



2013 CCAC PROGRAM DESCRIPTIONS

Adult Day Services

This section of standards is used in tandem with the standards in the service delivery process sections. The standards in this section include those topics that are most unique to adult day services programs.

An adult day services program is a nonresidential program that provides supervised care to adults of all ages in a supportive and safe setting during part of a day. Assessments of the persons served and their families/support systems and person-centered plans of care drive the delivery of services. An adult day services program provides or arranges for services that include, but are not limited to, therapeutic activities, nutrition, health and personal care, and transportation.

Adult day services programs typically deliver services through a social model and/or a medical model. Either of these might provide services to specialized populations of persons served.

By supporting family systems, an adult day services program enables the persons served to live and engage in the community and provides the family system with an opportunity to fulfill daily responsibilities and for respite. An adult day services program strives to optimize the dignity, choice, preferences, autonomy, and quality of life of the persons served.

Aging Services Network

The standards in this section include those topics that are most unique to aging services networks.

An ASN consists of two or more entities with formal contracts or under common ownership that cooperate with each entity regarding the delivery of multiple levels of care to persons served. An ASN:

- Provides access to and coordination of services based on the needs of the persons served and expectations of other stakeholders.
- Improves coordination of services.
- Improves effectiveness and efficiency of service delivery.
- Cooperates with the participating providers regarding:
 - Integrated strategic planning.
 - Financial resource coordination.
 - Service provision.
 - Geographic areas served.
 - Development, improvement, and sanctioning of participating providers.

Participating providers in the ASN:

- Have a philosophy of service delivery for the persons served.
- Have a code of ethics regarding:

- Business.
- Financial practices.
- Marketing.
- Clinical practices.
- Show adherence to public disclosure of performance for each participating provider.
- Have a mechanism to facilitate coordinated strategic and financial planning.
- Agreements regarding business and care delivery practices.
- Are operationally linked through referral and contracts to coordinate care and provide services to the same persons served.
- Are defined by contracts/agreements that identify, at a minimum:
 - Geographic service coverage.
 - Programs and services offered.
 - Populations served.
 - Financial relationships between the participating providers.

Assisted Living

This section of standards is used in tandem with the standards in the service delivery process and the residential process sections. The standards in this section include those topics that are most unique to assisted living programs.

Assisted living is a residential program that provides meals, housing, and a range of services for adults of all ages in a supportive and safe setting. An assisted living program strives to optimize the dignity, choice, preferences, autonomy, engagement in life roles, and quality of life of the persons served. The program might provide services for specialized populations of persons served.

Assisted living programs are provided in a variety of settings such as a small home with just a few individuals or a high-rise building housing several hundred individuals. Individual living accommodations can be private or shared and include a single room or a full size apartment.

Assessments of the persons served and their person-centered plans of care drive service delivery. A variety of services ranging from minimal to intensive assistance with activities of daily living such as bathing, dressing, eating, grooming, mobility, and toileting may be available. Assisted living programs may provide some health services and intermittent nursing care. Additionally, these programs typically offer housekeeping, laundry services, medication management, recreation programs, and transportation.

[Canada]

Note: *Assisted Living in the United States is known as Retirement Residences in Canada.*

Person-Centered Long-Term Care Community

Person-centered long-term care communities (PCLTCCs), also referred to as nursing homes or long-term care homes, may include freestanding homes, homes that are part of continuums of care, or homes that are part of health systems. PCLTCCs are residential programs that provide nursing and other services 24 hours a day, 7 days a week. These programs might provide services for specialized populations of persons served.

Autonomy, individual choice, cultural competence, and flexibility are the hallmarks of PCLTCCs. These programs foster a holistic culture of successful aging and self-determination where the voices of the persons served are heard.

In PCLTCCs, persons served are the experts regarding life in their home. Persons served make decisions about the rhythm of their day, the services provided to them, and the issues that are important to them in their home. Their families/support systems are welcomed.

In partnership with persons served and their families/support systems, personnel understand what services persons served want, how the services should be delivered, and how the persons served can be engaged in their homes. Assessments of the persons served and their families/support systems and person-centered plans of care drive high-quality service delivery.

Leadership cultivates relationships among persons served, families/support systems, and personnel. They commit to continuous learning and growth, empowerment, responsiveness, and spontaneity.

Persons served and personnel celebrate the cycles of life and connect to the local community to continue relationships that nurture the quality of everyday life and quality of care. A PCLTCC is a place where persons served want to live, where personnel want to work, and both choose to stay.

Home and Community Services

Home and Community Services (HCS) are person centered and foster a culture that supports autonomy, diversity, and individual choice. Individualized services are referred, funded, and/or directed by a variety of sources. In accordance with the choice of the person served, the services provided promote and optimize the activities, function, performance, productivity, participation, and/or quality of life of the person served.

The Home and Community Services may serve persons of any ages, from birth through end of life. Services may be accessed in a variety of settings including, but not limited to, private homes, residential settings, schools, workplaces, community settings, and health settings. Services are provided by a variety of personnel, which may include health professionals, direct support staff, educators, drivers, coaches, and volunteers and are delivered using a variety of approaches, supports, and technology.

Services are dynamic and focus, after a planning process, on the expectations and outcomes identified by both the person served and the service providers. The service providers are knowledgeable of care options and linkages to assist the person served; use resources, including technology, effectively and efficiently; and are aware of regulatory, legislative, and

financial implications that may impact service delivery for the person served. The service providers are knowledgeable of their roles in and contribution to the broader health, community, and social services systems.

Home and Community Services must include at least one of the following service delivery areas:

- Services for persons who are in need of specialized services and assistance due to illness, injury, impairment, disability, or a specific age or developmental need.
- Services for persons who need assistance to access and connect with family, friends, or co-workers within their homes and communities.
- Services for persons who need or want help with activities in their homes or other community settings.
- Services for caregivers that may include support, counseling, education, respite, or hospice.

Note: *A service provider seeking accreditation for Home and Community Services is not required to provide all four of the service delivery areas identified in the service description. However, it must include in the site survey all of the service delivery areas it provides that meet the service description.*

Case Management

Case Management proactively coordinates, facilitates, and advocates for seamless service delivery for persons with impairments, activity limitations, and participation restrictions based on the following:

- Initial and ongoing assessments.
- Knowledge and awareness of care options and linkages.
- Effective and efficient use of resources.
- Individualized plans based on the needs of the persons served.
- Predicted outcomes.
- Regulatory, legislative, and financial implications.

The delivery of case management may occur in a variety of settings that include, but are not limited to, a healthcare environment, a private practice, in the workplace or in the payer community.

Continuing Care Retirement Community

This section of standards is used in tandem with the standards in the service delivery process and the residential process sections. The standards in this section include those topics that are most unique to continuing care retirement communities.

A continuing care retirement community provides and/or arranges for a continuum of residential and support services from residential living through nursing care. Persons entering a continuing care retirement community sign a contract that specifies the provision of services throughout the continuum, usually but not always provided on one campus. A variety of contract types may be offered. The persons served benefit from coordination of care and services throughout the continuum.

The persons served have the choice of flexible accommodations that are designed to meet their changing needs over time. The continuing care retirement community may also provide services for specialized populations. A spirit of community with a focus on wellness combine to enhance the quality of life for the persons served.

Dementia Care Specialty Program

The standards in this section include those topics that are most unique to Dementia Care Specialty Programs.

A person-centered dementia care program values and fosters a dynamic culture that supports a partnership among persons served, families/support systems, and providers. Leadership recognizes that dementia care is a maturing, challenging, and forward-thinking field. It commits to providing the supports, resources, and education needed to stay current while enriching and optimizing the:

- Function and quality of life of persons served.
- Strengths of persons served.
- Capabilities of personnel.
- Performance of the program.
- Partnerships with families/support systems.

Through ongoing communication and assessment processes, the program demonstrates that it:

- Knows the histories, preferences, abilities, interests, skills, talents, and ongoing needs of persons served and recognizes and anticipates that these change over time.
- Bridges the person's past, present, and future.

Through these processes, persons served maintain their dignity and preserve their selfhood.

Leadership recognizes personnel's unique needs, abilities, interests, skills, and talents. It creates and supports a learning culture that provides teaching, coaching, modeling, supervision, and evaluation. Leadership oversees the evaluation of this learning culture in its performance improvement system.

Leadership creates an environment:

- In which persons served and personnel can thrive.
- That cultivates, supports, and maintains relationships.

- That maximizes function and optimizes independence.

Leadership maintains a safe physical environment for both personnel and persons served. Through leadership's attention to accessibility, usability, and appropriate assistive technologies, persons served maximize their functioning and optimize their independence as long as possible.

The program's corporate social responsibility includes its efforts, activities, and interests in integrating, contributing to, and supporting increased awareness of the preferences, abilities, interests, skills, talents, and ongoing needs of persons with dementia and their families/support systems. The program is committed to increasing the awareness of the needs of the persons served to regulators, legislators, educational institutions, payers, and the community at large.

Stroke Specialty Program

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.
- Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.