Community Health

Streamlining Accreditation Project

VICTORIA State Government | Health and Human Services

Glossary

AACQA	Australian Aged Care Quality Agency (an accrediting body that is an Australian Government statutory agency)
ACHS	Australian Council on Healthcare Standards (an accrediting body)
ACISS	Attendant Care Industry Standards Scheme
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers Advisory Council
CHC	COAG Health Council
CHS	Community Health Service
CIMS	Client Incident Management System
CSS	(Victorian) Child Safe Standards
CQI	Continuous Quality Improvement
DHHS	Department of Health and Human Services
DIAS	Diagnostic Imaging Accreditation Scheme
EFT	Equivalent full time (staff)
EQuIP	Evaluation and Quality Improvement Program
EQuIPNational	5 standards based on EQuIP5, assessed in conjunction with NSQHS
FOPMF	Funded Organisation Performance Monitoring Framework
HACC	Home and Community Care
HCS	Home Care Standards
HDAA	HDAA Australia (a JASANZ certification [accrediting] body)
HPR	Housing Provider Registration
HSS	(Victorian) Human Services Standards
ISO 9001:2015	International Organization for Standardization Quality Management Systems Certification
NATA	National Association of Testing Authorities
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme

NQSFCC	National Quality Standard (for child care)
NSQHS	National Safety and Quality Health Service (Standards)
NSDS	National Standards for Disability Services
NSMHS	National Standards for Mental Health Services
QIC	Quality Improvement Council Health and Community Services (Standards)
QIP	Quality Innovation Performance
RACGP	Royal Australian College of General Practitioners (Standards for General Practice)
RACS	Residential Aged Care Standards
VHIMS	Victorian Health Incident Management System

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Executive Summary

The Community Health Streamlining Accreditation Project aims to reduce the regulatory burden for community health services (CHSs) by streamlining accreditation processes and requirements.

To achieve this, consultants were engaged to map all current accreditation requirements that CHSs are required to satisfy across the range of State and Commonwealth funded programs. Specific information was sought from the consultants regarding the future role of Quality Improvement Council (QIC) standards.

Consultation with the broader sector for the project found that support within CHSs for quality standards was strong notwithstanding the associated burden. CHSs recognised and supported the principles of independent assessment, accreditation and continuous quality improvement as vehicles for achieving better service governance and delivering safe, high quality care.

The project confirmed the perception of a high level of burden associated with meeting accreditation standards for both Commonwealth and State funded programs. The burden ranges across accreditation fees, staff time involved in preparing for and managing accreditation, and the impacts of multiple on-site assessments alongside many other compliance requirements.

Recommendations of the report

The report identified a number of recommendations, which fall under four broad themes, these being:

1. Coordinating and streamlining accreditation arrangements for CHSs using multi-faceted approaches which reduce standards duplication and provide greater choice for CHSs.
2. Streamlining of accreditation standards and assessments at Commonwealth level, to strengthen quality frameworks and systems, and reduce unnecessary burden.
3. Supporting models that improve resource utilisation, in terms of quality and safety capability, and capacity.
4. Identifying and utilising other levers (i.e. market and regulatory levers) that induce standards owners and accrediting bodies to reduce burden, through mechanisms such as recognition of equivalences, bundling and management of evidence requirements.

Under each of the themes, a range of recommendations encompassing short, medium and longer term actions were proposed.

Actions that are being progressed

The following actions have been identified as actions that will have the highest impact, and can be progressed by the department. Planning and implementation of these actions has commenced.

- The 2017-18 Policy and Funding Guidelines have been amended to note that if CHSs are accredited for governance and management under a recognised standard set for a particular service (e.g. dental services), they are not required to gain governance and management accreditation for their Primary and Community Health funded services. This is completed.
- Reduce duplication between the processes for accreditation and the department's performance monitoring processes such as the Funded Organisation Performance Management Framework (FOPMF). This includes ensuring that departmental staff review recent accreditation reports before seeking information for a FOPMF review.

- Identify standards that are duplicated between standard sets applicable to CHSs, and advocate for standard owners to recognise equivalent standards to reduce the burden of accreditation. This advocacy can occur internally where the department is the standards owner, (e.g. Human Services Standards), noting that any recognition of equivalences should not detract from the integrity of evidence provided for the accreditation process.
- Build on the broader work underway as part of the Streamlining reporting for community health project to encourage more integrated approaches to quality and safety including:
    - improving data sharing mechanisms, and encouraging consideration of the range of accreditation standards applicable to platform providers (such as CHSs) when revising and developing new regulatory frameworks.
    - encourage whole-of-department consistency in developing and reviewing requirements in service agreements and program guidelines which relate to quality and safety measures, and removing duplication where this exists.
    - deferring participation of community health services in the new Client Incident Management System (CIMS) for 12 months from January 2018 - in view of the overlapping reporting requirements with the Victorian Health Incident Management System (VHIMS)
- Continue to advocate to the Commonwealth for simplification of national accreditation standards and expectations – promoting streamlining, recognition and other 'ask once, use often' approaches to measure what matters for safety and quality.
- Support CHSs in identifying effective models of practice, which would build the capacity and capability of CHSs to better manage service governance, quality and safety performance requirements, for example facilitating forums such as communities of practice.

Project Aims

The Community health streamlining accreditation project was undertaken to map all the current mandatory accreditation requirements applicable to CHSs and identify potential efficiencies to simplify and reduce the administrative burden associated with accreditation.

Methodology

The department engaged consultants to map the current mandatory accreditation standards and requirements that CHSs are required to satisfy, across the range of State and Commonwealth funded programs that they deliver.

Data was collected from CHSs, regulators, standards owners, accreditation providers, the department and other sector stakeholders. Standards mapping was undertaken for nine of the most prevalent sets of standards. The project was guided by a sector reference group comprising quality and safety managers from both integrated and registered community health services.

Building on the mapping exercise, and feedback provided through the sector reference group and broader consultation, the consultants were asked to provide options to streamline accreditation. Specifically, the department was keen to understand areas of commonality, variation and potential efficiencies.

Specific information was sought from the consultants regarding the QIC Health and Community Services standards. Quality Innovation Performance (QIP) owns these standards, which are the standards most commonly used by registered CHSs to meet accreditation requirements, in particular for the primary care services they deliver.

QIC Health and Community Services Standards (QIC Standards)

To understand the streamlining opportunities, specific advice was requested regarding the QIC Health and Community Services Standards (QIC Standards) including:

- Whether QIC standards could be subsumed by the NSQHS, Human Service Standards (HSS) and/or Home Care Standards (HCS).
- If the assessment is that QIC standards cannot be entirely subsumed by the NSQHS, HSS and HSC, to propose alternative models where QIC standards can be incorporated into any or all of the three sets of accreditation standards.
- Possible adaptations (similar to the HSS model) where organisations must meet service specific standards but can then choose an endorsed independent review body to meet governance and management standards.
- Assess whether existing requirements to use QIC standards could be broadened to provide CHS with more than one choice of accreditation for the specific program (i.e. the Community Health Program) or registration of a CHS.

The sector accreditation profile

Feedback from the sector confirmed support within CHSs for quality standards was strong, notwithstanding the associated cost and administrative burden. CHSs recognised and supported the principles of independent assessment, accreditation and continuous quality improvement as vehicles for achieving better service governance and delivering safe, high quality care.

The project confirmed the perception of a high level of burden on a complex sector, ranging across accreditation fees, staff time involved in preparing for and managing accreditation, and the impacts of multiple on-site assessments alongside many other compliance requirements. A summary of the findings from the accreditation profile is presented at *Figure 1.*

Figure 1: The Community Health Service Story

<table>
<tr><th colspan="3">The Community Health Sector</th></tr>
<tr><td>30 service types, including:
Community health
Commonwealth Home Support Program
Community nursing
Oral health
Alcohol and other drug
Child youth and family
General Practice
Complex care
Palliative care
Residential aged care
Disability services
Family violence services
Home care packages
…… and more</td><td>23 applicable standards including:
NSQHS Standards
Home Care Standards
Aged Care Standards
Human Services Standards (including Governance and Management standards)
QIC Standards (widely utilised in the sector)
RACGP Standards
Diagnostic Imaging Accreditation Standards
EQuIPNational
National Standards for Disability Services (where applicable)
National Standards for Mental Health Services
…… and more</td><td>Plus other compliance requirements, including:
Child safe compliance (no accreditation requirement)
Registration/ASIC compliance (registered CHSs)
CH minimum data set
Quality of Care Reporting
Victorian Healthcare Experience Survey
People Matter survey
Multiple Quality and Safety frameworks
VHIMS/CIMS (yet to be fully implemented)
FOPMF (contractual obligation non-regulatory)
CH Indicators
…… and more</td></tr>
<tr><td>Median Annual Accreditation fees:
$21.1k (integrated)
$18k (registered)
(range $500 – $376,000 pa)
= est $2.2m pa sector-wide[1]</td><td>SECTOR REPORTED POTENTIAL DUPLICATION OF REQUIREMENTS and INEFFICIENCIES IN PROCESSES</td><td>Median EFT allocated for accreditation:
1.0 (integrated)
0.5 (registered)
(range 0.05 – 20 EFT)
= est 127 EFT sector-wide[2]</td></tr>
<tr><td>INSUFFICIENT ACCREDITATION PROVIDER CHOICE</td><td>Average mandatory standards:
5 sets (integrated)
6 sets (registered)
(range 1-12)</td><td>INCONSISTENT REQUIREMENTS AND DUPLICATION</td></tr>
<tr><td>Average 7 assessments per three-year period
(range 2 – 26)</td><td>↘ ↓ ↙
→ BURDEN ←</td><td>Assessors onsite for 8.8 days per cycle
(range 1 – 33)</td></tr>
</table>

There are multiple reasons why this burden exists: the complexity of the sector; duplication across standards and provider requirements; lack of recognition of equivalences between standards; siloing of regulators and funders, including within government departments; lack of sophisticated supporting technologies; and in some cases, limited provider choice.

[1] Extrapolation from sector profile data based on 95% confidence level, with +/- 9% margin of error.

[2] Extrapolation from sector profile data based on 95% confidence level, with +/- 8% margin of error.

A key finding from the project is that many of the mandatory accreditation standards applicable to CHSs are owned and controlled by the Commonwealth or one of its entities. As such, the department is limited in its capacity to influence the application of these standards but does have a role in advocating to the Commonwealth to streamline accreditation arrangements, for example through a greater focus on recognition models and strategies.

The underlying data relating to financial burden showed that while CHSs, on average, spend $20,000 per annum on accreditation fees and employ less than 1 EFT staff to manage accreditation, the variation in financial burden was significant, ranging between $500 - $376,000 per annum in fees and 0.05 - 20 EFT staffing respectively.

Mapping of accreditation standards

The sector accreditation profile identified 12 sets of standards that are most commonly applicable to CHSs:

1. Child Safe Standards (not an accreditation scheme)
2. NSQHS Standards V2 (draft)
3. Home Care Standards
4. RAC Standards (not mapped)
5. Human Services Standards including Governance and Management Standards
6. QIC Standards 6th edition
7. RACGP Standards for general practice 5th edition (draft)
8. DIAS Standards (not mapped)
9. EQuIP component of EQuIPNational, based on EQuIP5
10. ISO 9001:2015 (not mapped)
11. National Standards for Disability Services 2nd edition
12. National Standards for Mental Health Services 2nd edition.

Of these, nine sets were nominated by the department for standards mapping.

The three sets of standards not included in this mapping activity were the DIAS Standards and the RAC Standards, both of which apply mainly to integrated CHSs. ISO 9001:2015, Quality Management Systems – Requirements was also not mapped as this only applied to three CHSs (small number of users).

Standards Mapping

The project team mapped the second level statement of the standards in question (this may be a criterion or an indicator, for example) against three domains – governance and management, service delivery, and community capacity building. The approach taken was one of maximal interpretation rather than face value. That is, the mapper used the full range of interpretive materials provided by the standards owner in undertaking the mapping, rather than interpreting the second level statement at its literal interpretation.

‘Coverage’ of a key function by a quality standard was determined by the level that the function was able to be comprehensively assessed within accepted assessment methodologies, using the interpretive materials provided. Coverage was then rated as strong, medium, weak or nil at this systems level, for each set of standards.

Analysis and Findings

This section details the findings and analysis drawn from the project reports. It is noted that the data available in the report is not exhaustive; 62 of 85 (73%) organisations responded to the survey. While the sample is not fully representative, it is still reflective of the diversity of the sector.

Median annual accreditation fees

The findings do not clearly demonstrate whether the cost of meeting accreditation standards is excessive, in view of the sectors' quality and safety agenda.

Median annual accreditation fees

$21.1k (integrated) or $18k (registered) (range $500 – $376,000 pa) = est. $2.2m pa sector-wide

Median EFT for accreditation

1.0 (integrated) or 0.5 (registered) (range 0.05 – 20 EFT) = est. 127 EFT sector-wide

Average mandatory standards

5 sets (integrated) or 6 sets (registered) (range 1-12)

Number and days of assessment

Average 7 assessments per three-year period (range 2 – 26)

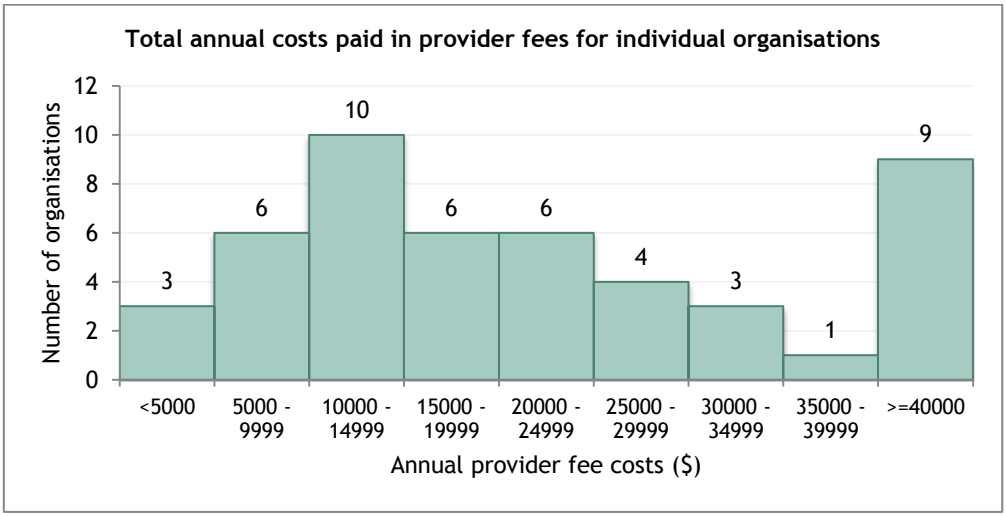
Assessors onsite for 8.8 days per cycle (range 1 – 33)

While the median investment may not reflect excessive burden, it is noted that the range across the 4 indicators demonstrates variation of practice in the sector.

Annual costs for each organisation ranged from $500 to $376,000 per annum. There was a broader range of costs for integrated CHSs than for registered CHSs, with integrated CHSs reporting both the lowest and highest annual provider fees.

Median annual costs were higher for integrated CHSs at $21,071, compared to registered CHSs at $18,007.

Figure 2: Total annual provider fees per CHS



Median EFT for accreditation

The overall average (mean) was heavily skewed by 3 integrated CHSs which reported allocating more than 10 EFT to mandatory accreditation activities. For this reason, the median figures provide a better guide to the general experience of the sector in relation to accreditation-related EFT.

The lower end of the allocation range (0.2 EFT and under) was of particular interest as these were likely to reflect organisations without a dedicated quality and compliance position, where accreditation-related activities were handled by a manager or coordinator as part of a more general management role. These arrangements potentially represented a heavy burden for the staff involved, especially at key points in the accreditation cycle.

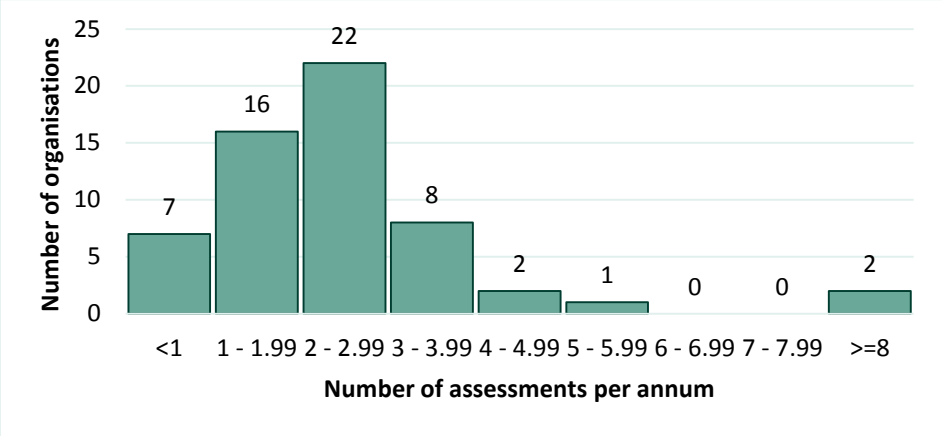
Number and days of assessment

Average 7 assessments per three-year period (range 2 – 26)

Assessors onsite for 8.8 days per cycle (range 1 – 33)

Figure 3 shows frequency of assessments (main and interim) reported by organisations. The majority of the sample (60%) reported 2 or more assessments per year, while over 22% reported 3 or more assessments per year.

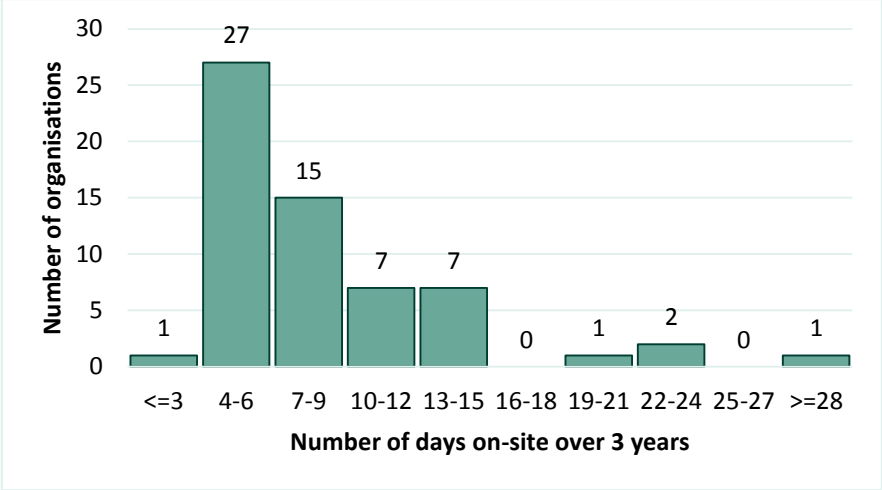
Figure 3: Number of assessments per annum, per organisation



The average total number of days that assessors were on-site for all mandatory assessments was 8.8 days over 3 years for all CHSs (see Figure 4 below). This was higher for registered CHSs, at 9.3 days, compared to 8.3 days for integrated CHSs.

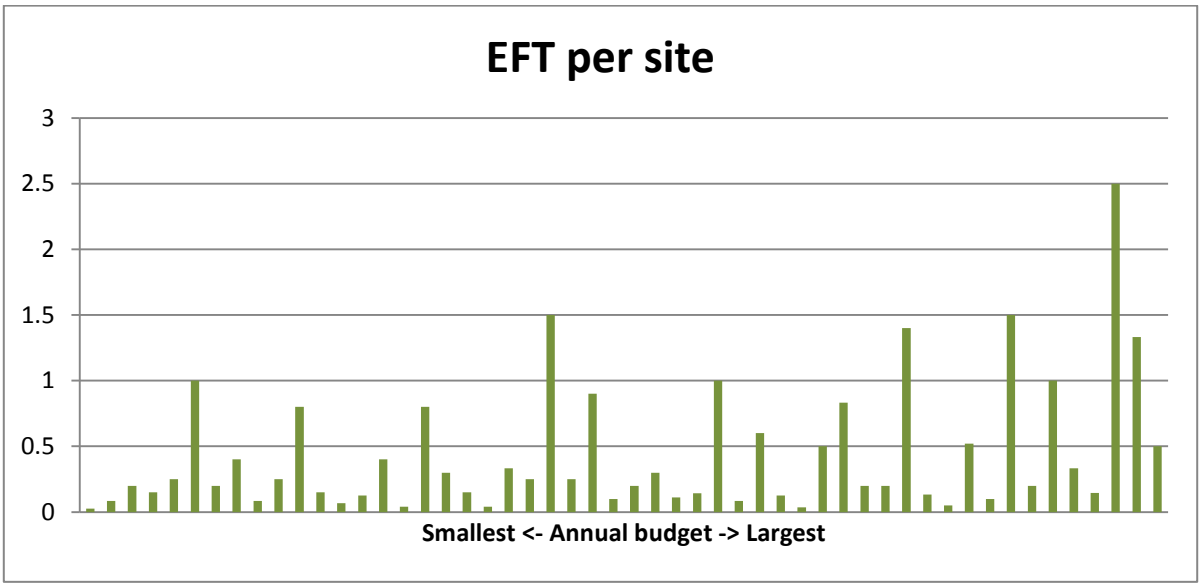
The consultant reports that these statistics reflect existing streamlining or integration of the accreditation process being utilised by CHSs. Where possible, CHSs bundle standards into multiple standards assessments and also utilise other means to integrate the assessment processes.

Figure 4: Number of days of on-site assessment over three years, per organisation

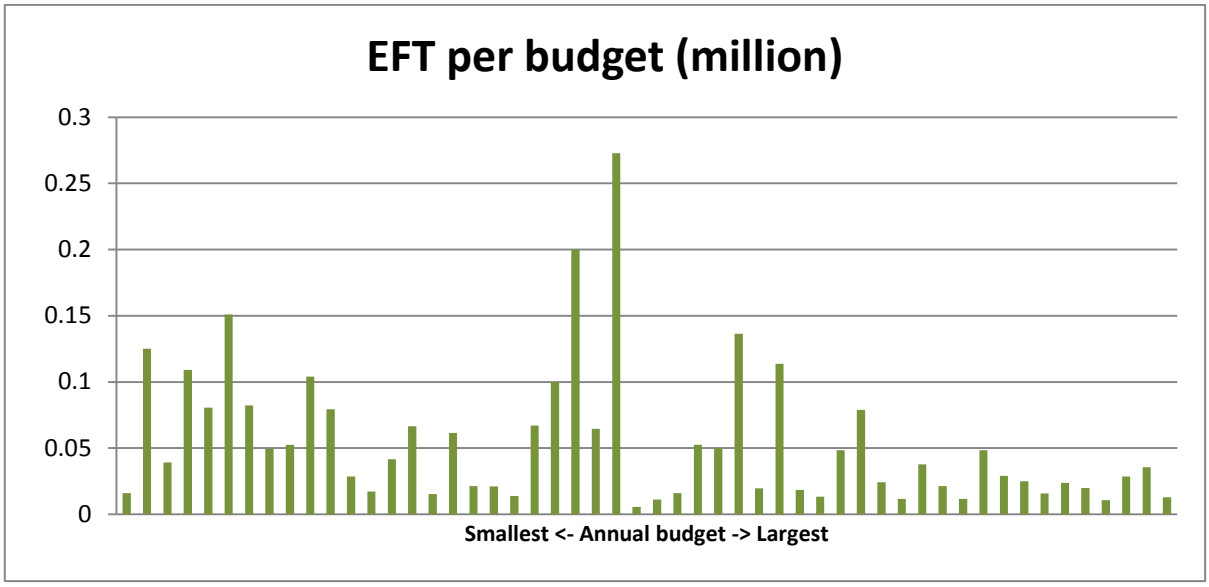


Does size or number of sites affect the accreditation burden?

To understand whether the size or the number of sites affected the number of EFT an organisation has to allocate to manage accreditation, the EFT per site, and per budget (in millions), were explored against the size of the organisation (as reflected by its reported operational budget).



The data suggests that there is not a strong correlation between the number of sites and the EFT allocated to manage accreditation at each site across the spectrum of organisational size (using reported annual budget as a proxy measure for size).



The data does not suggest a strong correlation between the number of EFT required to manage accreditation and organisational size (using reported annual budget as a proxy measure for size).

Did the mapping confirm duplication across standards sets?

The analysis demonstrated that there was overlap across the standards sets.

Table 2 below, demonstrates the extent of coverage of each accreditation standard against each domain. It also shows that only QIC and EQuIP Standards give strong coverage across all systems areas.

Table 2: What the standards measure, and how well

Domains	Strong coverage of this domain, overall	Moderate coverage of this domain, overall	Weak or no coverage of this domain, overall
Governance, and management, includes corporate services	QIC, EQuIP	NSMHS, HCS, NSQHS, RACGP	CSS, NSDS
Service delivery and service governance	QIC, EQuIP, NSMHS, HCS, NSQHS, and HSS	RACGP, NSDS	CSS
Community capacity building	QIC, EQuIP	NSQHS, HSS	CSS, HCS, NSDS, RACGP

HCS standards are currently being reviewed and subject to change by the Commonwealth. CSS are not part of an accreditation scheme, but are monitored as part of the FOPMF process.

Table 3 is a more detailed representation of the coverage of each accreditation standard.

Table 3: Standards coverage of organisational systems

	CSS [3]	EQuIP	HCS[4]	HSS	NSDS	NSMHS	NSQHS	QIC	RACGP
GOVERNANCE AND MANAGEMENT SYSTEMS									
Governance				(X)[5]					
Management									
Human Resources									
Financial management									
Risk management and legal compliance									
Knowledge management									
Managing physical resources and environment									
Managing relationships									
SERVICE DELIVERY SYSTEMS									
Service governance									
Service design and planning									
Service review and improvement									
Access and entry									
Needs assessment									
Care /case planning and review, case management									
Service delivery									
Consumer rights									
Cultural safety									
Service coordination									
Service integration and collaboration									
COMMUNITY CAPACITY BUILDING SYSTEMS									
Community engagement									

LEGEND	Strong coverage	Moderate coverage	Weak coverage	No coverage

[3] CSS does not have an associated accreditation scheme, although compliance is monitored through FOPMF

[4] HCS is currently under review and subject to change by the Commonwealth in 2018.

[5] To meet accreditation requirements, CHSs must also meet the governance and management standards of their selected Independent Review Body.

The mapping indicated that no single standard set could provide strong coverage across all domains, and as such the proposition that QIC could subsumed by another standard set (i.e. NSQHS Standards v2, HSS or HCS) was not demonstrated by the mapping. The mapping found that HCS came closest in coverage of QIC standards. Registered community health services view QIC Standards as the most suitable standards for whole-of-organisation coverage.

Future developments in relation to the NSQHS and other standard sets may strengthen their potential to provide coverage across the organisation. In addition, the trend towards modular approaches to accreditation, such as the approach proposed for the next version of the QIC Standards, is likely to present opportunities for CHSs to 'mix and match' standards to meet accreditation requirements.

Report recommendations

The review identified a number of recommendations, which fall under four broad themes, these being:

1. Coordinating and streamlining accreditation arrangements for CHSs using multi-faceted approaches which reduce standards duplication, and provide greater choice of accreditation providers.
2. Streamlining of accreditation standards and assessments at Commonwealth level, to strengthen quality frameworks and systems, and reduce unnecessary burden.
3. Support for models that improve resource utilisation, in terms of quality and safety capability, and capacity.
4. Identifying and utilising other levers (i.e. market and regulatory levers) that induce standards owners and accrediting bodies to reduce burden through mechanisms such as recognition of equivalences, bundling and management of evidence requirements.

Areas for action suggested by the project include:

1) Coordinating and streamlining accreditation arrangements

Reduce duplication between standards and provide more choice and flexibility

Provide greater choice and flexibility by:

- defining the scope of standards for governance and management that are required to be met by services that deliver Community Health Program funded activities
- clarifying that CHSs have choice about which standard set and provider they utilise to demonstrate compliance with the defined scope of standards, for their primary and community health funded activities.

Note these provisions have been included in the 2017-18 policy and funding guidelines. Due to the lead times that accreditation programs have (e.g. allowing for self-assessment timelines), the impact of this change may not be realised until 2018-2019 or beyond.

Advocate for greater recognition of equivalence between standards

There are opportunities to reduce duplication through advocating within the department for greater recognition of equivalences between the standards applicable to CHSs. Greatest opportunities exist with elements of accreditation requirements including:

- governance and management;
- common elements of service delivery systems; and
- consumer rights;

Integrate accreditation with other quality and safety performance measures and processes in the department

Undertake an internal review to identify governance, management and corporate service information that the department collects through a range of means. These findings can then be used to:

- identify areas of potential duplication with other performance measures that can be addressed, taking action where these are within the Community Based Health Policy and Programs Branch's control.
- advocate within the department to improve data sharing mechanisms.
- advocate within the department to rationalise the standards required for inclusion in an integrated approach to quality and safety.

The department should look to ensure that the Funded Organisation Performance Monitoring Framework (FOPMF) and accreditation against governance and management standards complement each other and do not duplicate, where both are requirements (as is the case for CHSs).

Advocate internally for whole-of-department consistency in developing and reviewing requirements in service agreements and program guidelines which relate to quality and safety measures, and removing duplication where this exists. For example, work towards removing duplication between incident reporting frameworks applicable to CHSs.

2) Streamlining of accreditation standards and assessments at Commonwealth level

The project provides evidence to support advocacy about accreditation burden to other regulators including the Commonwealth, citing the community health sector as a case study.

The department should advocate for simplification of national standards and expectations – promoting streamlining, recognition and other 'ask once, use often' approaches to measure what matters for safety and quality.

Possible avenues for advocacy with the Australian Commission on Safety and Quality in Health Care, and the Australian Health Ministers' Advisory Council (AHMAC).

3) Support for models that improve resource utilisation

It is recommended that the department assist CHSs to identify appropriate models of practice, which would build the capacity and capability of CHSs to better manage service governance, quality and safety performance requirements, including best practice approaches to efficiently managing accreditation obligations. The Victorian Healthcare Association could also have a role in the proposed actions.

The department could consider actions such as:

- coaching and facilitation programs which build capability
- community of practice models
- specific roles for quality capacity building (i.e. Quality Enhancement Officer roles)
- promoting the approach of Dental Health Services Victoria to enabling successful accreditation of public dental services to the NSQHS

4) Identifying and utilising other levers

The report recommended identification and utilisation of levers that induce standard owners and accrediting bodies to reduce accreditation burden. Actions could include DHHS collaborating with relevant stakeholders to strengthen processes for quality and efficiency of accreditation services delivered to CHSs.

Other potential actions not in the project report

Building on the actions identified in the report, other actions could include facilitating best practice discussions with organisations, to assess whether there are potential efficiencies that could be realised in relation to their accreditation obligations.

Ensuring that CHSs are aware of those standard sets that provide for some choice and flexibility around a defined scope of standards, such as the HSS offers in relation to governance and management.

Actions directed at promoting best practice could include showcasing of CHSs that have demonstrated a streamlined approach to accreditation.

In addition, the department is exploring an accreditation streamlining practice model, which could be piloted with a CHS to demonstrate efficient models of compliance with the range of applicable accreditation standards.