



Ontario Health –
East Region

Adult Day Program Guidelines

2025

accesscss

Connect to Community Support Services

Table of Contents

1. Acknowledgements	
2. Purpose and Scope	1
3. Guideline Components	4
3.1 Adult Day Program	5
3.1.1. Definition	5
3.1.2. Goals	5
3.2 Program Types	6
3.3. Client Profiles	7
3.3.1. Most Common Reasons for Referral	7
3.4. Core Programs & Services	8
3.4.1. Physical Wellness	9
3.4.2. Therapeutic Recreation	9
3.4.3. Personal Care Services	9
3.4.4. Nutrition	9
3.4.5. Medication Reminders	10
3.4.6. Care Partner Support & Education	10
3.4.7. Care Coordination	10
3.4.8. System Navigation	11
3.4.9. Community Engagement	11
3.4.10. ABI Specific – Life Skills	11
3.4.11. Specialized Programs	12
3.5. Operational Standards	13
3.5.1. Limits of Care	14
3.5.1.1. Eligibility Criteria	15
3.5.1.2. Intake Assessment	16
3.5.1.3. Holds	17
3.5.1.4. Care/Service Plan	18
3.5.1.5. Emergency Communication	19
3.5.1.6. Client Discharge	20
3.5.1.7. Transition Plan	21

Table of Contents

3.5.2. Human Resource Management	22
3.5.2.1. Staff Ratios	22
3.5.2.2. Staff Mix	23
3.5.2.3. Scope of Work	24
3.5.2.4. Role of Direct Program Staff.....	25
3.5.2.5. Job Descriptions	25
3.5.2.6. Experience and Knowledge	26
3.5.2.7. Recommended Staff Training Requirements.....	27
3.5.2.8. Staff Orientation	28
(Based on Corporate Organizational Policies of ADP Providers)	
3.5.2.9. Volunteer & Student Orientation	29
3.6. Program Hours & Days of Operation	30
3.7. Waitlist Management	30
3.8. Transportation	30
4. Quality Improvement and Performance Management	31
4.1. Quality	32
4.2. Quality Improvement	33
4.3. Performance Management	34
4.4. Logic Model	35



Acknowledgements

These Guidelines have been adapted from the *Central East Adult Day Program (ADP) Guidelines, 2020*. June 2024 onwards, leadership from the **Champlain ADP Providers Service Network, Seniors Care Network** in Central East, and **Victoria Order of Nurses** in South East collaborated to build on existing work and develop the *Ontario Health East Region Adult Day Program Guidelines*.

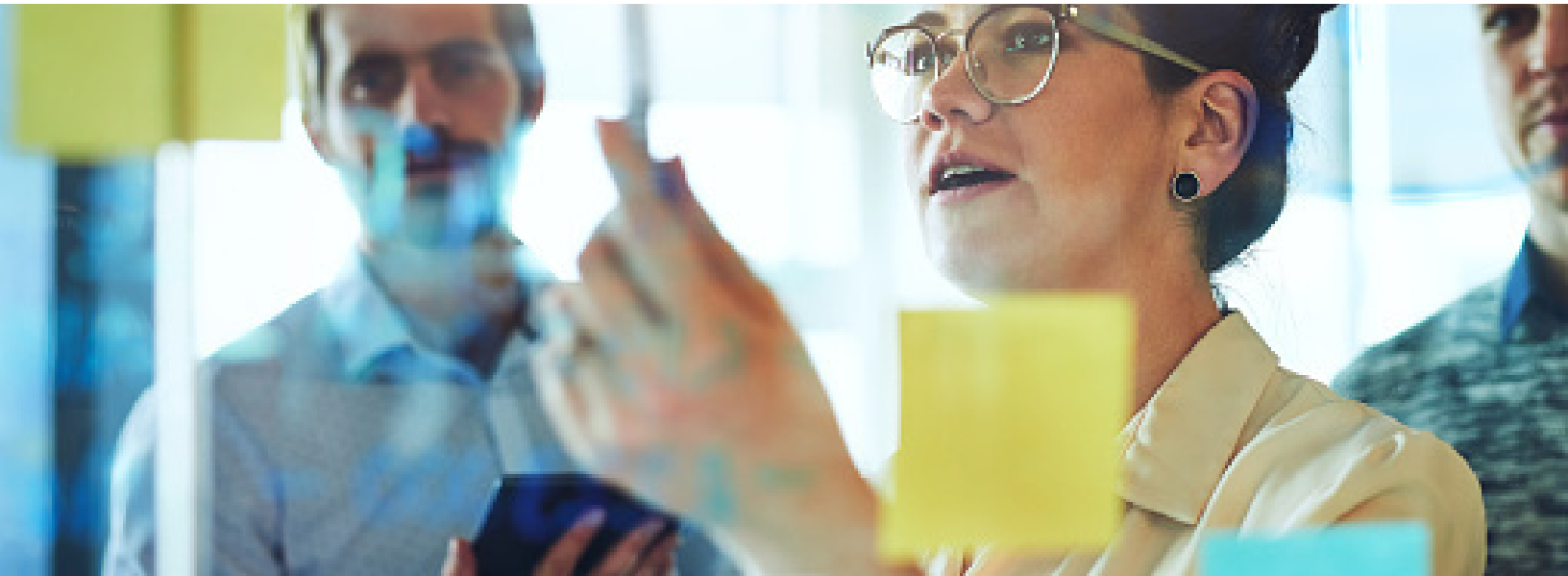
We would like to acknowledge the dedication and active contributions of the members of the Ontario Health East Adult Day Programs to the development of these Regional Guidelines.

This document will be hosted on [**Access CSS**](#).

Designed by _____

Xin Yi Dong, MHI, Evaluation Analyst Intern, Seniors Care Network

Purpose and Scope



The Adult Day Program Guidelines is a living document that was developed utilizing a co-design methodology.

The goal of the guidelines is to minimize undesirable variation and facilitate the provision of consistent, high-quality programs and services across the Region. We understand that some variation may be necessary to adapt these guidelines to specific programs, local circumstances, and the clients and their wishes.



Purpose and Scope

The following principles informed the ADP Guidelines development process:

01 Client-centred care

02 Supporting care partners

03 Accessibility

04 Cultural/Linguistic sensitivity

05 Equity/Diversity/Inclusion/Anti-Racism

06 Accountability

07 Alignment with the Institute for Healthcare Improvement Quintuple Aim,¹

08 Building capacity to meet the evolving needs of ADP clients

Purpose and Scope

The following figure depicts the ADP Guideline development process:

Figure 1 - ADP Guideline Development Process



01

Review of Evidence Resources

(Grey literature, methods employed by other jurisdictions)



02

Current State Analysis (Environmental scans)



03

ADP Engagement

(Validate findings, fill information gaps and identify key issues)



04

Ongoing ADP Engagement



05

'Co-Design' of Guideline components & identification of implementation barriers and facilitators



06

Finalize of ADP Guidelines & development of high-level implementation recommendations



Guideline Components

These Guidelines provide an overview of the population served, the minimum basket of programs and services to be offered by each provider and the operational standards informing organizational processes.

There are three main components to these ADP Guidelines:

1. **Client Profiles**
2. **Core Programs & Services**
3. **Operational Standards**

Adult Day Program

DEFINITION

An integrated support service that provides supervised programming in a group setting for Service Recipients (SRs) who require close monitoring and assistance with personal activities (e.g. hygiene, dressing, etc.)

The SRs include the frail and elderly and those with Alzheimer disease or related disorders, or physically impaired individuals who are relatively independent and can manage certain personal activities. Individuals may attend this service for five to twelve hours on average for a fee.

This service assists the participants to achieve and maintain their maximum level of functioning, to prevent early or inappropriate institutionalization and provides respite and information to their care partners. Components of the service include planned social and recreational activities, meals, assistance with the activities of daily living and minor health care assistance, e.g. monitoring essential medications.^{2,3}

GOALS

The goals of ADPs are to:

1

Assist participants to:

- live well in the community
- maintain their choice of residence
- facilitate the achievement of care/service plan goals

2

Support care partners in:

- their wellness
- caring for their loved ones at home

3

Collaborate with/contribute to a system of community-based care⁴



Program Types

As of 2024, there are fifty-five (55) Adult Day Program providers delivering services in Ontario Health East. There are three distinct types of ADPs:

- Traditional ADPs (inclusive of cultural, linguistic, sexual orientation, and gender-specific groups)
- Acquired Brain Injury (ABI) ADPs
- Specialized ADPs



Traditional

Older Adults living with frailty (including cognitive decline)



Acquired Brain Injury

- Regular
- Dementia
- Drop-in



Specialized

- Young Onset Dementia (YOD)
- Palliative
- Stroke
- Parkinson's Disease
- Dementia
- Mental Health

Guideline Components

Client Profiles

The most common reasons for referral for the three types of ADPs:

Traditional

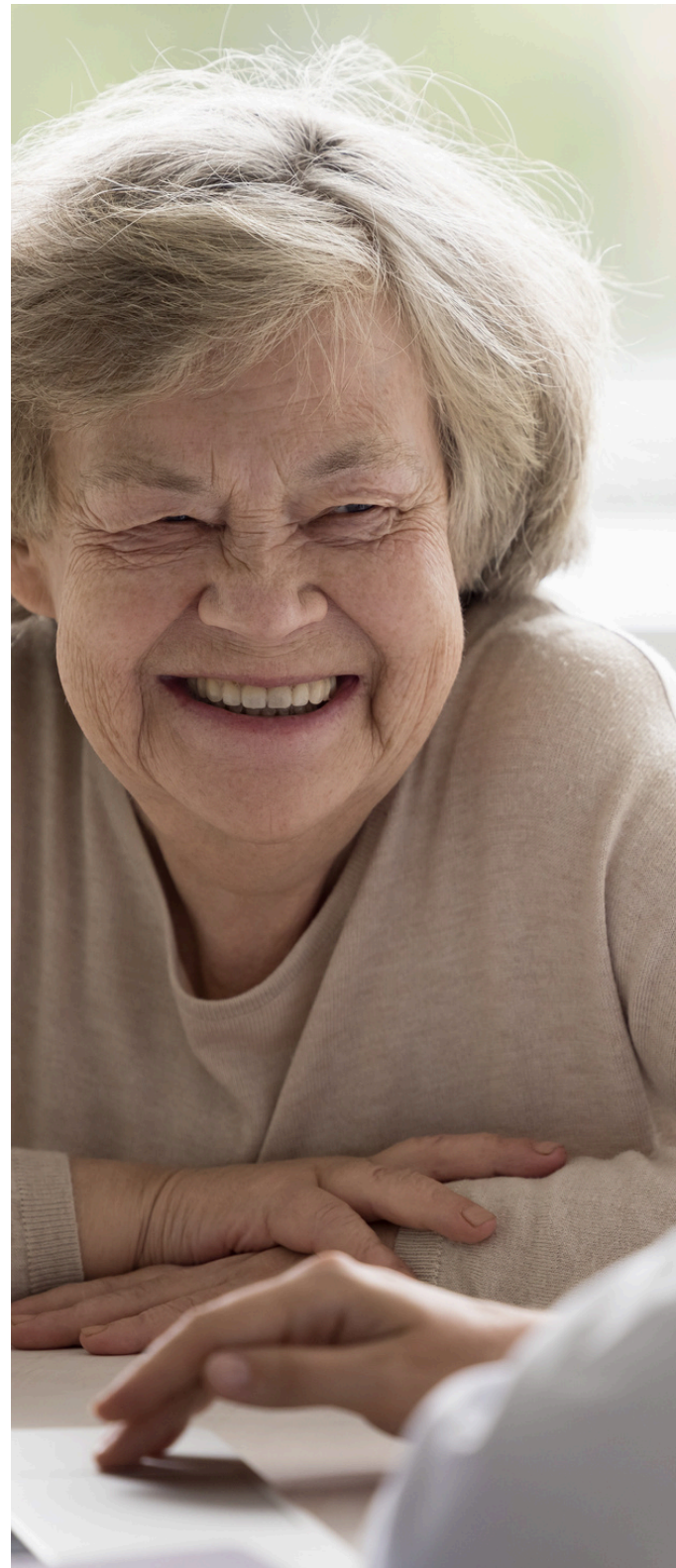
- Care partner respite
- Socialization
- Isolation
- Recreation
- Physical & intellectual/cognitive stimulation
- Therapeutic exercise
- Maximize 'function'
- Safety

Acquired Brain Injury

- Socialization
- Isolation
- Peer support
- Community engagement
- Care partner respite
- Mental health/addiction support
- Informal rehabilitation
- Responsive Behaviors

Specialized

- Condition specific needs (e.g., post-stroke clients, individuals living with Parkinson's Disease or those with advanced/ chronic renal disease or Chronic Obstructive Pulmonary Disease, mental health, those with higher personal care needs, etc.)
- Recreation
- Socialization
- Isolation
- Support for working care partners
- Peer support



Guideline Components

Core Programs & Services



Physical Wellness



Therapeutic
Recreation/Recreation
Programming



Personal Care Services

All ADPs are expected to deliver a core/minimum set of programs and services.



Nutrition



Care Partner Support
and Education



Community Engagement



Care Coordination and
System Navigation



Life Skills (ABI Specific)

These programs and services are described further and may be delivered in-person, virtually, or in a hybrid model/format. Recommendations for hybrid program delivery are outlined in the [Ontario Health \(East\) Central East Region Intra-COVID Hybrid Adult Day Program Model Guidelines](#).

Guideline Components

Core Programs & Services

Physical Wellness

Physical wellness includes activities that promote proper care for optimal health and functioning. The activities are designed to assist individuals to maintain mobility through balance, flexibility, endurance, range of motion, stability, coordination and strength. These activities also provide important opportunities for socialization (e.g., exercise, falls prevention, walking, physical games, drum circle, etc.).

Therapeutic Recreation

Therapeutic recreation includes activities that provide social, emotional, intellectual, cognitive, physical, and spiritual stimulation to promote independence and enhance function⁵ (e.g., tablet programs, music therapy, mental stimulation activities, dancing, art therapy, pet therapy, spiritual engagement, horticultural therapy, sensory stimulation, etc.). Therapeutic recreation should be delivered in a culturally sensitive manner and should be designed to actively engage the client by providing opportunities for a variety of activities with all levels of involvement.

Personal Care Services

Personal care services are unique to the client's needs. These services may include physical assistance or verbal cueing with activities of daily living depending on the client's functional ability (e.g., washroom assistance, feeding assistance, medication reminders, ambulation and transfers, dressing/clothing assistance⁶, etc.).

Nutrition

Hot or cold nutritious meals and snacks are individualized to dietary needs and served in settings that promote and foster positive social interactions (e.g., special event meals, birthday celebrations, cultural celebrations, baking classes, etc.). Nutrition related education and information may also be provided (e.g., diabetes education). All food preparation follows the Canada Food Guide and relevant staff hold Safe Food Handlers Certification.

⁵ Adapted from Enhanced Adult Day Program Service Standards (2019). Community Navigation and Access Program (Toronto Central LHIN), Working Group Report to the Ministry of Health and Long-Term Care.

⁶ Does not include wound dressing



Guideline Components

Core Programs & Services

Medication Reminders

Medication reminders are a service provided to clients to ensure that medications are taken as intended by the prescriber when the client is self-administering their own medications. Medications are accessible to the client but may be stored in a locked central location and brought to the client for use at the required times. Site staff remind clients when to take their medications or provide them with specific instructions to get the most benefit from the medications. Medications taken during the hours the client is at the program are reviewed during the initial assessment and re-assessments (or as needed) with care partners and/or clients.

Care Partner Support & Education

Support, education, guidance and resources are provided for families and care partners who are caring for ADP clients. These may include:

- Education regarding the understanding of client's behaviours and changes in client's needs
- Information about other support services in the community
- Social events where families are invited to take part in special events held at the ADP
- Family conferences where care partners are invited and encouraged to attend care planning conferences when appropriate to the clients' situation

Care Coordination

Care coordination involves organizing client care activities and sharing information within the circle of care to achieve safe, appropriate and effective care. Care coordination enables:

- Client's needs and preferences to be known ahead of time
- Care/service plan to be based on individualized client needs⁷

Guideline Components

Core Programs & Services

System Navigation

System navigation involves collaborating with colleagues and/or community partners (e.g., Ontario Health atHome coordinator, hospital discharge planner, primary care provider, Regional Care Planner, SMILE) to determine what services a client and their family/care partner may need in the community, and identifying the appropriate agencies to contact prior to discharge (e.g., Ontario Health atHome).⁸ The clients are assessed/re-assessed to identify and determine specific services that they may benefit from (e.g., home care support, specialized geriatric services, etc.). ADPs are committed to improving access, transitions, and coordination for clients and/or care partners.

Community Engagement

Community engagement is the process by which clients, care partners and/or community members are engaged to work and learn together on behalf of their communities. It can involve informing community members about an initiative, inviting their input, collaborating with them to generate solutions, and partnering with the community to address community issues.

Community engagement increases community cohesion and allows for the community to be invested in the outcomes. (e.g., intergenerational programming, Earth Day clean-up, collections for food banks, student placements, stroke survivor group, etc.).⁹

ABI Specific – Life Skills

Life Skills programs assist persons living with a disability to learn the basic skills of daily living. Services may include training in the ability to travel about the community alone, to live independently in a private residence, to maintain health through self-care and use of medical services, to live within their personal income, to maintain grooming and appearance, and to cope with other requirements of successful independent living.¹⁰

⁸ Adapted from the College of Respiratory Therapists of Ontario, GROW. Health System Navigator.

⁹ Tamarack Institute for Community Engagement (2020).

¹⁰ thehealthline.ca (2020). Services for Central East



Core Programs & Services

Specialized Programs

In addition to the above stated Core Programs & Services, some sites also provide specialized programs such as:

- Programs for individuals with advanced complex care needs, e.g., those with higher personal care needs, post-stroke clients, individuals living with Parkinson's Disease or those with advanced/chronic renal disease or Chronic Obstructive Pulmonary Disease (COPD), mental health.
- Dementia specific ADPs for those living with dementia where staffing ratios are higher and include sites with secure units.
- Young Onset specific ADPs for individuals living with young onset dementia whose care needs are different to those in Traditional and Specialized Dementia ADPs.



Guideline Components

Operational Standards

The following standards have been established to guide the operations of Adult Day Programs.

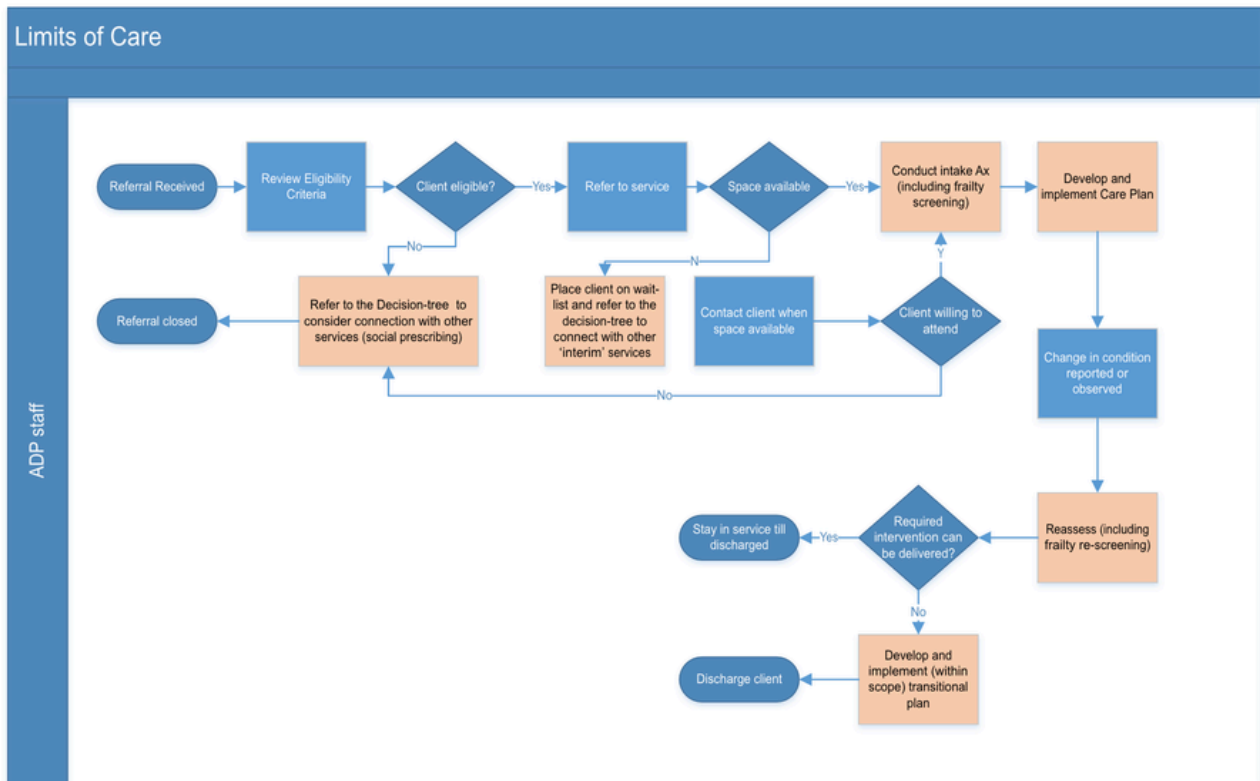
1. **Limits of Care**
2. **Human Resources Management**

Operational Standards

Limits of Care

Limits of care refer to the client's journey from admission to discharge. The following figure is a pictorial overview of the process:

Figure 2 - Limits of Care Process Map





Eligibility Criteria¹¹

Clients are eligible for ADPs if they are:

- Insured under the Health Insurance Act
- 18 years of age or older
- Frail, elderly and/or living with dementia or related disorders; routinely experiencing physical and/or cognitive challenges but can manage certain personal activities with assistance; and/or are socially isolated
- Able to transfer independently, with supervision or one person assist
- Residents of Eastern Ontario
- Presenting no serious risk to staff, volunteers and/or co-clients

Additionally, their care requirements cannot exceed the program's environmental or physical resources and staff expertise.



Limits of Care

Intake Assessment



An intake assessment will be conducted for each client accepted into the ADP and will include information on the following:

- InterRAI Community Health Assessment or InterRAI Home Care Assessment
- Medical history
- Current medications
- Leisure interest
- Social History
- Allergies/food sensitivities
- Substitute Decision Maker, Power of Attorney for Personal Care and/or Power of Attorney for Property
- Emergency contact information
- DNR status

A discussion with the client and care partner regarding the program, the terms of service, fees, subsidies available, privacy, Client Bill of Rights, consents/permission forms, transportation options, policies (e.g., vacation hold, hospital hold, respite hold, etc.) and the organization will be conducted.

Upon program admission client reviews and signs a comprehensive service agreement that clearly outlines program policies and practices.

Operational Standards

Limits of Care



Holds

Clients may be discharged if they are away from the program for more than 30 consecutive calendar days. This includes vacation, hospital and respite holds.

However, this may be negotiated on a case-by-case basis. Clients will be required to meet the eligibility criteria prior to returning to the program. Where fees apply, client may be charged for holds. Clients are to be made aware of this policy at the time of intake.



Operational Standards

Limits of Care

Care/Service Plan

A comprehensive/holistic client-centred care/service plan will be developed for each ADP client and will include information on the following:

- Physical ability (e.g., mobility and ambulation, exercise tolerance, pain tolerance, etc.)
- Cognitive needs
- Psychosocial needs
- Personal interests and needs
- Presence of responsive behaviours (triggers and successful interventions)
- Accommodations required (e.g., dietary, environmental)
- Activities of Daily Living assistance (e.g., personal care/toileting)
- Sensory aids (e.g., vision and hearing)
- Program preferences
- Supports being received at home (formal and informal)

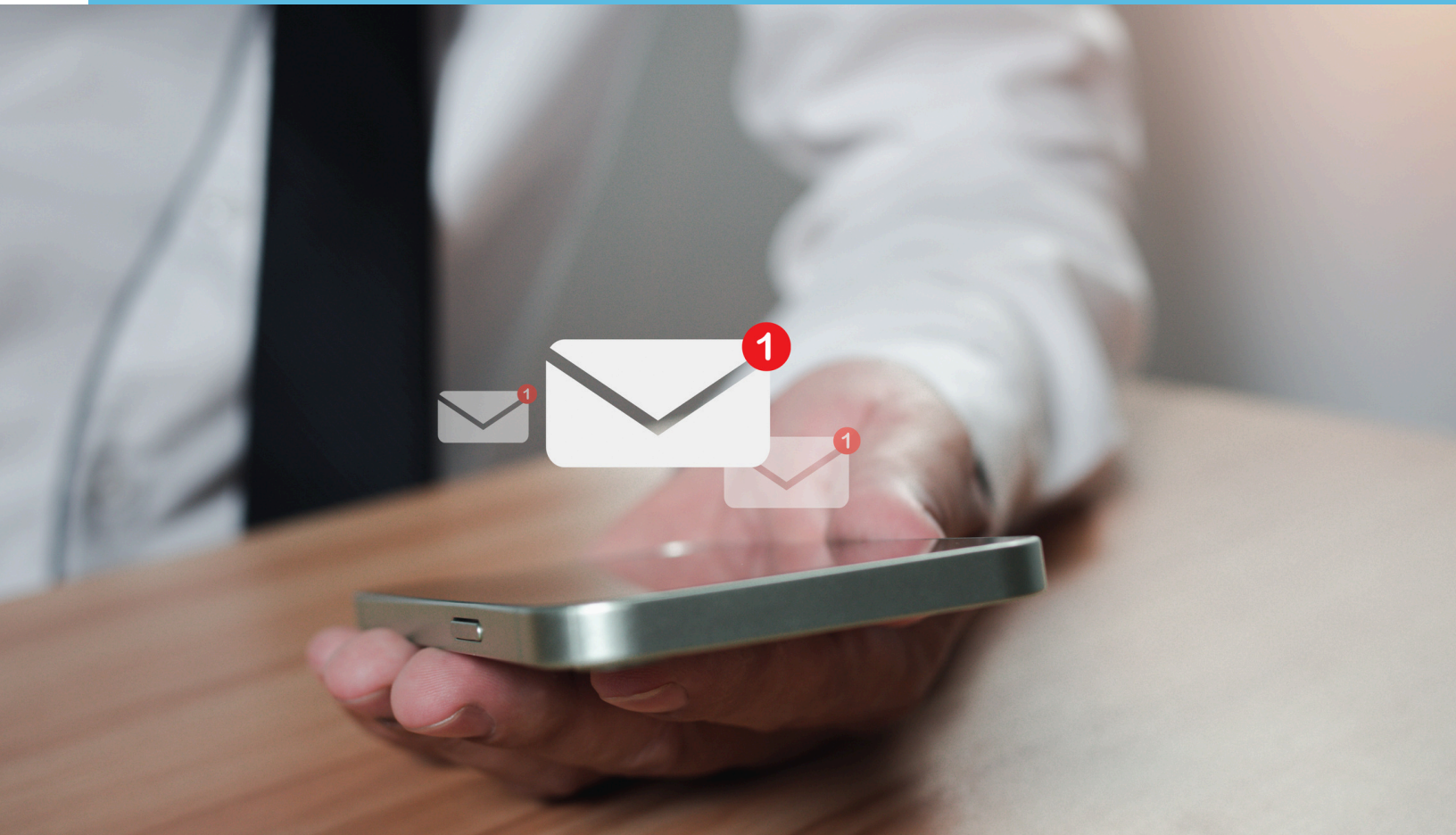
The care/service plan will be revised/updated every twelve months or more frequently if there is a significant change in the client's physical and/or mental health. A copy of the care/ service plan (initial and any subsequent) will be provided to the client/care partner.



Limits of Care

Emergency Communication

Processes will be defined by ADP providers to ensure prompt communication clients and caregiver on program emergency closures/modifications, e.g., inclement weather.



Limits of Care

Client Discharge¹²

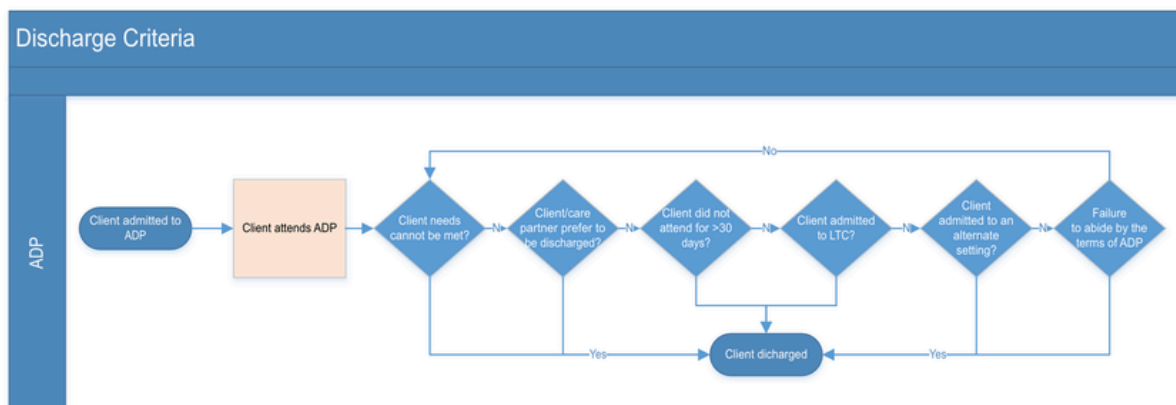
Adult Day Program providers may discharge clients if they pose risk to personal health and safety that cannot be managed by staff or if the client cannot be safely accommodated in the program.

A client will be discharged from the program for the following reasons:

- client needs can no longer be met by the program
- upon admission to long-term care
- upon admission to an alternate care setting
- client and care partner preference
- failure to attend the program for an extended period
- failure to abide by the terms of service of the ADP
- Additionally, client death warrants an automatic discharge.

The discharge criteria are depicted in the figure below:

Figure 3 – Discharge Criteria Process Map¹³



Once the decision to discharge has been made, the co-development of a transition plan will begin.¹⁴ The client or care partner will be assisted to navigate to alternate services.

¹² Adapted from Enhanced Adult Day Program Service Standards (2019). Community Navigation and Access Program (Toronto Central LHIN), Working Group Report to the Ministry of Health and Long-Term Care.

¹³ Adapted from Central Local Health Integration Network (2018). Adult Day Programs, Standard Manual and Best Practice.

¹⁴ Client death being an exception.

Limits of Care



Transition Plan

A transition plan will be co-developed for every client that is transitioned from the ADP into another facility/program and will include information on the following as needed:

- Physical ability (e.g. mobility and ambulation, exercise tolerance, pain tolerance, etc.)
- Cognitive needs
- Psychosocial needs
- Personal interests and needs
- Presence of responsive behaviours (triggers and successful interventions)
- Accommodations required (e.g. dietary, environmental)
- Activities of Daily Living assistance (e.g. personal care/toileting)
- Sensory aids (e.g. vision and hearing)
- Program preferences
- Supports being received at home (formal and informal)
- Additional information to support the client



Operational Standards

Human Resource Management

Staff Ratios

The staffing ratio may vary across different ADP types and throughout the day and week. Staffing is defined as paid employees providing direct services within the Adult Day Program. Does not include volunteers and administrative staff, eg: coordinators not working in the program. These ratios may require adjustment based on client's needs.

An overview of the **recommended** staffing ratios is given below:

Type of ADP	Recommended Minimum Paid Staffing Raio
Traditional Programs	1:4
Condition/ Diagnosis Specialized Programs	1:4
Young Onset Dementia	1:5
Specialized Dementia	1:3
Stroke	1:5
Parkinson's Disease	1:4
Mental health	1:4
Palliative	1:15
Acquired Brain Injury Programs - Regular	1:7
Acquired Brain Injury Programs - Dementia	1:5
Acquired Brain Injury Programs - Drop in	1:10

Operational Standards

Human Resource Management

Staff Mix

Staff capacity and competency must be consistent with the defined needs of the clientele being served and the scope of services being provided. To better serve their client population, each provider should have the flexibility within their funding to select the appropriate staff mix. This flexibility is also required to allow providers to continually adapt their staffing to the evolving needs of their clientele.

Program human resources may include:

- Personal Support Workers
- Program Activationists, Recreationists, and/or those with education in Gerontology
- Social Service Workers
- Developmental Service Workers
- Managers
- Administrative Support
- Registered Nurses/Practical Nurses
- Therapy Assistants
- Therapy Aides
- Activity Conveners/Coordinators
- Dietitians
- Social Workers
- Cooks
- Drivers
- Volunteers

Additional supplemental staff may be required at various times.



Human Resource Management



Scope of Work¹⁵

The ADP provider shall recruit, train, supervise and provide enough qualified staff to meet the client care requirements described in the client care/ service plans. The provider shall ensure that the staff assume responsibility for the care and support of each client in accordance with the care/service plan.

Staff should be able to communicate effectively, help clients and care partners navigate the health care system, link with other care providers, and have an awareness of other services offered in the community.

Staff are expected to provide services within their scope of practice and competency. They should cover for other roles when appropriate.

Operational Standards

Human Resource Management

Role of Direct Program Staff

Direct program staff develop, organize, implement recreation and physical activation programs that promote physical, social, emotional, intellectual and spiritual well-being. Additionally, they assist with personal support services (with the exception of YOD and ABI programs), medication reminders, and ambulation and mobility assistance (as applicable).

Job Descriptions

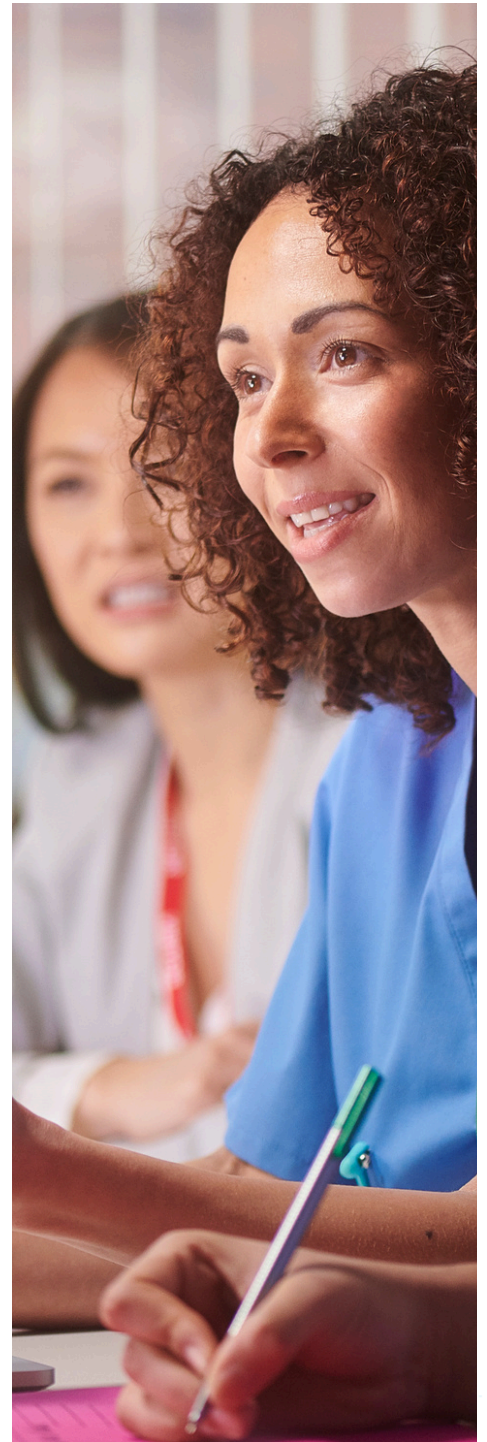
Job descriptions should be developed for all staff and should be made available to the respective individual.

Qualifications and Certifications

- Possession of a bachelor's degree or Community College Diploma in health, recreation/activation or social services related field and/or related experience in a social or health service setting.
- Personal Support Worker (or equivalent)

At least one of the program staff has training and or experience in Recreation Therapy/Activation, Gerontology

All staff have acceptable Vulnerable Sector Screening upon hire



Operational Standards

Human Resource Management

Experience and Knowledge

All direct program staff/team may have experience/knowledge in/of the following:

- community-based settings
- person-centered care
- dementia care
- client safety
- responsive behavior management
- mental health and addictions
- complex, chronic health conditions
- elder abuse
- documentation requirements
- care/service planning
- community resources
- digital technology and devices



Operational Standards

Human Resource

Management

Recommended Staff Training Requirements

While the list is not exhaustive, below are the recommended staff training requirements:



- First Aid and CPR certification
- Exercise and Falls Prevention Education
- Food Safety Training certification
- Gentle Persuasive Approach (GPA), U-First, Validation, Dementiability, Montessori and related Behavioural Support Ontario tools
- Suicide Prevention
- Non-Violent Crisis Intervention training
- EDIAR training
- Additionally, neuro-rehabilitation training is required for ABI direct program staff
- Emergency preparedness
- Missing Person

Staff are to be provided with all necessary training to perform their job duties and serve their defined client population. In addition, access to ongoing education to maintain current competencies that are reflective of best practices should be facilitated.



Operational Standards

Human Resource Management



Staff Orientation (Based on Corporate Organizational Policies of ADP Providers)

The staff orientation will include, but is not limited to, the review of:

- Ontario Health East Adult Day Program Guidelines
- Purpose of the program
- Responsibilities of the clients, informal care partners and responsibilities of the program
- Services provided by program
- Respective job description
- Performance appraisal timelines
- Performance appraisal timelines
- Confidentiality, privacy and informed consent
- Occupational Health and Safety
- Infection Prevention and Control
- Workplace Hazardous Materials Information System (WHMIS)
- Customer Service
- EDIAR training Incident reporting process
- Medication assistance procedures
- Client complaints processes
- Accessibility for Ontarians with Disabilities Act (AODA) training
- Workplace Violence and Harassment
- Policies and procedures of the service provider
- Complaint Resolution

Operational Standards

Human Resource Management

Volunteer & Student Orientation

ADP providers may recruit volunteers and offer student placements. Agencies will have policies in place that support and value the role of volunteers and students.

The volunteer and student orientation will include, but is not limited to, the review of:

- Organizational overview
- Code of conduct
- Dementia specific training
- Client specific care (understanding of client care needs and care/service plan, care/ service plan will be shared as appropriate)
- Infection Prevention and Control
- Signs of abuse and neglect
- Privacy and confidentiality
- Safe food handling (if applicable)
- Personal care training (for students)
- Workplace Hazardous Materials Information System (WHMIS)
- Accessibility for Ontarians with Disabilities Act (AODA) training
- Workplace Violence and Harassment
- Complaint Resolution
- EDIAR training
- Emergency preparedness
- Missing Person
- Additionally, all students and volunteers require a Police Services vulnerable sector check.

Additionally, all students and volunteers require a Police Services vulnerable sector check.



Guideline Components

Program Hours & Day Operation

Hours of operation and days of operation vary among sites with a minimum of 5 programming hours per day. Operating hours per day range from 5-12.

Waitlist Management

There are various factors that need to be considered when managing a waitlist. These include:

- level of care required to accommodate the waitlisted client
- space availability
- ongoing needs of rostered clients
- needs of the waitlisted client
- accommodation at other program locations
- working status of care partner

Waitlisted clients may be invited to attend programs for shorter periods of time to facilitate integration, when possible.

Transportation

ADP providers will assist clients and/or care partners by referring and/or coordinating options for transportation through internal, contracted or community providers.

Quality Improvement and Performance Management

Clients and care partners accessing ADPs expect the high-quality programs and services. While most ADPs are in organizations that define their own expectations for quality, there is also a need to consider quality through the lens of an inter-organization, networked system of ADPs.

- **1. Quality**
- **2. Quality Improvement**
- **3. Performance Management**
- **4. Logic Model**

Quality Improvement and Performance Management

Quality

The Institute of Medicine suggests that quality is



the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.¹⁶

Elements of Quality

Health Quality Ontario identifies the elements of quality as

- Safe
- Effective
- Client-centered
- Efficient
- Timely
- Equitable

Quality Improvement and Performance Management

Quality Improvement



Quality improvement is a systematic, formal approach to:

- the analysis of performance and efforts to improve it. In health care, quality improvement is a proven, effective way to improve care for patients, residents and clients, and to improve practice for staff. It is a continuous process at each home, practice or organization and should be an integral part of everyone's work, regardless of role¹⁷
- making changes that lead to better patient outcomes and stronger health system performance¹⁸

Every organization is expected to have compliments, complaints and incident management processes. It is expected that information obtained from these processes will be utilized to identify and implement quality improvement initiatives.



Quality Improvement and Performance Management

Performance Management



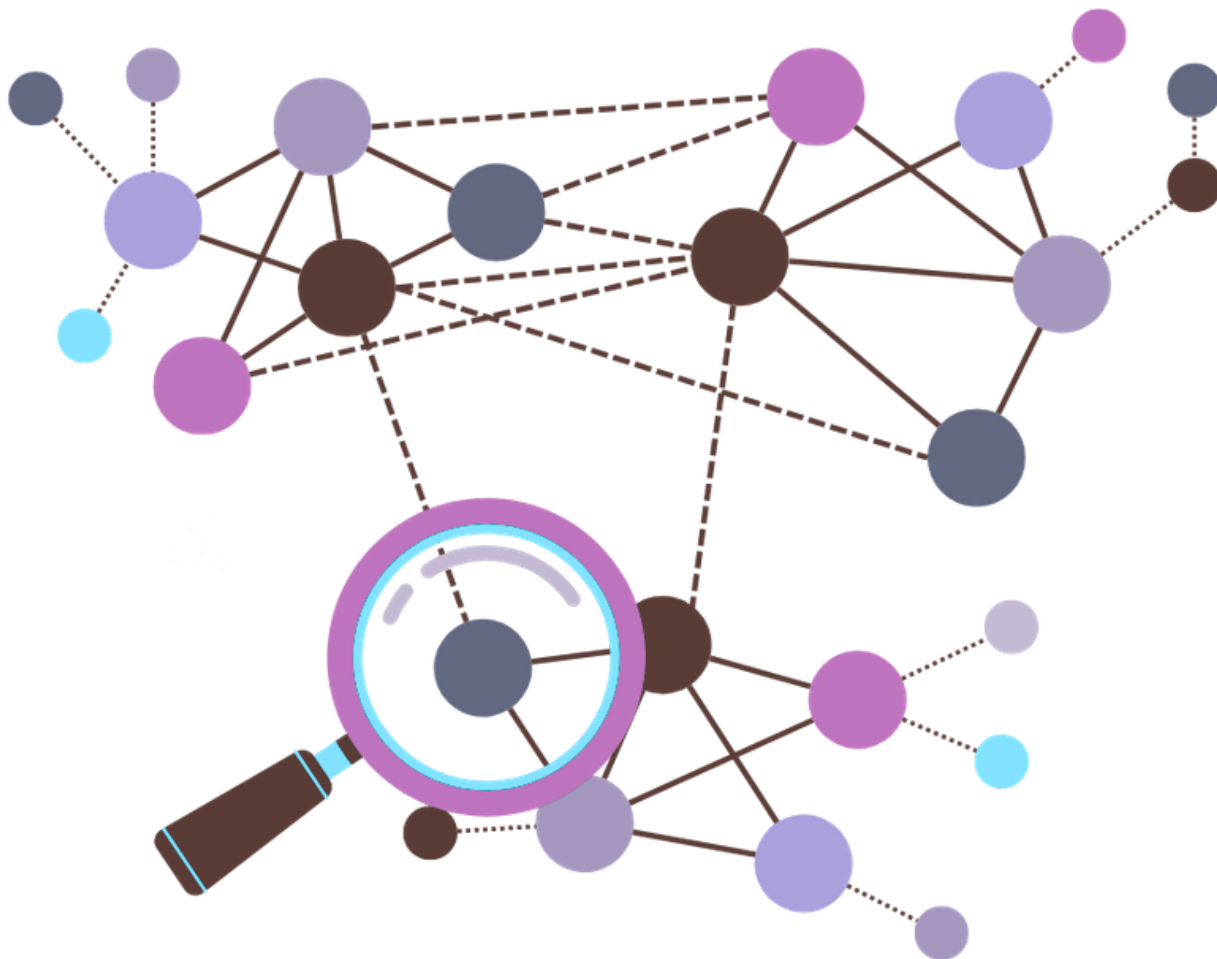
Performance Management is the organization wide effort to harness the power of all quality initiatives and to align them with the identified strategic priorities. Data collection and monitoring are key to effective performance management.

Quality Improvement and Performance Management

Logic Model

"The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program."¹⁹

In order to determine a collective vision, standardize cross-regional performance management and facilitate the achievement of the IHI Quadruple Aim, the logic model on the following page has been developed



**Central East Adult Day Program (ADP)
Logic Model**

VISION	A network of high functioning ADP providers collectively contributing to a system of high quality, client friendly, community based care				
AIM	Provision of high quality, standardized, person-centered, equitable and cost-effective ADP services across Central East Ontario to enable individuals to achieve or help maintain their maximum level of functioning in their residence of choice				
OBJECTIVES	Achievement of Quintuple Aim				
TARGET POPULATION	Residents of Central East Ontario who are frail, elderly and/or those living with dementia or related disorders, or those who routinely experience, physical and/or cognitive challenges (but can manage certain personal activities with assistance), and/or those who may be socially isolated				
COMPONENTS (Target Audience)	Population Health (Public)	Patient Experience (Clients and Care Partners)	Value/Cost (Decision makers, Funders)	Provider Experience (Staff, volunteers and students)	
INPUTS		<ul style="list-style-type: none"> Facilities Equipment & Supplies Human Resources: <ul style="list-style-type: none"> Administration Front line Support Staff 	<ul style="list-style-type: none"> Volunteers and/or Students OHE Funding Non-OHE Funding Training (Staff & Volunteers) Transportation 	Equity (Equity, Diversity, Inclusion, Anti-Racism)	
ACTIVITIES	<ul style="list-style-type: none"> Design programs & services to meet the evolving/emerging needs of the target population. Develop and distribute communication materials to increase public awareness about ADP programs & services 	<ul style="list-style-type: none"> Conduct intake assessments Develop holistic person-centered care plans Deliver programs and services Provide care partner support and education Conduct client and care partner Experience Surveys 	<ul style="list-style-type: none"> Deliver cost-effective programs and services Enable equitable access 	<ul style="list-style-type: none"> Provide capacity building opportunities Recruit and train staff Recruit and train volunteers Conduct Staff Experience Surveys Recognize staff and volunteer contributions 	<ul style="list-style-type: none"> Embed Equity, Diversity, Inclusion, Anti-racism (EDIAR) principles in all patient process Provide EDIAR training and education for staff, volunteers and students
INDICATORS -	<ul style="list-style-type: none"> # of communication materials distributed % of referrals by referral source (YOD, ABI) 	<ul style="list-style-type: none"> % of client experience/satisfaction surveys completed % of care partner client experience/satisfaction surveys completed Average length of stay in the program % of discharges by reason 	<ul style="list-style-type: none"> Ratio of FTE to attendance day 	<ul style="list-style-type: none"> Staff retention rate Frequency of provider experience survey % of provider experience surveys completed 	<ul style="list-style-type: none"> % of operational process reviewed through an EDIAR lens # EDIAR education sessions held % of staff trained % of volunteers trained % of students trained

July 29, 2024



The following evidence resources were consulted in the preparation of this document:

Agency for Healthcare Research and Quality (2020). Care Coordination. Retrieved from [https:// www.ahrq.gov/ncepcr/care/coordination.html](https://www.ahrq.gov/ncepcr/care/coordination.html)

Central Local Health Integration Network (2018). Adult Day Programs, Standard Manual and Best Practice.

Champlain LHIN (2015). Service Reference Document, Community Support Sector.

College of Respiratory Therapists of Ontario, GROW. Health System Navigator. Retrieved from https://www.crto.on.ca/pdf/GROW/Health_System_Navigator.pdf

Enhanced Adult Day Program Service Standards (2019). Community Navigation and Access Program (Toronto Central LHIN), Working Group Report to the Ministry of Health and Long- Term Care.

Health Quality Ontario (2017). Quality Compass.

Health Quality Ontario (2013). Quality Improvement Science.

HNHB LHIN Adult Day Program and Respite Review (2014), Working Group Findings and Recommendations.

Institute of Medicine (1990) Medicare: A Strategy for Quality Assurance. Washington D.C.: National Academy Press.

Ministry of Health and Long-Term Care, Health System Information Management Division Health Data Branch, Data Standards Unit, Ontario Healthcare Reporting Standards v11.0, Chapter 10, Community Support Services , 2019/20, page 86.

South East LHIN. Common Basket of Services Program Template.

South West LHIN (2012). Assisted Living, Supportive Housing and Adult Day Programs Initiative.

South West LHIN (2013). Assisted Living/Supportive Housing/Adult Day Programs for Special Populations Final Report.

South West LHIN (2013). ADP Redesign.

Tamarack Institute for Community Engagement (2020). Retrieved from https://www.tamarackcommunity.ca/communityengagement?gclid=Cj0KCQjwoaz3BRDnARIsAF1RfLeKjAsXvO1AE-blDD3D4E9VBKNhiiBXP4qGyldoJCHy8q3tSZ4fN4HYaAgi9EALw_wcB

W.K. Kellogg Foundation (1998). Logic Model Development Guide



