

Developing Province-Wide Standardization in Volunteer Organizations

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Abstract

Given the unprecedented shortage of skilled professional caregivers in Ontario's health sector, what role can the voluntary sector play in providing non-medical home care services? And how important is it to have province-wide standardization and accreditation for volunteer organizations such as hospices? This paper first analyzes the organizational challenges to developing standards and then uses concepts from complexity science to formulate three principles – recognition of domain leaders, minimum specifications and focus on a common purpose – as the basis of a collaborative, consensual model for the Ontario Hospice Association's province-wide standards initiative. Examples of quality dimensions, criteria and outcome measures that form the accreditation process are described. Finally, the author examines the initiative's overall strengths and weaknesses, outlines added values of standardization and accreditation and describes lessons learned.

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Prologue

You're leaving your house to get some shopping done. It used to be a mundane chore. But now it's almost a luxury.

Your partner has recently been diagnosed with a terminal illness, and wants to live at home – as fully as possible and for as long as possible.

You have been a part of this decision and totally agree with it – but it is so very difficult.

Your partner is getting thirty hours of home care a week – and you count yourself lucky. You know other people who are getting much less than this.

What those thirty hours mean is that while you're at work, someone is there to look after your partner – most of the time. But when you come home, you're on your own.

You've just been connected to your local hospice association, and they're sending a volunteer to give you four hours of respite care – four whole hours. You can get some shopping done, or some banking. Or maybe just sit and have a coffee and feel a little peace and quiet – a time to try to re-group just a little bit.

The volunteer arrives, and you're on your way.

Would you ever think to ask if this volunteer has any training to deal with the emotional and psychological trauma of people who are dying? To answer questions like, “Why me?” To know how to listen and understand?

Would you ever think to ask if this volunteer clearly understands that medical procedures are beyond their boundaries – even if your partner asks?

You and your partner have a “Do not resuscitate” order – if they are dying, let them be. You know that if you call 911 the paramedics have a legal responsibility to actively resuscitate – even if it is absolutely obvious that someone is dead.

Would you ever think to ask the volunteer if they understand this order? To ask if they completely understand what you, your partner and the hospice have agreed is to be done if your partner is dying when they are alone with them in the house?

Why do we need standards for volunteers? So that you won't ever have to ask these questions when a hospice volunteer walks into your house.

Introduction

The state of health care in Canada today is under intense scrutiny. In 1984, when the Canada Health Act was put in place, the focus was on physicians and hospital services. Today there is a growing recognition that the home is increasingly where care is taking place. There is also the recognition that no standards exist for home-based care, and that little study or attention has been devoted to this growing area of health care delivery.

Using the example of the Hospice Association of Ontario (HAO), this paper examines how volunteers can help address the serious shortages of health care professionals and home care workers by providing the non-medical, compassionate care that consumers indicate is so vital – care that Canadians, in a national survey, ranked as equal in importance to pain and symptom management, and other appropriate forms of medical care.

The paper also makes use of knowledge gained through the a series of interviews conducted by the author with consumers, government representatives, health care consultants and community-based health care providers, for a presentation to the McGill International Institute (Napper, 2002). While the public rates the medical care that is being provided to them as highly satisfactory (Gregg et al. 2002), these interviews indicate how important non-medical, compassionate care is to them, and how this care is not always available.

In addition, the paper examines how, through standardization and the development of an accreditation process, the voluntary home health sector can develop the same level of standards that are being called for within the paid home care sector.

The paper also looks at three underlying principles that HAO developed in order to create a province-wide standardization process involving ninety fully autonomous member organizations at varying levels of development.

The first and most important principle was the recognition that hospice Executive Directors were domain leaders. HAO would acknowledge their leadership role in developing the standardization initiative, and would take the lead only in determining how best to assist the movement and build its capacity.

The second principle was that minimum specifications (“minspecs”) be agreed upon, and that all hospices, no matter their size or complexity, should meet these agreed standards. Given the HAO hospice members’ autonomous structures and their history of independent development, minimum specifications would make it possible for HAO to acknowledge their distinct institutional cultures, while still ensuring consistency in their core services.

The third principle was that the initiative would focus on their one overall common purpose, and on the most important aspect of hospice services: in-home client care.

These three principles were successfully used to develop four components: (1) province-wide standards of client care; (2) outcome measures, key policies and procedures based on these standards; (3) a province-wide training manual; and (4) an accreditation model.

The paper concludes by examining the strengths and weaknesses of this approach, its potential for future sustainability and the major lessons learned as a result of engaging in this process.

The overall strength of the process was in the understanding that its design needed to take into account hospices’ autonomous and independent cultures. Hospices would not accept a hierarchical, top-down approach to developing something as fundamental as province-wide standards and outcome measures.

Another strength was that standardization was the right initiative at the right time. Both the HAO Board of Directors and individual hospices were becoming increasingly concerned that without agreed standards the faults of one hospice might damage the reputation of all. This realization meant that both the Association and its members were motivated to participate in a province-wide standardization initiative.

The greatest potential weakness of this process was that if hospices disagreed so seriously that they could not agree upon any standards the initiative might fracture the movement and destroy hospices' trust and respect for each other.

The overall danger in this process was that HAO was working on the edge of complexity – sometimes very close to chaos. As the process was uncertain and unknown, HAO risked its reputation with its members by undertaking a major initiative, which it knew had to produce results, but which it knew little about and for which it could not rely on precedents for implementation.

Is the HAO initiative sustainable in the future? The greatest strength of the project was that it was member-driven and member-developed. As executive turnover occurs in hospices and new senior staff come on board, will they accept the HAO standards developed by their peers, or will they call for significant changes? HAO will need to monitor ongoing acceptance of these standards through annual orientation sessions for new senior staff members, or risk their eventual rejection by the next generation of hospice executives.

Finally, what can be learned at a deeper level from this initiative? First we see that complex initiatives of this sort tend to create paradoxes at the outset. We should not expect that the outcomes will be what we have planned. Within this initiative, it might have been assumed that a process designed for autonomous, independent organizations at varying stages of development would produce flexible standards that could be interpreted by hospices in various ways. This is the opposite of what occurred. While the process was flexible, creative and interactive rather than prescriptive, the result was the development of standards and outcome measures that would be rigidly and equally applied to all hospices throughout Ontario.

Another paradox is that these autonomous, independent hospices not only agreed to this rigidity – they also made some elements (such as outcome measures) more stringent than was originally suggested to them. The third paradox is that this very rigidity could actually increase the hospices' capacity to offer diverse, customized services at the local level, or to align themselves with other organizations. Ironically, the rigidity of the

standards allows hospices these freedoms as long as they apply agreed standards to their new activities.

The second lesson is to take risks for what you believe in – to lead and follow from a position of promise, not of anxiety and doubt.

The third, and perhaps most important, lesson is to genuinely respect the thoughts, concerns, cares and expertise of others and to intimately involve them in the processes that will affect them. If people do not genuinely believe in the other's worth, or cannot trust each other's integrity, the development of new and comprehensive initiatives within an association of fully autonomous and independent members cannot succeed.

1

Public Concern – A Public Need

In 2002, two comprehensive reports to the Canadian government – *The health care of Canadians*, the final report of the Standing Senate Committee on Social Affairs, Science and Technology (commonly known as the Kirby, LeBreton Report) and *Building on values: The future of health care in Canada*, the final report of the Commission on the Future of Health Care in Canada (commonly known as the Romanow Report) – identified significant weaknesses in the current health care system and recommended major changes in how health care is delivered and funded. The public is increasingly expressing a high level of concern about health care (Leatt and Nickoloff 2001), and there is a general concurrence that healthcare as defined by the Canada Health Act no longer reflects the reality of medical care in this country (Coyte 2001; Leatt and Nickoloff 2001; Stabile 2001).

In 1984, when the Act was put in place, the focus was on physicians and hospital services. Since then there has been a “tidal wave of change within the Canadian health care system that has swept across most components of the health system and come to rest upon the shores of the home and community care sector” (Coyte 2001).

Today, Canada’s health care system is “facing challenges that have not been faced before – a very high level of public concern about the future of Medicare, serious shortages in health human resources in selected areas, escalating costs associated with advancements in the diagnosis and treatment of disease and an increasing interest in the potential merits of privatization in some parts of the health system” (Leatt, Nickoloff 2001).

A *Globe and Mail* editorial of 18 November 2002 echoed these concerns: “Canadians are disconcerted by their medical system, but, despite considerable provocation over the past decade, they have not given up on its ideals. What they seek is certainty: the certainty that high quality and timely care will be there for them when they need it.”

There is a growing recognition that the home is increasingly the place where post-acute, chronic and palliative care is taking place (CIHI Final Report 2001; Coyte 2000; Stabile 2001). Both the Kirby and the Romanow reports acknowledge this reality.

According to the Romanow report, “Home care is one of the fastest growing components of the health care system. . . The advantages are obvious. People get to stay in their own homes . . . [and] maintain their independence . . . and there is growing evidence that investing in home care can save money while improving care and the quality of life for people who would otherwise be hospitalized or institutionalized in long-term care facilities” (Romanow 2002).

As Senator Kirby acknowledges in his report, “The need for home care will become a major challenge as the baby boomers age, average life expectancy rises, health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of informal care-giving by family members” (Kirby, LeBreton 2002).

There is also the recognition of a need to develop standards for the delivery of care in a home setting (Atkinson 2000; CIHI 2001; Health Canada 2001; Kirby, LeBreton 2002; Leatt et al. 2000; Leatt and Nickoloff 2001; Wiles 2002).

Last, there is the recognition that no such standards exist, and that little information or attention has been paid to this growing area of health care delivery. “Little consideration has been given to coordination of services at the community and individual levels [and] insufficient attention has been paid to provision of services closer to home and in the community” (Leatt et al. 2000). These opinions are echoed by other home care research and reports (CIHI 2001; Kirby, LeBreton, 2001).

Similarly, no province-wide standards for the voluntary home health care sector exist. A search of more than seventy-five websites of volunteer organizations within the home health care sector produced no materials on standardization. During a meeting of the Ontario Coalition for Equitable Access to Home and Community Care, which is made up of eleven provincial home care associations, members confirmed that none of their

organizations had developed province-wide standards for volunteers; nor did they know of any other organizations that had developed these materials.

An interview with a respected consultant in the area of standards development confirmed that standardization was a relatively new endeavour within the volunteer home health care sector, which at that time had no materials of its own on standardization. A further search of more than 200 websites, undertaken to identify already-existing accreditation programs for the volunteer hospice sector, revealed that no such programs existed.

If the development of standards is important within the paid home care sector, it is even more so in the unregulated world of the volunteer. This is especially true of the hospice volunteer who cares for highly vulnerable individuals – often on an unsupervised, one-on-one basis in people’s homes.

Using the example of the Hospice Association of Ontario (HAO), this paper examines the role that the voluntary sector can and does play in providing non-medical health care in a home or home-like setting. It also examines how, through standardization and the development of an accreditation process, the voluntary home health sector can develop the same level of standards that are being called for within the paid home care sector.

But first, what is home care? And why is it increasingly in Canadians’ homes that post-acute, chronic and palliative care takes place?

2

What Is Home Care?

Home care, according to a Health Canada policy paper (2001), can be defined as “an array of services which enables clients, incapacitated in whole or in part, to live at home, often with the effect of preventing, delaying, or substituting for long-term care or acute care alternatives.”

This same report goes on to identify “three overwhelming areas of agreement [about home care] among all jurisdictions:

- “That home care can prevent and/or serve as a substitute for facility-based care
- “That given the choice most individuals would prefer to receive services in their home
- “That the time has come to modernize the Canadian health care system by instituting a ‘national approach’ in which the provinces, territories and federal government work together to provide affordable access to a consistent ‘basket’ of home care services for all Canadians.”

Home care may also be able to provide better care and save money:

Initiatives to monitor and quickly re-stabilize clients result in better care than letting clients deteriorate over longer periods of time. As stable clients cost less, it may also save money.... Provided the necessary supports are in place, palliative care should result in fewer trips to the hospital and save money. Respite care can allow families to care for their loved ones for longer periods of time... Step down care is less costly than hospital care and allows clients to recover to the point where they can go home rather than to a long term care facility. (Hollanger 2002)

According to Dr. Peter Coyte (2000), the recent changes in Canada’s health care system are “just the beginning of a new era which will see the return to in-home care, just as the home was the setting for health care in the last century.”

Within this new era of in-home care, what is the role of the voluntary home health care sector? How can it help address the concerns facing Canada's health care system?

First, volunteers can help address the serious shortages of health care professionals and home care workers. A June 2002 CIHI report showed that Canada's physician supply peaked in 1993 and has since declined by five percent, bringing the per capita physician ratio down to the level it was fifteen years ago. A 2002 Canadian Nurses Association report on nursing supply and demand for the next ten to fifteen years predicted a shortage of 78,000 RNs in 2011 and 113,000 RNs by 2016.

There is also a growing demand for home care workers. "The aging of the population, increased substitution of in-home and community-based care for hospital and nursing home care, demands of patients and clients for care in their own homes, and growing public expenditures for home care are powerful factors underlying the demand for home care workers"(Health Canada 2001).

However, current funding sometimes allows for only sixty hours a month of home care, and "poor working conditions (pay, training) lead to high turnover" (Wiles 2002). "The challenge of recruiting and retaining an appropriate number of skilled and unskilled personnel to respond to the growing demand in the home care sector is a key challenge being faced right across the country. Other key issues that need to be addressed relate to the education and level of training of home care workers, salaries and benefits and working conditions facing home care organizations" (Leatt and Nickoloff 2001).

These shortages mean that health care professionals and home care workers must apportion their time carefully. While the public rates the medical care that is being provided to them as highly satisfactory (Gregg et al. 2002), interviews with health care consumers (Napper, 2002) indicate how important non-medical, compassionate care is to them, and how this care is not always available. As one interviewee said:

When I am in clinic waiting for my chemo – I know I am just about to fall apart sitting in that large room with everyone else who is just as terrified as me. You try to do as you're told. You get through it by shutting out your emotions. It's so important just to have someone say "Hi" and to say that they'll be around afterward if I want to talk. They don't have to be professionals – just people talking to people.

Another interviewee spoke about the experience of a friend who was about to have a double mastectomy:

The preoperative assessment was good – but the nurse’s manner was so disconnected my friend didn’t feel she had any interest in anything except her breasts. No one took her hand and looked her right in the eyes and said, “Let’s talk.” After her double mastectomy, she was sent home without anyone asking what kind of personal, emotional support she had at home. Time is the main factor that causes all of this – and in health care especially, time is money.

In cases such as these, the shortage of physicians and nurses as well as other paid staff makes it impossible to take the time to provide compassionate, personal aspects of care. While hospice palliative care volunteers cannot deliver medical care, they can provide this non-medical, compassionate care that consumers indicate is so vital, and that Canadians, in a national survey, rank as being just as important as receiving medical care such as pain and symptom management (Ipsos-Reid 1997).

Volunteers can also help to address the lack of continuity of medical care. “One of the special issues often mentioned by home care clients and workers is the importance of continuity of care. . . One of the bitterest complaints of clients is the disruption and lack of confidence that occurs when many different workers enter their home” (Health Canada 2001). As one client said, “When you’re on home care you have different nurses every day or every visit – you have new people all the time – and every time, these new people ask you the same questions over and over again. It is so tiring, and it is so frustrating.”

Instead of having different volunteers visiting clients, Ontario’s volunteer hospices match one volunteer to one client and family. Once that match has been made, from the first home visit until a death occurs, the same volunteer provides emotional, psychological and spiritual support to the client. This same person also provides respite care and bereavement support to the family for up to a year after a death.

The third value provided by volunteers is an economic one. While the cost effectiveness of home care delivered by paid staff needs further study (Atkinson 2000; Stabile 2001), there seems to be consensus that paid home care can be cost-effective at least as a substitute for care provided in long-term care facilities (Health Canada 2002).

The cost effectiveness of home health care delivered by volunteer hospices has been confirmed by a recently completed economic impact study of the sector prepared for HAO (Kubursi 2002) – the first of its kind in Canada. According to this study, the Government of Ontario would need to spend more than \$20 million in direct expenditures – \$8 million for volunteer activity alone – to replace the services of these volunteers. Given that the government allocates approximately \$4 million to these services annually (HAO 2002), Ontario’s volunteer hospice palliative care sector is extremely cost effective.

Finally, volunteer hospices can provide a measure of integrated care to their clients.

- Ontario’s hospices are client-centred. They view the client and family as one entity, and go to where the client is – to homes, residential hospices, hospitals and long-term care facilities.
- They are a part of a multidisciplinary team, and act as advocates by connecting the family to other supports throughout the community.
- They provide holistic support including spiritual, respite, emotional and bereavement support.

As well as working within their own communities, hospices throughout Ontario work as a collaborative unit – communicating and learning from one another’s best practices.

But providing a continuum of compassionate care in a cost-effective, integrated manner is not enough. In order to become trusted partners within the home health care sector, volunteer organizations such as HAO and its members must prove that the quality of care they offer is such that health care professionals and other community organizations will feel comfortable working with them and can confidently recommend them to their patients.

Ontario’s hospices are thus accountable to a wide variety of individuals and organizations: clients and families, professional care givers, their own volunteers, paid staff and other social service agencies, as well as donors, government and the community at large.

3

Standardization – The Challenges

If developing standards and an overall vision for paid home care organizations is recognized as being important (Atkinson 2000; Health Canada 2001; Leatt and Nickoloff 2001), then developing these standards for an otherwise unregulated volunteer hospice palliative care movement is even more important. Every client and every family member must be assured that their volunteer hospice will deliver compassionate, consistent and high-quality care.

Initiating a province-wide standardization of the volunteer hospice movement posed several challenges. Given the lack of available literature on developing standards for volunteer hospices, the first challenge for HAO was to accept responsibility for this initiative, even though there were no known models to follow – to provide initial leadership based on “here-and-now opportunities” (Greenleaf 1977), while ensuring that the initiative would ultimately provide the best possible volunteer hospice palliative care to people throughout Ontario.

The second challenge was to determine what elements would make up the standardization initiative.

The third challenge was to deal with the fact that Ontario’s hospices are at various stages of development – from newly-formed and totally volunteer-run agencies to a twenty-year-old hospice with 1,200 volunteers that is currently building a “hospice village” housing a residential hospice, a day program and a research program.

Fourth, HAO’s ninety member organizations in Ontario are spread across hundreds of kilometres, and the Association could not afford to bring them together regularly so as to develop standards through an ongoing consensus-building process.

Fifth and last, HAO member hospices are *complex adaptive systems* (Begun et al. 2002): they exhibit diversity; they learn from experience; and they are all interconnected. Moreover, each hospice has an executive director and a Board of Directors – a totally autonomous structure that is not controlled in any way by a central body such as HAO. This structure means that the Association could not take the relatively “easy” approach of dictating what standards were to be developed. A hierarchical approach would not work with autonomous and fiercely independent member organizations. Only “covert leadership” based on persuasion and nuance would be successful. It called for HAO to energize people “by treating them as respected members of a cohesive social system” (Mintzberg 1998).

It also called for HAO to blend democratic and authoritative styles of leadership. The democratic style of leadership was used “by spending time getting people’s ideas and buy-in . . . [and building] trust, respect and commitment.” Another advantage of using this leadership style is that, “because [hospice executive directors] have a say in setting their goals and the standards for evaluating success, people operating in a democratic system tend to be very realistic about what can and cannot be accomplished (Goleman 2000).

HAO also used the authoritative style of leadership “by framing the individual tasks [each of the five standardization initiatives] within a grand vision . . . and defining standards that revolve around the vision” (ibid.). The vision – the overarching goal – was that everyone in Ontario, no matter where they might live, would have equal access to consistent, high-quality and compassionate volunteer hospice palliative care.

Given these realities, what were the necessary components of the standardization initiative, and what methodology could be used to develop materials that would be applicable to every hospice, regardless of its size, location or complexity of services? HAO established three basic principles, which together served to identify the necessary components and inform the entire standardization process.

The first and most important principle was the recognition that hospice Executive Directors are “domain leaders”: individuals whose influence is based on their expertise within hospice palliative care (Gardner 1996). HAO’s role would be to acknowledge their

wisdom within their domain and to take the lead only by focusing on how best to assist the hospice movement and build its capacity (Greenleaf 1977). HAO's challenge was to "get work done through other people" and to ensure its staff and its consultants had the "emotional intelligence" – the social skills – not only to work with hospice Executive Directors throughout Ontario, but also, if necessary, to engage a variety of external stakeholders in the process.

HAO needed to understand that

one cannot speak of leaders who cause organizations to achieve superlative performance, for no one can cause it to happen. Leaders can only recognize and modify conditions which prevent it; perceive and articulate a sense of community, a vision of the future, a body of principle to which people can become passionately committed, then encourage and enable them to discover and bring forth the extraordinary capabilities that lie trapped in everyone that are struggling to get out. . . . In the deepest sense, distinction between leaders and followers is meaningless. In every moment of life, we are simultaneously leading and following. (Hock 2000)

The second principle was the idea of minimum specifications, or "minspecs" (Zimmerman et al. 1998), which would require that all hospices, regardless of their size or complexity, meet the agreed-to standardization initiatives. HAO member hospices belong to the organization by choice; though they value HAO's work, they are fiercely independent. They began their hospices themselves and in response to the perceived needs of their own communities. Given their autonomous structure and their history of independent development, the minspecs approach meant that HAO could respect this local independence, while still ensuring consistency in core hospice services.

While the word "minimum" ordinarily implies the application of the least amount of service or effort – the lowest common denominator – this is not what the concept of minimum specifications means. The specifications themselves are high and should (as hospice representatives often commented during the standardization process) "demand a stretch" on the part of members in order to achieve them; they raise the bar on care delivery and on the expectations of hospice services. What the minspecs approach demands is that all hospices agree to deliver a minimum number of high-quality services or features. Only if all hospices know what these levels of services are, and agree to provide them, can province-wide volunteer hospice palliative care services be consistent.

Minimum specifications would guarantee this high quality while still allowing hospices to customize programs to their individual community.

The third principle was that, given the diversity of hospices and their autonomous nature, the initiative should focus on their common purpose, and on the most important aspect of hospice services – in-home client care.

Given these principles, it was decided that the standardization initiative would consist of the following five components:

1. Province-wide standards of client care for the volunteer visiting program
2. Outcome measures (targets and indicators) based on these standards
3. Key policies and procedures also based on these standards
4. A province-wide training manual to ensure that all volunteers were providing consistent service
5. An accreditation model

HAO's three principles – recognition of domain leaders, agreed minspecs and a common purpose in terms of in-home client care – also led to the development of a collaborative, consensual model, which, despite the organization's limited financial capabilities, could ensure three key components:

1. The process would be led by hospice Executive Directors (domain leaders).
2. From the beginning of the initiative, every hospice, no matter what its size, would have an equal ability to review progress and make comments to be incorporated into the materials.
3. External stakeholders would be given an equal opportunity to engage in the initiative.

The model included four other important elements:

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1. A Working Group was established, consisting of hospice Executive Directors from every region of Ontario.
 2. Hospices and identified external stakeholders were all invited to review the material twice and to suggest additional inclusions or deletions each time. (Such additions, however, would be incorporated only with the unanimous agreement of the Working Group.)
 3. The revised third draft would be reviewed at HAO's annual conference, when hospice members would have a final opportunity to make comments and ask for revisions.
 4. After final revision, the standards, training manual and other documents would be distributed to all hospices and external stakeholders for implementation.

This model, which HAO first tested during the development of standards for client care, seemed cumbersome when it was designed. Although it allowed hospices maximum and equal involvement in each step, if HAO members had very divergent beliefs about what the standards should or should not contain, the material would take considerable time to develop. Also, if agreement could not in fact be reached, the initiative could prove to be destructive to the movement as a whole.

When an additional eighty-five external stakeholders were identified and invited to be a part of the entire review process, along with HAO's ninety hospice members, it really did seem that the process would be unworkable. However, no other process satisfied the three principles that HAO regarded as essential to a successful outcome.

These three principles also followed the three principles of fair process:

- *Engagement.* “[Involve] individuals in the decisions that affect them by asking for their input and allow them to refute the merits of one another’s ideas and assumptions.”
- *Explanation.* “Everyone involved and affected should understand why final decisions are made as they are.”

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- *Expectation clarity.* “Once a decision is made, managers [or in this case members of the Working Group] state clearly the new rules of the game. Although the expectations may be demanding, employees [hospices] should know up front by what standards they will be judged and the penalties for failure” (Kim and Mauborgne 1997).

Clearly, this initiative belonged in the sphere of complexity management. HAO would not be able to control the behaviour of its hospices; the only option was to authentically engage with them. There was also a high level of uncertainty when the initiative began, since both HAO and its members were far from agreement and thus could not accurately predict the outcome.

However, although the Association received a flood of comments on the first review, the suggested changes were remarkably consistent. The Working Group of domain leaders had done their work well. During the second review, the flood became a river. At the conference – the final opportunity for members to make comments and suggest revisions – the river became a very small trickle.

Not only had the process worked, it had done so in a relatively short period of time, and HAO members viewed it very positively. The entire time that had elapsed from the beginning of the initiative until the final review and membership approval was 18 months. At the end of these 18 months, HAO surveyed its members about their satisfaction with the developed standards:

- A full 98 percent of the membership said they found the document easy to read and understand.
- Ninety-seven percent indicated that the standards addressed all the minimum expectations for client services anywhere in Ontario.
- Eighty-five percent stated they would have little or no difficulty in meeting the standards.
- The idea of the Working Group proved to be most valuable. Its members reviewed all iterations of the standards before they were sent to members, and

their decision to include revisions at each stage of membership review allowed continuous progress to be made.

This process avoided some of the drawbacks usually associated with the democratic style of leadership, where ideas are mulled over, consensus remains elusive and the only visible result is scheduling more meetings (Goleman 2000).

Quality Dimensions, Criteria and Complexity

During the process of designing the standards, HAO was very fortunate to have had the assistance of the Ontario Community Support Association (OCSA), which had developed draft standards and criteria for its own members. Although these OCSA standards were not yet approved by the Long-Term Care Division of the Ministry of Health (the funding body), the organization very graciously agreed to allow HAO to adapt their material in developing its own standards.

Of particular assistance was OCSA's use of *quality dimensions*: measurable components that can be examined so as to determine if the agency is providing quality service according to certain standards (CCHSA 1997). The HAO manual, "Client Service Standards for the Volunteer Hospice Visiting Service," identifies and outlines five such quality dimensions.

Table 1. Client Care Standards for Volunteer Visiting Services

Quality Dimension	Description
Accessibility	The community being knowledgeable about the service, and the service being accessible to all major groups within the community.
Competence	The volunteers having the appropriate knowledge and skills levels to provide the hospice palliative service.
Client Perspective	Clients and caregivers being involved in the decision making concerning their care and being satisfied with the care they receive.
Safety	The service to the client/caregiver being provided in a safe manner.
Continuity	The service being coordinated with other service providers.

Using these five dimensions, HAO then adapted OCSA’s Standards and Criteria or developed its own within each of these dimensions. Table 2 shows criteria for the first Quality Standard.

Table 2. Information

Standard 1.1	The hospice shall have an ongoing process for informing the public and other service providers of its service.
Criteria	Description
Criterion A	The information includes: how to access the system; the types of supports provided; who provides the service; who needs the service; availability of the service; catchment area; and any specialty service
Criterion B	A variety of mechanisms can be used, including pamphlets; information sessions; meetings with physicians, Community Care Access Centres etc.; radio, television, newspaper and educational fairs; partnerships with health organizations
Criterion C	The materials and programs are sensitive to the needs of specific ethnocultural groups and special needs groups in the community.
Criterion D	Mechanisms are used that continuously identify areas for improving the process (e.g. need for earlier referrals).

Altogether, sixteen standards based on minimum specifications – each with its own criteria – were developed and endorsed by HAO members, in order to deliver an agreed-to number of high quality services which met the criteria outlined above.

The next step of the process, as planned by the Association, was to allow a minimum of one year to assist members in learning to apply these standards as an integral part of their work. To begin this step, two months after the final release of the standards document, HAO sent a survey to its members asking them to identify barriers to implementation, as well as asking if any of them had begun to implement.

The astonishing response was that the only barrier to implementation identified by the members was time, and that a full 86 percent of hospices had already begun

implementation. Clearly, HAO members had become the driving force – the leaders – of this initiative.

It was up to HAO to follow this lead (Greenleaf 1977) by developing the second identified step in the standardization process: the development of outcome measures (targets and indicators) based on the member-endorsed standards of client care. The goal was to help HAO members monitor how well they were addressing the quality dimensions and meeting the standards in order to assist their quality improvement efforts.

In the process of developing outcome measures, and in response to members' concerns about time constraints, HAO took into account the two cautions mentioned by the Broadbent Report (PAGVS 1999) on voluntary sector accountability and governance:

- Onerous regulations and reporting requirements must be avoided or the spirit of volunteerism itself could be undermined.
- The considerable diversity within the sector must be respected and accommodated.

The following criteria were therefore used in the selection of indicators and targets:

- Ease in collecting data
- Availability of required resources (reasonable cost and time)
- Usefulness and relevancy of results
- Ability of hospice to improve the situation if a target is not met

The collaborative and consensual model developed for the standards initiative was again applied, and the following steps were taken:

- HAO established an Indicators Working Group made up of hospice Executive Directors.
- Members of the Indicators Working Group reviewed and revised draft indicators and targets.

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- HAO member agencies received a copy of the draft indicators and targets for input at five regional meetings held throughout Ontario.
 - Revisions were made after each regional meeting and before being presented to the next regional meeting.
 - The targets and indicators were reviewed again at HAO's annual conference.
 - Final revisions were made and sent to all members.

The one change to the consensual model developed for the standardization process was the addition of regional meetings held with hospice members throughout Ontario. The reason for this additional step was that HAO had developed twenty outcome measures and could not determine whether members would find all twenty valuable, or whether they would decide, using the minspecs approach, that only five or six outcome measures would be sufficient. Also, if they did decide to use only a minimum number, which ones would they choose?

By acknowledging that hospices were complex adaptive systems accustomed to receiving messages from others, transforming these messages, and then sending them to others (Zimmerman 2002), HAO was able to use an iterative approach. The first group's suggestions formed the materials presented to the second, and so on, so that the material presented at the final regional meeting was a compilation from the rest of the province. In each meeting, HAO was able to ask if members wished to adopt only some of the measures, and to let each group know what the previous group had determined.

It is a mark of the dedication and professionalism of Ontario's hospices that, in each of the five regional sessions, hospice Executive Directors unanimously chose to include all twenty developed targets and indicators in the standardization process rather than to limit them to four to five measures. In addition, rather than being concerned about their ability to meet a particular measure, they in fact strengthened some of them. For example, one suggested target was that 80 percent of primary caregivers were satisfied with the service the client received; the Executive Directors raised the target to 90 percent. It was suggested that the number of validated complaints from clients, caregivers or other service providers concerning a breach of confidentiality should be targeted at .01 percent; hospice Executive Directors changed it to zero. The measuring sticks that hospices chose

for themselves clearly reflected a desire to ensure that all hospices, whatever their size, complexity or history, would be accountable for the delivery of high-quality and consistent service.

In developing these targets and indicators, HAO built on the already-endorsed standards by developing a series of charts that included:

- The already-developed and member approved quality dimension, standard and criteria
- The newly-developed indicators that would be used to monitor how well the standard and the criteria were being met
- The target which set the goal the hospice was to achieve

The chart also contained suggestions for how to collect and analyze information. To complete the outcome measurement exercise, each hospice – on an annual basis – would tabulate:

- The result the hospice achieved based on its analysis of information
- Factors affecting achievement of target (this box provided an opportunity for the hospice to list any targets not achieved, state the reasons and identify key areas for improvement)
- Quality improvement strategies (if a specific target was not achieved, the hospice could outline approaches it would use to achieve the target)

Table 3 shows the further development of the standardization process.

(For examples of standards, criteria and outcome measures from the second, third, fourth and fifth quality dimensions, see Appendix I.)

Table 3. Accessibility

Quality Dimension: Accessibility				
The community being knowledgeable about the service and the service being accessible to all major groups within the community.				
Standard 1.1				
The hospice has an ongoing process for informing the public and other service providers of its service.				
Criteria				
<p>A. The information includes: how to access the system; the types of supports provided; who provides the service; who needs the service; availability of the service; catchment area; and any specialty service</p> <p>B. A variety of mechanisms can be used, including: pamphlets; information sessions; meetings with physicians, Community Care Access Centres etc.; radio/television/newspaper & educational fairs; and partnerships with health organizations</p> <p>C. The materials and programs are sensitive to the needs of specific ethnocultural groups and special needs groups in the community.</p> <p>D. Mechanisms are used to identify areas for improving the process.</p>				
Indicator 1	Target	Collecting Information	Analysis	Results
Number of referrals	Annual increases	Review data base	Count number of referrals	
Indicator 2	Target	Collecting Information	Analysis	Results
Number of referrals by source	Referrals from at least three different sources	Review sources of referral annually	Count of total referrals from each source	
Indicator 3	Target	Collecting Information	Analysis	Results
% of clients served (by age, gender, location, diagnosis, language)	Varies with individual hospice	Review of data base	e.g. number of females divided by total number of clients, multiplied by 100	
Factors affecting achievement of target:				
Quality improvement strategies:				

Both these initiatives (as Table 4 shows) were very much within the realm of complexity management as defined by Zimmerman et al. (2001).

**Table 4. HAO Standards and Outcome Measures:
Congruency with Complexity Management**

Complexity Management Characteristics	HAO Standards and Outcome Measures
Engagement	<p><i>"Leaders . . . cannot control the behaviour of all the agents in the system. They cannot control changes either inside or outside their organizations. The alternative is to engage, authentically, with others."</i></p> <p>HAO members are autonomous. The Association could not dictate the standards of outcome measures to be used by individual hospices, and needed members' approval and endorsement throughout the process.</p>
Adaptation	<p><i>"Everyone engaged in complex system behaviour receives messages from others, transforms, and sends messages to others."</i></p> <p>HAO used an iterative approach to developing outcome measures by holding meetings throughout Ontario. The first group's suggestions formed the materials presented to the second, and so on so that the material presented at the final regional meeting was a compilation from the rest of the province.</p>
Uncertainty	<p><i>"In complex situations, neither prediction nor control is possible. The complexity manager must recognize various horizons of certainty."</i></p> <p>Adoption of standards and outcome measures was voluntary for members. There is inherent uncertainty that comes with having no "authority."</p> <p>Additional uncertainty was caused by not knowing if the material was suitable for HAO's diversity of membership</p>
No End in Sight	<p><i>"Complexity managers recognize the emergent nature of organizational reality. They understand the past and present intimately because they form the grounding and raw materials for a future that will self-organize."</i></p> <p>While seeking approval for the outcome measures, hospices were already suggesting that the standards be reviewed.</p> <p>HAO cannot determine the result of this review - of throwing open the entire discussion of standards to the membership in the future.</p>
Difference is Valued	<p><i>"Too much similarity . . . leads to inflexibility and insularity. Difference . . . provides the energy for change. When a group focuses on differences that make a difference, they are able to generate new insights, structures and relationships."</i></p> <p>Each regional meeting to discuss outcome measures mixed together new and small hospices with well-established agencies, and hospices located within rural, remote and urban settings.</p> <p>The discussions focused on their different capabilities, needs and programs, and then focused on how to forge outcome measures that were strong enough – universal enough – to be implemented by all HAO members, no matter their size, sophistication or jurisdiction.</p>

In addition, by combining the expertise of members, a knowledgeable consultant, external stakeholders and the desire of HAO’s Board of Directors to create value for its members, a generative relationship was developed that would allow “the parties to learn as they co-create a new product, service, distribution process or solution” (Zimmerman 2001). HAO members and the Association fulfilled the four key aspects of generative relationships:

- There were enough differences among the hospices themselves and among members and the Association to see the development of standards from different perspectives.
- Both the working group and the member-centred approach gave authentic opportunities to talk and listen to each other.
- All the participants acted together to create the first-ever standards and outcome measures for the volunteer hospice movement in Ontario.
- From the very beginning of the project, all parties had reason to work together for their mutual benefit.

However, these first two steps of HAO’s standardization initiative were *not* congruent with complexity management in two areas.

**Table 5. HAO Standards and Outcome Measures:
Incongruence with Complexity Management**

Complexity Management Characteristics	HAO Standards and Outcome Measures
Adaptation	Through regional meetings, HAO used an iterative approach to develop outcome indicators. However, the only way that hospices received and sent messages to each other was through HAO rather than receiving them directly.
Difference is valued	Although the same standards and outcome measures could be used by all hospices, whatever their circumstances, there was no discussion about different ways of delivering service – hospices are remarkably similar in their philosophy and delivery of care.

The Stacey Matrix

In *Edgework*, Zimmerman et al. present the “Stacey Agreement and Certainty Matrix” as a helpful tool for considering “the appropriate management actions in a complex adaptive system based on the degree of certainty and level of agreement on the issue in question” (1998, 136). The Stacey Matrix can be used to analyze the first two steps of HAO’s standardization process.

Anarchy – Far from Agreement and Far from Certainty

Before the standardization process began, HAO had just emerged from a period when members viewed it as being distant and unresponsive to their needs. HAO’s Board of Directors wanted to heal past differences and find an initiative that was valuable in itself and would also create bonds between the Association and its members. However, there was no agreement and no certainty as to what this project should be.

At the same time, some HAO members were uneasy with the practices of other members, which might adversely affect their own reputations. Still, there was no agreement or certainty about how to change the current situation.

The Edge of Chaos – The Zone of Complexity

During several meetings, the Board discussed the danger of hospices not having consistent standards for client care. The Board became convinced that HAO and its members needed to develop standards, but there was no agreement about how to go about the project or what the standards might look like.

After discussions with key hospice representatives, HAO members themselves saw the advantages of adopting standards. Developing these standards became a new priority for the Association, but again there was little agreement or certainty about what these standards might look like.

Complicated – Toward Certainty

HAO was successful in raising funds for the initiative. So there was a financial certainty about the project; but the board was still far from certain about the finished form of the initiative.

The funding made HAO members more certain that the project could be done and their election of a Working Group made them more certain that they would have control over the initiative.

Toward Agreement

The road toward agreement was built by HAO extensively consulting its members at every step.

Simple

From the perspective of HAO and its members, what has become close to certain and close to agreement is the particular model developed by the Association in order to build consensus.

A further analysis, however, clearly indicates that the idea of being in a relatively simple zone of certainty and agreement is incorrect. Once HAO had demonstrated an ability to develop province-wide standards for client care, its members requested that the Association work with them to develop standards for residential care, day hospice programs, spiritual support and alternate therapies. While the Association would willingly do so, at the present time it does not have the human or financial resources to accommodate its members.

Ironically, just as the project seemed to become relatively simpler than it had been, its very success threw HAO back to the edge of complexity – far from certain about how to proceed, and far from agreement as to its continuing role and how to meet members' demands.

Also, while HAO began to see parts of this process as being relatively simple, both the Association and its members still faced the future challenge of endorsement and implementation of an accreditation model. If there were major impediments to full implementation, then the project would go back to the edge of complexity as new, more workable patterns were sought.

Last, HAO members have requested that the Association assist them by developing client and volunteer satisfaction surveys to be used by all hospices, as well as consistent audit tools to ensure province-wide consistency. While this is an indication of the trust they put in HAO's ability to develop these materials, it again sends the Association into the area of complexity in terms of how to go about accomplishing these additional member-driven tasks.

While HAO members were looking to the Association to develop additional standards, the third and fourth initiatives – the development of key policies and procedures and a province-wide training manual – were being launched.

The development of policies and procedures was again based on the same three overarching principles:

- Viewing hospice Executive Directors as “domain leaders”
- Development of key policies and procedures that all hospices could adopt (minimum specifications)
- Focusing on the members' common purpose, and on the most important aspect of hospice services – in-home client care

As hospice members had already developed client-care policies and procedures, this initiative was much more easily developed than the first two. A Working Group was once again established, but this time its role was to review already-developed policies and procedures and determine which ones were key.

Fifteen hospices from across the province responded to HAO's invitation to send their policies and procedures. From these samples, the Working Group chose one format, and

then selected what they believed to be key policies and procedures, which all hospices would be able to implement. These were intended to translate the five quality dimensions identified in HAO’s “Client Service Standards for the Volunteer Hospice Visiting Service” (2001) into key policies and procedures that are required in order for the service to:

- meet HAO’s Client Service Standards for Ontario’s Volunteer Hospice Palliative Care Visiting Service (liability)
- comply with fiduciary duty and statute-imposed risks (compliance)
- let the public know what services are being provided (transparency)
- look carefully at what is being done and its impact on people (accountability)

These key policies do not necessarily reflect each standard or criterion that supports the five quality dimensions. Rather, they provide a framework to support the ongoing policy development of member hospices.

The following is an example of a policy and procedure from HAO’s “Key Policies and Procedures for the Hospice Visiting Service” that is based on the policy area of accountability.

Quality Dimension 1: Accessibility – the community being knowledgeable about the service and the service being accessible to all major groups within the community.

Key policy area: Accountability

Topic: Who speaks for *Hospice Name*

Purpose: To define the role of hospice volunteers when representing *Hospice Name* to the community.

Policy Definition: Volunteers are authorized to act as representatives of *Hospice Name* as indicated within their volunteer job descriptions and only to the extent of such written specifications. Prior to any action or statement that might significantly affect or obligate *Hospice Name*, volunteers must consult with and seek approval from appropriate supervisory staff. These actions may include, but are not limited to:

-
- Public statements to the press
 - Coalition or lobbying efforts with other organizations
 - Agreements involving contractual or financial obligations

Procedure:

<i>Responsibility</i>	<i>Action</i>
Volunteer	Report any request to represent the hospice to their Supervisor of Volunteers
Supervisor of Volunteers	Report request to Executive Director or designate
Executive Director	Appoint appropriate spokesperson
	Policy implementation and monitoring

While developing the policies and procedures, HAO and its members also began the fourth initiative: developing the province-wide volunteer manual. Creating the manual was not within the sphere of complexity as all hospices had already developed extensive educational training materials. Following the principle of recognizing hospices as the experts, HAO asked members to send in their existing training manuals and materials. Again, a significant number – twenty-five hospices from rural, northern, remote and urban centres throughout Ontario – sent their materials.

This generous response, while most appreciated, made the process extremely labour-intensive. HAO had twenty-five chapters – one from each hospice – for each of fifteen separate training components. That made a total of 375 separate chapters that needed to be read, evaluated, and edited down into one manual. However, the hospices’ response produced an excellent training manual, which was a compilation of best practice and expertise throughout the province. A Working Group reviewed the manual but, as the material was already member-generated, the additional steps of the reviewing process were not taken. The manual was sent to all members after this review.

4

The Accreditation Process

At this point, HAO thought it would be able to take a break from further developing the accreditation model. The first four steps were completed, and it was thought that members would not accept the idea of developing an accreditation process for at least two years. This amount of time would allow them to fully implement standards and to become familiar with utilizing outcome measures. At the next regional meeting, however, hospice representatives themselves first began to discuss the development of an accreditation process, and then unanimously voted that HAO should start the initiative as soon as possible. Once again, hospices took the lead.

Thus the planning began. The first determinations around developing an accreditation model were as follows:

- The focus would be to assist each member to continually improve their services within the specific delivery area of visiting hospice volunteer client services.
- The accreditation process would assist in achieving the overarching goal of ensuring that no matter where people live in Ontario, they have equal access to consistent, high quality and compassionate hospice palliative care.
- HAO's accreditation process would, if possible, be built around its already-developed standards and outcome measures.
- There would be the same level of member involvement that had characterized previous standardization initiatives.

Accreditation could provide an excellent means for HAO member hospices to improve credibility in the hospice palliative care community, strengthen team spirit within their organizations and, most importantly, improve initiatives related to visiting hospice volunteer client services.

However, to accomplish these objectives, member organizations, external stakeholders and partners would need to see that HAO's accreditation process was both credible and viable. Only by researching successful accreditation programs both nationally and internationally could HAO develop an evidence base in order to develop its model. The first step, then, would be to complete a literature review in order to explore accreditation options and identify models that would assist HAO in developing its accreditation process. Among other things, the review sought to identify:

- National and international accreditation programs in both health care and community based sectors
- Potential support systems for developing the accreditation process
- Established accreditation programs specifically for volunteer-based, in-home hospice palliative care services

The results of an extensive review of more than 200 Web sites indicated that HAO's initiative to develop an accreditation program specifically for a home-based volunteer visiting hospice program would be a "Canadian first." In addition, the literature review indicated that there were no pre-existing accreditation programs for the volunteer hospice palliative care sector in North America or any other jurisdiction.

This discovery, in terms of the Stacey Matrix, clearly put HAO's standardization initiative back into the sphere of complexity – of not knowing what the Association's accreditation process would look like, and not having any certainty about how to implement such a project. What was certain and known, however, was that the consensual model, based on the three principles of hospices as the leaders, minimum specifications, and focusing on client services, was a model that had worked well and could be used again.

The Stacey matrix was a very apt tool for describing this stage of the accreditation model. There was a constant back and forth flow from complexity – facing the unknown and being uncertain as to the final outcome – to the known and certain, which was the process that would be used.

The first step in developing the accreditation initiative was to analyze the results of HAO's comprehensive literature review in order to determine the elements of currently successful programs. This analysis identified sixteen organizations as potential informational sources for developing an accreditation process for Ontario's volunteer hospice movement (see Appendix II).

These organizations met one or more of the following criteria:

- Accreditation experience in the voluntary sector
- Innovative client-centred approach
- Potential to share information or develop partnership relationship
- Recognized international leaders in the field

The literature review also identified seven international organizations with specific aspects of their accreditation programs and initiatives that seemed to be congruent with HAO's standards-based and consensual model (see Appendix III):

- Literacy Volunteers of America (USA)
- World Health Organization, Regional Office for the Americas (USA)
- Kooperation für Transparenz und Qualität im Krankenhaus (Germany)
- The Health Quality Service (United Kingdom)
- The Australian Council on Healthcare Standards (Australia)
- The Baldrige National Quality Program (USA)
- Community Health Accreditation Program Inc. (USA)

The next step in the literature review was to identify "best practice" elements common to these established accreditation programs:

Accreditation based on outcomes/performance measurements. Accreditation programs have evolved over the years from a review and assessment of internal and external processes (policies and procedures) to a comprehensive assessment of the outcomes of these processes. This transition has been the result of initiatives in many different countries to develop national or regional standards.

Recognition of a particular accreditation process by all members of the health care team. Hospice palliative care is, by definition, a multi-disciplinary, team-based approach to meeting client and family needs. Successful accreditation programs revealed participation and contributions by all members of the health care team.

Involvement of member agencies throughout the development process. In order to enhance acceptance by member organizations and their endorsement of the process, successful accreditation programs have been developed through member involvement.

Accreditation based on client-centred materials. HAO Standards for Client Care, as well as its policies, procedures, indicators and targets, all focus on the care of the client and the family. Most accreditation programs nationally and internationally are comprehensive in scope. They review everything from maintenance to governance to patient care. However, client-centred care remains the focus of review.

Accreditation based on both self-assessment and external assessment. The key to successful accreditation programs lies in the integrity of the accreditation review. Generally speaking, the literature search identified the usage of both self-assessment and external assessment.

Continuous improvement or adaptation of the accreditation process. Accreditation is synonymous with quality improvement. Each accreditation program has built-in processes both for the member organization to continue to work to improve quality and for the accreditation program to renew and update itself.

(For a description of how the accreditation programs of the seven previously identified international organizations illustrate these key elements, see Appendix IV.)

This comprehensive literature review and analysis accomplished two objectives first developed when HAO began its accreditation model:

1. It gave HAO an internationally supported evidence base that would be credible in the eyes of the Association's member organizations, external stakeholders and partners.
2. It clearly showed that effective accreditation programs contain the three basic elements that HAO had already developed:
 - across-the-board standards endorsed by the hospice palliative care community
 - outcome or performance measures, with core indicators and targets
 - self-evaluation and external peer review, using the same working tools (like the HAO indicator charts)

Given the inexperience of HAO's members with self-evaluation, attention was paid to the caution voiced by the Panel on Accountability and Governance in the Voluntary Sector report (1999) that excessive or onerous regulations and reporting requirements must be avoided (lest the spirit of volunteerism itself be undermined). The panel also pointed out that the considerable diversity within the sector must be respected and accommodated. Accordingly HAO decided to develop a two-stage certification process that would build on self-evaluation as the first step toward a full accreditation model.

Stage One Accreditation

This accreditation certificate will indicate that the hospice has implemented HAO's Client Service Standards. HAO will issue an *Accreditation Certificate, Level One* upon submission of a statement of implementation of standards approved by the Board of Directors of the submitting hospice.

Stage Two Accreditation

This accreditation certificate will indicate that the hospice has completed a self-evaluation using the indicators and targets and has identified both service improvement and best practice. HAO will issue an *Accreditation Certificate, Level Two* upon submission of a statement of self-evaluation approved by the Board of Directors of the submitting hospice.

Stage Two Accreditation will be awarded every two years. Continued certification will be based on evidence of service improvement as identified in previous submissions.

As HAO members throughout Ontario reach Stage One and Stage Two accreditation levels, the overarching goal of offering consistent, compassionate and high-quality care to everyone in need will be achieved. While hospices may differ in the types of programs they offer, in terms of client services they will resemble a hologram. “If you divide a hologram, each part, no matter how small, shows the whole image intact.” (Senge, 1990)

Developing an external peer review will be the next stage of HAO’s accreditation process. While this is an essential element of accreditation, it is a costly process that may demand a new “arms length” organization to provide accreditation services for the volunteer hospice palliative care movement. The current resources of both HAO and its member organizations preclude the development of this initiative at this time.

Even if funding were readily available, HAO members will need to become familiar with Stage One and Stage Two Accreditation by going through the cycle twice before any external peer review can be initiated.

During the first cycle, hospices will be able to identify and quantify factors affecting achievement of their targets and their individual quality improvement strategies. During the second cycle, they will be able to analyze how they have or have not met the target since their first audit. As well, they will be able to analyze if their success or failure has been based on factors that are external and uncontrollable, or internal and subject to improvement in the next cycle.

Once hospices have gone through two cycles of Stage One and Stage Two Accreditation, they will be able, on an individual basis, to identify any of their own potential problem areas. They will also be able to identify particular successes in achieving their targets.

By working with its members throughout Ontario to analyze the results of hospice audits, HAO will be able to identify best practices that can be communicated to all hospices throughout Ontario. The hospice movement's well-established culture of mentoring or "buddying" could also be used to link hospices that have developed best practice with others that are looking for specific quality improvement strategies. This process also meets another objective developed during the planning stages of this initiative: that the focus be to assist members to continually improve their services within the specific delivery area of visiting hospice volunteer client service.

Now that HAO has designed its Stage One and Stage Two Accreditation initiative, the next step will be for the Association to seek member input and endorsement by following its already established consultative, consensual process of:

- establishing a Working Group to review, change or edit this document and distribute it to HAO members, other members of the hospice palliative care team and key external stakeholder groups for comments, suggestions, etc.
- coordinating two rounds of HAO members and external stakeholders being invited to make suggestions and revisions before presenting the draft model at HAO's annual conference (see Appendix V)
- preparing to conduct a trial accreditation with two HAO members – one in an urban setting, and one in a rural/remote area.

If the trial accreditation programs are successful, and after members become familiar with implementing Stage One and Stage Two of HAO's accreditation program, the next and final step will be to develop an external peer review. Established health accreditation programs have already developed standards for paid, professional staff and for large, freestanding institutions such as hospitals. However, these programs are not readily transferable to the voluntary home-based sector.

The key elements of the external review process could well be based on the “Promising Practices” model developed by the Literacy Volunteers of America, whose accreditation process stood out in the literature review as having the best fit with HAO and its member organizations: first because it is based on setting standards for independent, volunteer-based affiliates; and, secondly, because its client focus is based on the delivery of services by volunteers. It also uses a consensual model that combines the quality improvement process of member organizations with the identification of new standards to be used by all members in the next accreditation cycle.

This innovative, external peer review process will be the final step in realizing the overarching goal of HAO and its members – to ensure that no matter where people live in Ontario, they will have equal access to consistent, high quality and compassionate volunteer hospice palliative care.

Major organizational initiatives cause organizational change, and HAO and its members are no exception. These changes, as shown in Table 6, can be analyzed using the organizational models developed by Mintzberg, Ahlstrand and Lampel (1998). While standardization moved HAO *members* more towards Mintzberg’s Professional Model (and even, to a small degree, the Machine Model), it moved the Association from the Professional Model to an Adhocracy as it responded to new demands to develop standardization-related projects for various self-regulating member hospices.

Mintzberg’s Missionary Model presents a “strong culture, [in which] its members are encouraged to pull together, and so there tends to be a loose division of labour . . . Values and beliefs shared among all the members hold the organization together” (Mintzberg et al. 1998). This model can also be used to analyze HAO and its members, and the change in the organizational structure brought about by the standardization initiative (see Table 7).

After four years of effort, the successful implementation of four province-wide standardization initiatives and the imminent launch of the fifth initiative, what can we say about the strengths and weaknesses of the approach that was taken? When should this process be applied, and when should it be avoided? What future threats might it face? Is it sustainable? What were the unexpected results and benefits? And what are the most

important lessons learned – lessons that changed both the individuals and the organizations involved in the project?

Table 6. HAO and Mintzberg Organizational Models

Mintzberg Organizational Model	Congruent with HAO Standardization Initiative	Incongruent with HAO Standardization Initiative
Machine Model	HAO members, by agreeing to endorse and implement the Association’s standardization initiative (standards of client care, indicators and targets and key policies and procedures), are providing significantly more consistent care.	The standardization process is built on the idea of minimum specifications which still allows each hospice to offer “customized” and individualized services according to the needs of its own particular community and its own abilities to offer services.
Entrepreneurial Model	In order for HAO’s standardization process to succeed, each hospice must have one person who acts as a champion of the initiative. Given the competing needs and ever increasing demands being put on hospices, implementation could not occur without this on-going commitment.	At the heart of HAO’s standardization initiative is the need for all hospices - and all hospice leaders – to act in concert and uniformly adopt and then endorse HAO’s standards. This cooperative spirit of accepting standards developed by a provincial body own is not a usual characteristic of the Entrepreneurial Model.
Professional Model	Standardization of skills is the mark of Mintzberg’s professional organization.	A weakness of this model is a potential irresponsibility to clients. However, the central culture of hospices is their belief in the inherent value of each individual and in providing care that is both client centred and focused. As volunteer organizations, hospices are dedicated to valuing volunteers’ skills and to being inclusive of their community.
Adhocracy Model	HAO hospice members often develop projects and programs to meet specific client needs within their community. Standardization has been taken on as one more project that meets clients’ needs.	As a response to the need of the entire “community” of Ontario, standardization means that all hospices meet the same minimum specifications under a central initiative rather than developing their own specific projects.

Table 7. Mintzberg’s Missionary Organization

<p>Descriptive of Individual Hospices</p>	<ul style="list-style-type: none"> ▪ Every hospice is dominated by the same culture of caring for others, a desire to make the last stages of life as full and as comfortable as possible, and an absolute belief in the importance of every human being. In each organization, everyone from the Executive Director and Board Members to indirect and direct service providers is valued for the particular contribution and perspective that they bring. ▪ The standardization initiative – by emphasizing consistent, high quality and compassionate care – appealed to this culture of caring and excellence. During regional meetings, individual members very carefully listened to each other’s concerns and pulled together to adapt standards and indicators that could be used by everyone. ▪ The initiative was member-centred in that hospices and external stakeholders were invited to review the materials at three separate times in their development. During full staff meetings and board meetings, hospices asked for opinions and comments from everyone in their organizations.
<p>Descriptive of HAO</p>	<ul style="list-style-type: none"> ▪ The standardization initiative further strengthened HAO’s culture of leading through following (Hock 2000) – understanding its members’ needs and recognizing their expertise. HAO involved members and external stakeholders at every step of development and implementation. Rather than seeing their expressed concerns and suggestions as “threats” or impediments to progress, HAO welcomed them as a sign of how important and valuable the initiative was to its members. ▪ Everyone on HAO’s staff was encouraged to review and help develop the standardization of materials, and everyone was proud that the Association’s members fully endorsed the initiative. This has led to the development of an accreditation process that will again see all HAO staff being involved in research, proposal development, membership participation and pilot testing. ▪ This process also led an even greater appreciation, among HAO staff, of the dedication and caring of hospice members. They witnessed hospices consistently “raising the bar” when it came to indicators and targets. For instance, the original target for breach of confidentiality was set at a maximum occurrence of 1 percent. HAO’s hospices saw confidentiality as the cornerstone of everything that they do, and changed the target to reflect a “zero tolerance” level. This dedication influences how every HAO staff member interacts with its members.

The overall strength of the process was the understanding of the autonomous culture of hospices. While HAO's member retention rate of 99 percent over the last four years shows that members do value the work of the Association, they are fiercely independent; they would not accept a hierarchical approach to developing something as fundamental as standards and outcome measures. HAO could only have succeeded by recognizing the independence and expertise of hospices, while at the same time indicating to members that this initiative was within the realm of responsibility of the provincial body. Both members and the Association needed to be equally motivated and involved, for "like performance, a strategy is made into vision by a two-way current. It cannot happen alone, it needs assistance." (Westley and Mintzberg 1989).

The other key reason for success was that standardization was the right initiative at the right time (Greenleaf 1977). HAO's Board of Directors was becoming increasingly concerned that, without standards defining what hospices could and could not do, the actions of any one hospice might damage the reputation of all. The Board was also becoming increasingly aware of its own responsibilities for developing standards. This unease, however, was not clearly articulated by either the Board or by members. In a strategic planning exercise that took place just before standardization was initiated, the need to develop standards was not articulated by either the Board or by hospices. "Rarely do the earliest signs for strategic change come from the company's [or the charity's] formal horizon scanning or reporting systems. Instead, initial sensing of needs for major strategic changes is often described as 'something you feel uneasy about.'" (Mintzberg et al. 1998)

The greatest potential weakness of the standardization process was that it entailed a very significant risk. While it did succeed, it could have led to fundamental divisions amongst member organizations and a permanent weakening of the hospice movement. This danger was offset by allowing hospices maximum and equal involvement in each step. Was standardization important enough to risk fracturing the fundamental working relationships between HAO and its members, and between hospices themselves? Now that it is almost complete and successful, it is difficult to argue against the initiative. However, this danger was not adequately explored by HAO before beginning the project, and this lack of exploration must be acknowledged as a weakness.

The initiative also called for HAO to blend democratic and authoritative styles of leadership. The democratic style of leadership, “spending time getting people’s ideas and buy in [and building] . . . trust, respect and commitment” (Goleman 2000) could have resulted in an interminable number of meetings, with little being resolved. HAO had only a bare minimum of funding to complete the project, and these funds would have run out with little or no resolution or standardization development having taken place.

HAO also used an authoritative leadership style by “framing the individual tasks [i.e., the five standardization initiatives] within a grand vision . . . and defining standards that revolve around the vision” (Goleman 2000). The vision – the overarching goal – was that everyone in Ontario, no matter where they might live, would have equal access to consistent, high quality and compassionate volunteer hospice palliative care. The weakness of this approach is that it fails “when a leader is working with a team of experts or peers who are more experienced than he is; they may see the leader as pompous or out-of-touch” (ibid.). Ironically, treating hospice Executive Directors as “domain leaders” was one of the underlying principles that HAO determined crucial for success; but this very principle could have caused the initiative to fail.

A related irony is that, except for overall coordination and information gathering and dispersal, HAO deliberately took on the role of follower. However, because of the success of the initiative, the Association’s members view it as very capable within this arena – as a leader. As such, they have now requested, and indeed expect, that HAO will take on a number of related activities, such as developing and administering province-wide satisfaction surveys and a standardized audit process for program evaluation. They are also requesting that HAO develop standards for other programs such as child bereavement, day programs and spiritual support. While these requests are a mark of the increased value that members see in HAO, they also pose a threat. HAO’s current financial and human resources preclude it from fulfilling these expectations. The Association’s continued inability to meet the expanded expectations of its members could eventually lead to an erosion of their confidence in the Association.

The overall danger in using this process was that HAO was operating within the area of complexity – sometimes very close to chaos. The process was both uncertain and

unknown, and so HAO risked its reputation with its members by taking on a large initiative which it knew little about and which had no precedents for implementation.

Again, the irony is that this process was built on the recognition that strategy is “not a linear process. The validity of strategy lies not in its pristine clarity or rigorously maintained structure, but in its capacity to capture the initiative, to deal with unknowable events, to redeploy and concentrate resources as new opportunities and thrusts emerge and thus to use resources most effectively when selected.” (Mintzberg et al. 1998). Had it failed, this strategy would have damaged HAO’s reputation not only with its members and external stakeholders but also with its funding bodies who expected to see concrete results from their investments.

There is a tendency, when any large-scale project is successful, for others to emulate the process in the belief that it will succeed in their arenas as well. Despite HAO success, some of the standardization project’s underlying principles might not succeed in other organizational cultures. For example, at the heart of the process was the belief that the member hospices, not HAO, were the experts. This process can only be successful if member organizations also see themselves as being competent, independent players who would not necessarily welcome “top-down” initiatives. In a hierarchical association, members would be more likely to view “head office” as being the experts and expect the association to develop appropriate standards for them. If an association of this sort were to ask members for significant input on standardization, this desire to involve them could be perceived as a weakness – a lack of expertise, or a failure of leadership – with a resulting loss of credibility for the association.

5

The Future of the HAO Initiative

Given that the initiative is successful, and that the process was appropriate, what does the future hold? Is this initiative sustainable, or will it be subject to such severe constraints that it may fail?

The greatest strength of the project is that it was member-driven and member-developed: the people who would be asked to use the standards were the same people who developed and endorsed them (Patton 1997). As these people leave hospices and new people come on board as senior staff members, how will they view these standards? Will they accept them as being developed by their equals – domain leaders in their own sector – or will they call for significant changes? While these requests could be managed in terms of altering standards, if the requests involved changing the entire accreditation model, it could return HAO and its members to the position where they began the initiative four years ago.

HAO will need to monitor the continued acceptance of these standards as turnover occurs among Executive Directors. Perhaps HAO should consider holding a half-day orientation session for new Executive Directors at the annual conference. In addition to giving the overall organizational history of HAO, this session could be used to speak about major initiatives such as the standardization initiative and how it was developed.

In future years, the session could be expanded to include workshops on areas of concern to new Executive Directors, which would be a way of identifying their acceptance not only of the standardization initiative but also of other initiatives, in areas such as public awareness and public policy. This session would also be a convenient way for HAO Board Members and staff to meet new Executive Directors, answer any questions they might have and begin to build a relationship with them. It could also serve other purposes, such as the opportunity to create a “buddy system” between experienced Executive Directors and new hospice staff members.

Is the standardization initiative robust enough to be accepted by other volunteer hospice palliative associations in provinces throughout Canada? Ontario's initiative is congruent with the Norms of Practice developed by the Canadian Hospice Palliative Care Association. However, other provinces could interpret these norms very differently, and develop different standards and outcome measures. If these standards and measures were to vary considerably from Ontario's, HAO and its members could be asked to abandon their work in favour of standards developed in other jurisdictions.

What are the unanticipated opportunities – the added value – that this initiative has opened up? The first is the opportunity to bring this standardization process, as well as its products, to other provincial and national charitable organizations that have not undertaken the same comprehensive standardization initiative. It opens the possibility of working with these associations to develop a standardization initiative for all home based volunteer care organizations in Ontario – and perhaps even in Canada.

The second unforeseen benefit has been the change in perception of HAO and its members by Ontario's senior bureaucrats. HAO has just begun to meet with representatives of the Ministry of Health and Long Term Care Ontario to update them on its standardization initiative. During these meetings, HAO is requesting that, in light of the Kirby and Romanow reports and given that Ontario has one of the most competent and comprehensive volunteer hospice palliative care programs in Canada (as illustrated by the standardization initiative), the government commits itself:

- to work with hospice palliative care representatives to develop government policy recognizing home based hospice palliative care as a core service with designated funding
- to develop a province-wide “Strategy for End-of-Life Care” similar to the government’s Stroke Strategy and Alzheimer’s Strategy
- to fund an HAO-coordinated two-day conference at which government and stakeholders throughout Ontario would develop a common vision and make recommendations for an integrated end-of-life strategy that would provide a continuum of care for terminally ill people throughout Ontario

When the standardization initiative was presented to the Executive Director of Long Term Care Ontario, her response was that the Association had proven itself as a credible organization that deserved a seat at the table. And very recently, HAO was informed by another senior bureaucrat that the government was developing a policy paper on palliative care, and – because of its standardization initiative – HAO would be invited to participate in the development of this policy paper.

Finally, what are the deeper lessons and insights that fundamentally change the way that individuals and organizations live and think and believe?

The first lesson is that paradox is all around us. When we begin an initiative, we cannot expect that the outcomes will be what we planned, and what we think will be positive factors and strengths may equally turn out to be liabilities and weaknesses.

It might have been presumed that a process developed for complex adaptive systems – HAO’s member hospices – would produce standards that were emergent and flexible. This is the opposite of what occurred. The lack of existing standards and accreditation models demanded that the development process be flexible, creative and iterative, rather than prescriptive. But within this process, the use of minimum specifications that would be applicable to all hospices, whatever their size or complexity, meant that the resulting standards would be stable and equally applied to all.

Another paradox is that a group of ninety hospices, all autonomous and fiercely independent, would agree to participate with their province-wide Association in an activity that would result in a fixed framework being imposed upon them. Not only did they agree, but they also made some elements, (such as outcome measures) more rigorous than was originally suggested.

The third paradox is that this very rigour and consistency may well be the reason that hospices will be able to continue to be emergent – to develop different services customized to their communities, develop partnerships or align themselves with other organizations of their choice. Ironically, the consistency of the standards allows hospices the freedom to do what they need to do, as long as they apply these standards to new activities.

Last, the three principles that underpinned the entire process – hospices as experts, the need for minimum specifications, and the focus on client services – can be characterized as operating within the realm of complexity management. However, they can also be seen as the Association’s “steel rods.” While the outcome was unknown and uncertain at the beginning of the initiative, these three principles were, in fact, unvarying minimum specifications for the process itself.

The second lesson is that organizations ought to take risks for what they believe in – dare to step into space and trust that others will not let them come to harm. The words of Parker Palmer (2000) come to mind: “We have places of fear inside of us, but we have other places as well – places with names like trust and hope and faith. We can choose to lead from one of those places, to stand on ground that is not riddled with the fault lines of fear, to move others forward from a place of promise instead of anxiety.”

The third lesson seems the simplest. It is to genuinely respect the thoughts, concerns, cares and expertise of others and to intimately involve them in processes that will have an effect on them. If there is one single principle that made HAO’s standardization process successful, it was the fundamental belief that hospice Executive Directors were the experts and that they must be involved at every step. Management theories about what works, what doesn’t work and why, are exceptionally valuable for analyzing and understanding the past and framing possibilities for the future. But without genuine belief in each other’s worth and trust in each other’s integrity, the development of new and comprehensive initiatives within an association of fully autonomous and independent members cannot succeed.

Appendix I

Standards, Criteria and Outcome Measures from Selected HAO Quality Dimensions

<p>Quality Dimension 2</p> <p><i>Client Perspective.</i> Clients and caregivers being involved in the decision making concerning their care and being satisfied with the care they receive.</p>				
<p>Standard 2.2</p> <p>Clients and caregivers are respected as individuals and involved as appropriate in all aspects of their individual program plans as developed by a qualified coordinator at the Volunteer Hospice Visiting Service.</p>				
<p>Criterion</p> <p>A. The individual program plan is based on the assessment information and in keeping with the statement of client rights, developed with the client or substitute decision maker, and takes into account their expectations and preferences; a plan of action which reflects and builds upon the individual's strengths and abilities; and the systematic and ongoing assessment of the client.</p> <p>B. The Volunteer Hospice Visiting Service has a format for recording program plans.</p> <p>C. The individual program plan is reviewed in consultation with the client as defined by the specific Volunteer Hospice Visiting Service or when there is a significant change in the client's status.</p> <p>D. The plan must include both what is and is not to be provided by the volunteer when completing their client assignment.</p>				
Indicator 8	Target	Methods to Collect Information	Analysis	Results
<p>Percentage of caregivers who report being involved in deciding service received:</p> <p>Emotional support (i.e. anticipatory grief, bereavement support)</p> <p>Relief from caregiving</p> <p>Referral resource information (e.g. power of attorney, wills, funeral arrangements, advocacy)</p>	<p>80% report being involved in deciding service received</p>	<p>Survey a minimum of 50 caregivers or 50% of the total (whichever is smaller)</p>	<p>Number reporting being involved in deciding service received divided by the number of respondents multiplied by 100</p>	
<p>Factors affecting achievement of target:</p>				
<p>Quality improvement strategies:</p>				

Quality Dimension 3				
<i>Safety.</i> The service to the client/caregiver being provided in a “safe” manner.				
Standard 3.7				
The hospice has a process to maintain confidentiality of information.				
Criterion				
The agency has documentation of each client’s consent for release of information. The client is informed of what the release of information entails.				
All paid staff and volunteers are educated on the need for confidentiality and sign a Statement of Confidentiality form.				
The agency has written policies and procedures concerning confidentiality of information.				
Indicator 17	Target	Methods to Collect Information	Analysis	Results
Number of validated complaints from clients/caregivers, other service providers concerning breach of confidentiality	0	Collection of validated complaints received in 6-month period	Count of validated complaints received in 6-month period	
Factors affecting achievement of target:				
Quality improvement strategies:				

Quality Dimension 4				
<i>Competence.</i> The Volunteers having the appropriate knowledge and skills level to provide hospice palliative care services.				
Standard 4.1				
The hospice has a process for the ongoing education and training of the volunteers who provide hospice palliative care to clients.				
Criterion E				
It is mandatory that all volunteers have completed the HAO training (a minimum of 30 hours).				
Indicator 18	Target	Methods to Collect Information	Analysis	Results
Percentage of volunteers who have completed the HAO approved modules	100% of volunteers have completed the HAO approved modules	Audit a minimum of 50 volunteer records (or 50% of the total depending which is the smaller number) Review of attendance at training sessions	Number completing approved modules divided by 50 multiplied by 100	
Factors affecting achievement of target:				
Quality improvement strategies:				

Quality Dimension 5				
<i>Continuity.</i> The service being coordinated with other service providers.				
Standard 5.1				
The Volunteer Hospice Visiting Service provides the client and caregiver with consistent volunteer/volunteer care team members in order to promote continuity of care.				
Criterion				
The volunteer/volunteer care team balances the needs of the client'/caregiver and the volunteers.				
Indicator 19	Target	Methods to Collect Information	Analysis	Results
Percentage of clients with same volunteer or volunteer care team	80% of clients have the same volunteer/volunteer care team	Audit a minimum of 50 client records (or 50% of the total depending which is the smaller number)	Number of clients with same volunteer care team divided by 50 multiplied by 100	
Factors affecting achievement of target:				
Quality improvement strategies:				

Appendix II

Information Sources

The following organizations were identified as potential informational sources for developing an accreditation initiative for Ontario's volunteer hospice palliative care movement.

- Baldrige National Quality Program (USA)
- Canadian Council on Health Service Accreditation
- The Rehabilitation Accreditation Commission
- Council on Accreditation (USA)
- Do-it (United Kingdom)
- Health Services Accreditation (United Kingdom)
- Hospice Patients Alliance (USA)
- Kooperation für Transparenz und Qualität im Krankenhaus (Germany)
- Literacy Volunteers of America (USA)
- National Quality Institute
- Palliative Care Australia (Australia)
- Australian Council on Healthcare Standards
- Volunteer Development Agency (Northern Ireland)
- Volunteer Accreditation Network
- Wetherbee Resources Inc. (USA)
- World Health Organization

Appendix III

Accreditation Programs Congruent with the HAO Model

Organization	Description of Accreditation Program
Literacy Volunteers of America (USA)	<p>The Literacy Volunteers of America (LVA) has built its accreditation model on the establishment of standards for independent, volunteer-based affiliates. It has created a continuous improvement model with a three-year cycle set as a baseline for member organizations to meet.</p> <p>The keystone of the LVA model is the identification of “promising practices” which are nominated by member organizations. This means that members’ “best practices” form the basis of the accreditation.</p>
World Health Organization, Regional Office for the Americas (USA)	<p>The World Health Organization (WHO) has identified a partnership-based approach for the start-up and strengthening of quality improvement and accreditation mechanisms throughout the world. It is currently engaged in a global inventory of quality improvement processes to identify methodologies in use and describe the various efforts in health service and hospital accreditation.</p>
Kooperation für Transparenz und Qualität im Krankenhaus (Germany)	<p>This is a newly developed accreditation program. It is focused on the identification of standards and indicators of quality and the concept of internal quality management. Its structured self-assessment process relies on a framework of measuring performance in health care practice.</p>
Health Quality Service (United Kingdom)	<p>The Health Quality Service (HQA) combines a comprehensive set of standards covering hospice (and other health care services) with an organizational assessment process. It incorporates elements of the ISO 9000 standard. In particular, it takes a holistic approach that places patient experience of care at the centre of its model.</p>
Australian Council on Healthcare Standards (Australia)	<p>The Australian Council on Healthcare Standards has collaborated with Palliative Care Australia in developing standards to cover the continuum of care and infrastructure standards. Standards dealing with the continuum of care are concerned with access (how well the needs of the people served by hospice are met), entry (admission) and care planning. These parallel HAO’s quality dimensions for client service standards.</p>

<p>Baldrige National Quality Program (USA)</p>	<p>The Baldrige National Quality Program offers an annual award of excellence to healthcare organizations (as well as businesses and educational organizations) within the United States. It has developed a series of criteria for performance excellence that are focused on delivering ever-improving value to customers as well as overall organizational performance. While not directly transferable to the voluntary hospice sector, standards contributing to adding value and community building offered insights into developing the accreditation model.</p>
<p>Community Health Accreditation Program Inc. (USA)</p>	<p>The Community Health Accreditation Program (CHAP) is the leader in improving quality of care in the home care industry in the United States. It was approved in 1992 as the “deemed authority” (i.e., if an organization is accredited by CHAP, it will receive government funding) by the US federal Medicare program, making its standards and accreditation process the “gold standard” within the American community and home care sectors.</p>

Appendix IV

Key Elements of the Accreditation Process (Best Practices)

Identified Best Practice	Examples/Practitioners
<i>Accreditation based on outcomes/performance measurements</i>	<p>Community Health Accreditation Program (CHAP)</p> <p>CHAP measures programs against standards of excellence that have been developed for each area of review across a spectrum of home- and community-based health care organizations, including freestanding hospices. The process is comprehensive, with standards having been set in all areas of clinical and management operations and the focus on outcomes in many areas.</p>
	<p>Health Quality Services (HQS)</p> <p>The program provides the opportunity for hospices to assess their services against a set of national standards. It aims to establish a culture of quality focused on continuous self-improvement and standards that include the patient's experience.</p>
	<p>Palliative Care Australia (PCA)</p> <p>The organization has developed a national hospice palliative care accreditation program. The standards and criteria include those concerned with how health care organizations help people to access services and the timely meeting of patient needs.</p>
<i>Recognition of a particular accreditation process by all members</i>	<p>Kooperation für Transparenz und Qualität im Krankenhaus, (KTQ)</p> <p>This new accreditation program affirms the involvement of all partners of the health care system in its project to develop an accreditation program for hospital-based programs.</p>
	<p>HQS</p> <p>HQS works with health care professionals, Royal Colleges, and professional associations to develop standards.</p>
	<p>Australian Council on Healthcare Standards (ACHS), Canadian Council on Health Service Accreditation (CCHSA), CHAP</p> <p>All of these organizations rely on the expertise of health care professionals and managers to continuously develop and maintain its national accreditation program.</p>

<i>Involvement of member agencies throughout the development process</i>	<p>Literacy Volunteers of America (LVA)</p> <p>Each three-year accreditation cycle builds upon the previous cycle, so that current member-identified standards (“promising practices”) become standards in the next accreditation cycle. It has created a Tool Box Review Process to facilitate ongoing contribution to the accreditation cycle by member organizations.</p>
	<p>CCHSA</p> <p>CCHSA relies on the expertise of members to review and refine draft standards so as to reflect an accreditation process for the particular sector. Updating the CCHSA program relies on sector involvement.</p>
	<p>Canadian Standards Association</p> <p>CSA has relied on a development process based on the particular expertise of a “technical committee” drawn from experts within the sector seeking accreditation standards.</p>
	<p>ISO 9000</p> <p>ISO relies on the communication by a particular industry of the need for a standard. It uses a formal, internationally based process to define standards. This process seeks to involve both the industries involved as well as the various countries internationally where ISO standards will be used and recognized.</p>
<i>Accreditation based on client-centred materials</i>	<p>HQS</p> <p>HQS works with patients and service users to develop standards for service provision that focus on the patient’s experience of care.</p>
	<p>LVA</p> <p>LVA’s approach is based on best practices that have shown results in effective instruction by member volunteer literacy programs. The success of the students informs the creation of the best practices.</p>
	<p>Rehabilitation Accreditation Commission</p> <p>RCA includes cultural competence, a focus on values and a patient-centred approach in its peer-review process for accreditation.</p>
	<p>ACHS</p> <p>ACHS considers how well the organization’s services are coordinated with other services needed by the patient/consumer.</p>
<i>Accreditation based on self-assessment and external assessment</i>	<p>RCA</p> <p>Accreditation through a consultative peer-review process.</p>

	<p>CHAP</p> <p>CHAP completes accreditation through a self-study and peer review completed by trained site visitors.</p>
	<p>CCHSA, HQS, KTQ, PCA</p> <p>All these bodies complete accreditation through self-evaluation and external peer review.</p>
	<p>ISO 9000 and CSA</p> <p>Both use a cohort of technical auditors or experts who complete the audit. These experts have received certification for auditing purposes.</p>
<p><i>Continuous improvement/ adaptation of the accreditation process</i></p>	<p>LVA</p> <p>LVA’s development of “Promising Practices” combines the quality improvement process of member organizations with the identification of new standards. Members identify new best practices and propose their adoption by all members as “Promising Practices” in the next accreditation cycle.</p>
	<p>HQS</p> <p>HQS accreditation incorporates the identification of items for action within the standard framework worksheets and in the summary of next steps. These inform the ongoing development of standards.</p>
	<p>Baldrige National Quality Program (USA)</p> <p>The program was originally established on a competitive continuous quality improvement framework. The introduction of a competitive approach focuses accreditation on quality improvement in order to maintain excellence.</p>

Appendix V

Hospice Association of Ontario Accreditation Model Working Group Timetable

Deadline	Activity
11 December 2002	HAO distribution of Working Document to committee members
13 January 2003	Working Group to submit comments to HAO
20 January 2003	HAO to compile comments and distribute to Working Group
28–29 January 2003	Working Group to meet
10 February 2003	HAO to incorporate comments and distribute to Working Group
17 February 2003	Working Group to submit additional comments to HAO, HAO to compile
25–26 February 2003	Working Group to meet
14 March 2003	HAO to incorporate comments and distribute Working Document to HAO Hospice Members
1 April 2003	HAO Members to submit comments to HAO
30 April 2003	HAO to incorporate comments and distribute to Working Group
20–21 May 2003	Working Group to meet
30 May 2003	HAO to incorporate Working Group comments and distribute to HAO Hospice Members
20 June 2003	HAO Hospice Members to submit comments to HAO, HAO to incorporate and distribute to Working Group
8–9 July 2003	Working Group Wrap-up Meeting; Committee to approve final Draft Document
25 July 2003	Final draft reviewed by Working Group for the Conference on 12–13 Sept.
12 September 2003	Final Review of draft document at HAO annual conference

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Community Health Accreditation Program Inc. <http://www.chapinc.org>

Health Quality Service. <http://www.hqs.org.uk>

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