provincial strategy to help streamline services, promote integration and build community capacity of care and services for seniors. In particular, Strategy Stream 2 of the Central Local Health Integration Network's (LHIN) *Aging at Home* Plan for year one intends to enhance service delivery through a platform for integration, shared infrastructure and collaborative service models among Central LHIN community support services. *The Central Community Support Services Network* advocated this collaborative approach and proposed several project deliverables, approved in principle at the February 26, 2008 Central LHIN Board of Directors meeting. Final approval of the initiative was received on June 9, 2008.

The purpose of this report is to identify and document best practices for Adult Day Programs, Transportation, and Homemaking services. Evidence is gathered through a literature review (provincial, national, and international) that includes journal articles, case studies, departmental reports, and standards developed in other Western Nations experiencing population aging. Findings from these sources will pave the way for a consistent, standardized, measureable, high quality, and safe service delivery model for seniors in the Central LHIN.

Standards are important for identifying what is expected of organizations providing services and delivering care. They need to be clearly stated and measurable so that organizations being assessed know exactly what is expected from them. Good practice standards from the United Kingdom (UK), Australia, the United States (US) and Canada are described in this next section.

Service Delivery Standards in the United Kingdom, Australia, United States, and Canada

It is generally agreed that the most comprehensive standards developed for quality care come from the UK (Jinks et. al, 2008). The Commission for Social Care Inspection (CSCI) regulates, inspects and reviews all social care services in the public, private and voluntary sectors in England. The CSCI is an independent body set up by the Government to ensure continuous improvements in social care and stamp out bad practice. The CSCI inspectors report their findings to the Government and publish a report to Parliament every year on the overall state of social care.

If adult social care services do not meet national minimum standards set by the UK Department of Health, the CSCI has legal power to place conditions on them to improve services (http://www.dh.gov.uk//DH_4087381).
Furthermore, adult social care services have a determined amount of time to meet these

conditions by law. The CSCI also checks that proper systems are in place to deal with any complaints from service users.

The inspection evidence collected is then used to promote best practice and support decision makers in local and central government to develop future policies (http://www.csci.org.uk).

The *Care Standards Act of 2000* (CSA) reformed the regulatory system for care services in England and Wales. Up until this point, health and social care services were regulated by local councils and health authorities. For equality and consistency purposes, the CSA established a broad range of guidelines to ensure effective management practices for all of England and Wales, including staff development, health and safety of premises and the overall conduct of state and independent healthcare establishments and agencies. Lastly, the National Care Standards Commission (NCSC), an independent, non-governmental public body, was formed to regulate the health and social care sectors (http://www.dh.gov.uk).

Regarding domiciliary care (Home Care) in the UK, up until the publication of the National Minimum Standards (Department of Health, 2003), home care services were not officially regulated. Therefore, the standards represented a significant change in the monitoring of home care provision. Services are now required to adhere to a range of indicators relating to person-centred care, protection of users and workers, and staff and business policies that operate within the standards.

Currently the UK does not have national standards for transportation services. The UK Department of Health intends to provide national standards for what people can expect from transportation services, as well as explore options for accrediting independent sector providers of these services, to ensure common minimum standards (Our Health, Our Care, Our Say, 2006).

In Australia, the Standards for Community Services outline what is expected of organizations that receive funding from the Department of Communities. They set minimum requirements for the ways in which organizations plan and manage client services, recruit and support staff, and meet their governance responsibilities (Standards for Community Services, 2008).

In the United States, programs and policies vary from state to state. However, the majority of Adult Day Services (ADS) are required to possess licensure or certification in accordance with state standards. Twenty five states require licensure, ten states require certification and four states require both licensure and certification (in these states, Medicaid and non-Medicaid providers have different requirements) (Weissert et. al, 1990). It is interesting to note that a number of states (Massachusetts, Ohio, California, Oregon, and Pennsylvania) voluntarily sought accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) for their ADS centres. CARF accredits ADS to maintain the standards agreed by the National Adult Day Services Association (NADSA).

Accreditation is offered by a number of professional or provider organizations with external review and evaluation against established quality standards set by their respective professional organizations. One of the oldest accreditation organizations in the United States is the *Joint* Commission on Accreditation of Healthcare Organizations (JCAHO). The JCAHO is an independent, not-for-profit organization established in 1952, governed by a board composed of physicians, dentists, administrators, nurses and members of the public. JCAHO evaluates the quality and safety of care for a wide range of health care organizations in the United States and in other countries including hospitals, free standing surgery centres, primary care centres, diagnostic and therapeutic centres, nursing homes, mental health clinics and home care services.

Other states may monitor care facilities and ADS through multiple departments that have developed another set of standards that define quality care (e.g., Department of Health, Licensure, and Department of Aging) either simultaneously or at different time intervals.

Accreditation Canada is a national, not-for-profit, independent organization that assists health care services to assess and improve the quality of care they provide to their clients. Accreditation Canada's national standards were developed through consultation with Canadian healthcare professionals. Standards exist for a range of health service programs, including acute care, assisted reproductive technology, cancer care, community health, health systems, home care, long term care, mental health and rehabilitation. The assessment approach of Accreditation Canada has two main steps:

- A self-assessment by the organization of its compliance against the national standards and
- An independent peer review of the organization's compliance against the same standards by Accreditation Canada surveyors during an on-site survey. Surveys are generally undertaken once every three years.

There is no statutory enforcement for accrediting health care or community services in Canada nor does there appear to be any link between accreditation status and access to public funds. That is, the Accreditation Canada process is a voluntary one.

In the past four years, home care organizations and direct service providers in Canada have seen a rise in accreditation. Today, accreditation of home care programs through Regional Health Authorities or on their own is a common occurrence across the country. Eight of the 13 provinces/territories identify that they have achieved or are planning to achieve accreditation through Accreditation Canada. Quebec, Manitoba, Newfoundland and NWT are the only jurisdictions where accreditation is mandatory. In Quebec the accrediting body is the Québec Council of Accreditation (Portraits of Home Care, 2008).

Within the agencies of the Central LHIN there is no common program or service delivery standard, albeit, much work has been done by independent agencies within the community service sector. For example, in Ontario, member agencies of Hospice Association of Ontario (HAO) are expected to meet all the minimum standards and criteria which are stated in HAO's Client Service Standards for the Volunteer Hospice Visiting Service. These provincial standards and accreditation enables hospices to assess and evaluate their competence, service delivery, accessibility, safety and continuity of care. The model to guide hospice palliative care presents a conceptual framework, the 'Square of Care', principles and norms of practice for all aspects of patient and family care (Ferris, et al., 2002)

Despite differences in the accreditation process between countries, the major finding identified in the literature review was that most respected standards were transparent, indicated accountability, and were able to measure performance. They included stakeholder participation in their development and in some countries encourage the involvement of government in mandating.

The methods used in determining and developing the CSS Network, Capacity Building Initiative best practice guidelines are discussed in this next section.

Methods/Rationale for Developing and Determining Best Practice Guidelines

In Canada, community support service agencies are key to enabling seniors to "age at home" and maintain their independence for as long as possible. In-home care, in particular, meets people's personal daily living needs, reduces the number of hospital emergency visits and delays

admission to long term care facilities (Hollander, Chappel, 2002).

For the most part, each community support service agency develops their service(s) according to their own values and mission. This includes fee structures, eligibility criteria, hours of operation, etc. In Canada, national service delivery standards or regulated service delivery guidelines do not exist for community support services. Seeing that the accreditation process is voluntary, there is no common set of standards that services need to abide by. As a result, access and quality vary across the country, province and within the Central LHIN. This can present challenges to provincial and local funders who may seek to assess criteria for quality as measured by defined standards.

It is generally believed that each volunteer Board of Directors shows dedication and passion to the agency they serve. However they may have limited experience and/or knowledge in bringing separate providers together for an integrated and multi disciplinary approach to service delivery. With the introduction of the LHINs and new legislation, Boards of Directors must prepare for new forms of collaboration and integration to meet the operational reforms in Ontario.

It was generally agreed that for consistency purposes it is desirable to first develop a minimum set of agreed-upon terminology that defines key terms for the sector. For the purpose of this report, the Capacity Building Initiative of the Central Community Support Services Network has agreed to adopt the language of Accreditation Canada to define Service Delivery Best Practice Guidelines. Specific terms and service definitions were also taken from the Ontario Healthcare Reporting System. (see Appendix A).

Our overall approach for determining service delivery best practice guidelines for Adult Day Programs, Homemaking and Transportation Services is illustrated through national, provincial and local models of service delivery standards with organizations that represent a mission to promote excellence in providing health care in Canada. At a national level we consulted Accreditation Canada and the Commission on Accreditation of Rehabilitation Facilities (CARF).

At a provincial level, we consulted the Ontario Association of Community Care Access Centres (OACCAC), Personal Support and Homemaking Services Schedule. Much work has been done through the Ontario Community Support Association (OCSA) around service delivery standards for community support services. The guidelines developed have integrated the existing work from OCSA for all services. Also, for areas where there were gaps in Canadian content, we proceeded to seek data from international bodies of accreditation and community service standards.

The Central LHIN has identified four system level goals – access, coordination, quality and efficiency. These form the foundation for an integrated system. In an effort to reduce fragmentation and enhance collaboration, we have identified the key practices to support the Central LHIN system goals for each program.

In addition to the system goals, each organization must be attentive to client needs and strengths as well as to the needs of their families and caregivers in order to deliver high-quality and community based services. Our service delivery practices demonstrate an organized and responsive approach to our core business. Firstly, we assess the needs of each client, coordinate their individual plan and conduct regular follow up assessments to track their health status and develop appropriate interventions. Secondly, we oversee service delivery operations including staffing qualifications, programming and collaboration with other agencies. Having clear written practices and procedures for service delivery provides transparency to our clients about what they can expect from us considering our limited resources. A focus on responsiveness at all stages of delivery helps us support each client to best meet their needs.

The diagram below illustrates our methods as outlined above:

Future Directions

The proposed best practice guidelines provide a framework for community support agencies to develop systems for the management of good service delivery and for continuous improvement in the quality of care.

Development of best practices is about a commitment to continuous improvement. This is achieved by review of practice and outcomes, the sharing of knowledge and findings, and embracing opportunities for improving services. The recommendations are based on the best available evidence and expert opinion collected to date. Consequently, the implementation of these recommendations to enhance and implement the proposed best practice guidelines must be a dynamic, flexible and learning process that can be adjusted based on new findings, emerging client needs and available resources.

The next step in the implementation phase is for agencies to complete a self-assessment and improvement action plan to address gaps in their service delivery practices for transportation, homemaking and day programs. Sector-wide compliance to the practices and gaps will be summarized, while strategies to address gaps will be developed collaboratively, where appropriate. An on-line system to track progress at both the agency and sector level will be established as a step towards accountability and transparency. Feedback from the agency evaluation process will be utilized for the development of best practice guidelines for additional community support services identified through an annual priority-setting process. Best practice guidelines are needed for all community support services in the absence of legislation or regulation. Guidelines must be regularly updated to ensure compliance with new policy directions, research and evolving practice to be effective.

It is proposed that an ongoing and dynamic self-assessment process will ensure regular review of the services provided by community support agencies in the Central LHIN. The overall intention is that by implementing best practice guidelines, the end result will be consistency and an overall improvement in the quality of service delivery. Through this process, it is critical to promote recognition of staff and agency efforts to build the professional image of the community support sector within the community and the broader health care sector.

During the course of our work on best practices, standard performance indicators were in development for the community support services sector through the new Central LHIN service accountability agreements. These indicators will be added to the best practice guidelines once approved.

Common practices for data collection will be required to support sector-wide comparison of data and evaluation of the appropriateness of the indicators selected. Once baseline data is established, research and selection of benchmarks can be implemented. However, the selection of appropriate indicators and benchmarks is only one step of a process that must include understanding existing procedures and creating links between benchmarking, continuous improvement and evaluation. It is critical that practices that contribute to good performance results be identified and shared across the sector.

Further work is needed on practices for program assessment and evaluation which is defined as a measure of outcomes against stated objectives. This consists of collecting information to inform decision-making and assess the effectiveness of strategies and programs. After the data is collected, it must be analyzed and assessed to be put into a useful format. Assessment methods vary according to the resources available from very casual and sporadic to highly quantified and formalized procedures. The most effective processes are usually found when evaluations are formalized and scheduled. Some areas that are included in the evaluation and program

assessment are: the services provided; client satisfaction; program efficacy; and skills and abilities of staff. Common program assessment and evaluation practices were seen to be important to ensure consistency and quality of services.

We are not persuaded that simply setting best practice guidelines will fully address quality of services. However, it is a framework from which each practice represents an ability to mobilize resources, including time, money, or in-kind resources, and each opens into a myriad of possible resourcing strategies. The guidelines can provide direction to organizations; funders, the public and clients to set mutually agreed expectations for service in order to obtain optimal results.

Ontario is expected to experience dramatic changes and pressures in the funding environment which will further necessitate a re-shaping of how the community support services sector operates to ensure maximum effectiveness. Further work is needed to develop and successfully implement a new integrated service delivery model which will require the organizations involved to work together in a way that is different from today. This will require a concerted effort and significant leadership for successful transformation.

It is hoped that the best practice guidelines being developed through this initiative will provide an opportunity for further consultation with knowledgeable peers. This work augments the scope of learning about best practices that currently exists in the community support services sector across Ontario.

Sources

To develop the Service Delivery Best Practice Guidelines, the following were reviewed and considered:

Determining the Potential to Improve the Quality of Care in Australia Health Care Organisations (2001). Australian Council on Healthcare Standards and Health Services Research Group University of Newcastle, , 2nd Edition.

Domiciliary Care: National Minimum Standards-Regulations (2003). London: The Stationary Office, Department of Health.

Ferris, Frank D. and Balfour, H. et al. (2002) A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice. Canadian Hospice Palliative Care Association

"Innovations in Best Practice Models of Continuing Care for Seniors" (March 1999). Federal/Provincial/Territorial Committee (Seniors) for the Ministers Responsible for Seniors,

Matthews Pegg Consulting Pty Ltd, (July 2003). "Standards Setting and Accreditation on Literature Review and Report National Framework for Standards Setting and Accreditation in Health", Department of Health and Aging,

National Adult Day Services Association (1999). Adult Day Services Manual. Washington DC

"Our health, Our Care, Our Say: A New Direction for Community Services" (January 2006). HM Government, UK Department of Health, www.dh.gov.uk/assetRoot/04/12/74/59/04127459.pdf

Weissert, W.G., Elston, J.M., Bolda, E.J., Zelman, W.N., Mutran, E. & Mangum, A.B. (1990), Adult Day Care: Findings from a National Survey, Baltimore, John Hopkins University Press, May 2005

Website Resources

Accreditation Canada
www.accreditation-canada.ca

Canadian Home Care Association - Portraits of Home Care 2008
www.cdnhomecare.ca

College of Nurses of Ontario
www.cno.org

Commission on Accreditation of Rehabilitation Facilities [CARF]
www.carfcanada.org

Joint Commission on Accreditation of Healthcare Organizations
http://www.jcaho.org

National Minimum Standards for Adult Placement Schemes
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087381

Ontario Association of Community Care Access Centres www.oaccac-ont.ca

Ontario Community Support Association
www.ocsa.on.ca

"Partners in Caregiving: The Adult Day Services Program", Wake Forest University School of Medicine, 2002,
http://www.rwjf.org/newsroom/featureDetail.jsp?featureID=183&type=2

Registered Nurses Association of Ontario
www.rnao.org

Seniors Health Research Transfer Network
www.ehealthontario.ca

Toronto Regional Geriatric Program
www.rgp.toronto.on.ca

U.S. Department of Health and Human Services: Regulatory Review of Adult Day Services: Final Report
http://aspe.hhs.gov/daltcp/reports/adultday.htm#intro

APPENDIX A

Ontario Healthcare Reporting System (OHRS) Terms and Definitions

Community Support Services

The Provincial Sector Code definition is "Programs and services to assist people and target groups, directly or indirectly, to live in their communities with a higher degree of independence. The goals are to promote and maintain health, well-being, safety, independence and prevent premature institutionalization." [Ontario Healthcare Reporting Standards, 2008 Provincial Sector Code]

Transportation-Client

Pertaining to activities that arrange to provide transportation to medical appointments, shopping and to various social activities and programs. Transportation is provided by the entity's staff or volunteers to eligible service recipients using private cars, entity's vehicles, and public transportation or assisting the service recipient to walk to the destination. This is a door-to-door service.
(FC. 7258214 CSS IH COM)

Day Services

An integrated support service which provides supervised programming in a group setting for service recipients who require close monitoring and assistance with personal activities (e.g. hygiene, dressing, etc.) The service recipients include the frail and elderly and those with Alzheimer's disease or related disorders, or physically impaired individuals who are relatively independent and can manage certain personal activities. Individuals may attend this service for five to twelve hours on average for a fee. This service assists the participants to achieve and maintain their maximum level of functioning, to prevent early or inappropriate institutionalization and provides respite and information to their significant others. Components of the service include planned social and recreational activities, meals, assistance with the activities of daily living and minor health care assistance; e.g. monitoring essential medications.
(FC 7258220 CSS IH COM)

Homemaking

Pertaining to the activities that assist service recipients living in home with shopping, light housekeeping, meal preparation, paying bills, caring for children and laundry and training the person to perform these activities. The funding is for both the administration/coordination costs of providing the service to eligible service recipients as well as the labour and transportation costs of providing the service. The service recipient is responsible for the direct cost of service, i.e. shopping items, food, etc. For services under the *Homemaking Nurses Services Act*, the services will be provided by hired employees or contracted resource through a claims based program, on a monthly basis.
(FC 7258231 CSS IH COM)

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