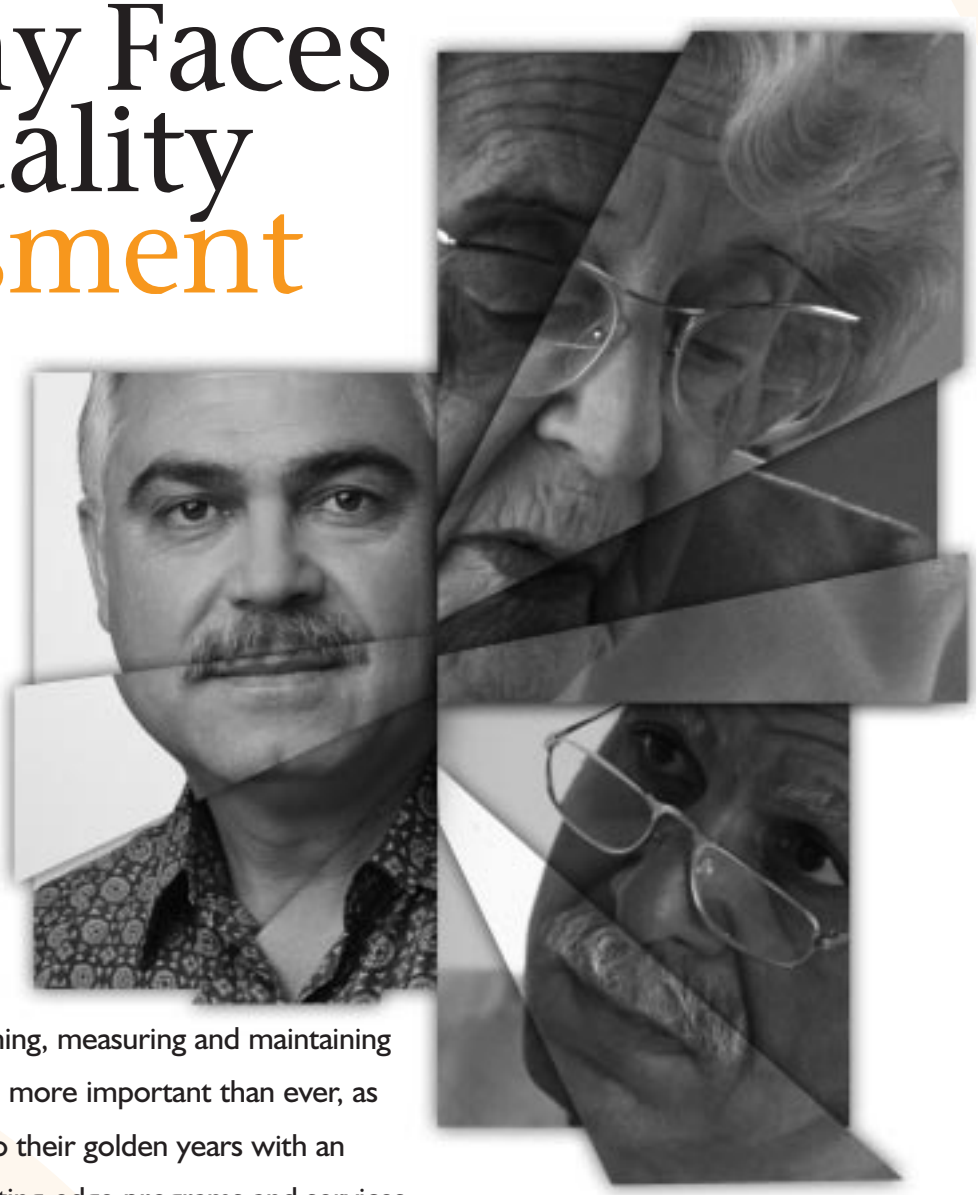
The Many Faces *of* Quality Assessment



by Amanda Finnegan

Aging services providers consider concepts like "quality," "quality of life" and "quality indicators" almost every day, while they work in the face of constrained budgets, staffing crunches, increasing regulation and a growing exposure to liability. Defining, measuring and maintaining quality within organizations is more important than ever, as the baby boomers march into their golden years with an expectation for high-end, cutting-edge programs and services.

"Consumers are doing their homework," says Chris MacDonell, managing director, CARF-CCAC, assisted living/adult day services.* "They are looking for what an organization does and how well it does it. They want to know where gaps exist and how the organization is addressing these areas for improvement." Boomers are diligently shopping for care for their parents. Tomorrow they will be purchasing retirement living for themselves.

The culture of long-term care is changing, and with this transformation comes changing notions of quality. Traditional quality assessment thinking often emphasized elements of "structure" (the human, physical and financial resources needed to provide care) or "process" (the technical and interpersonal activities that take place in a setting) over individual or population-based "outcomes" (the actual changes in a person's or population's health status). In the past, for example, a stroke patient's ability to walk farther after rehab therapy was viewed as less significant than the quality of the equipment and physical plant used to rehabilitate the person.

Fortunately, trends are shifting toward assessing the individuals being treated and their responsiveness to the care rendered. In a white

**CARF and the Continuing Care Accreditation Commission (CCAC) merged in February.*

paper, "Quality Oversight and Culture Change in Long Term Care," published in the *Journal of Social Work and Long-Term Care,* Deborah Wilkerson and MacDonell wrote that the "increased importance of consumerism is evident everywhere," and that the information age has only furthered this trend. Not surprisingly, their research shows that older adults want mostly the same things younger people want out of life: freedom to conduct their lives as they choose at the time of their choosing, supportive environments, the company of loved ones, and safe, comfortable surroundings.

Why is measuring quality across the continuum so difficult?

An Inconsistent Vocabulary and Competing Benchmarks

First, aging services lacks a standard vocabulary. The growing variety of senior care options creates fragmentation within health care systems, observe Michael Anikeeff and Glenn Mueller in "Senior Housing and Long Term Care: Defining the Business," published in the *Senior Housing and Care Journal*. This, they state, leads to confusion for consumers and "an inability to benchmark operating performance for managers and policy makers." Academic aging research initiatives are equally thwarted by the diverse and varied language in use. How do you discuss an intricate subject—much less problem-solve related challenges—without common, fundamental definitions?

> THE PUBLIC OFTEN DOES NOT ASSOCIATE QUALITY CARE WITH AGING SERVICES, AND YET INCREASINGLY DEMANDS IT.

Providers also find it a challenge to measure quality because they do not always know what target to shoot for in order to benchmark themselves against the competition.

"There are literally hundreds of resident satisfaction and quality assessment tools from which providers can choose," says Susan Ganson, director of quality at CARF-CCAC, "so it's hard for them to benchmark their organizations against 'the best' without one standardized measurement tool. What does 'the best' look like?" In addition, she notes that quality is a somewhat subjective term, and perceptions vary widely about what quality care and services mean for older adults. "One resident might consider a meal which is served at the proper temperature of high quality," she says, "while another might not be satisfied with a menu with less than six entrees."

A Common Vision, but Diverse Perspectives

Providers, payers, the government, insurers and quality oversight organizations, such as licensure and accreditation bodies, each play a role in revo-

Beyond the Minimum Data Set: LCRC Puts Quality First

A year and a half ago, Life Care Retirement Communities (LCRC), a multisite organization headquartered in Des Moines, Iowa, received a challenge from its board. It was asked to go beyond minimum quality data requirements and find the cutting edge. "We believed it was an essential step on the road to quality," says Karen Coburn, corporate compliance officer at LCRC. "We wanted to be ahead of the game."

The staff chose a quality tool* that met their needs, and by January 2002 all nine communities were submitting data for all of their residents.

"The quality tool … enables our organization to benchmark itself not only against a national, normative database, but also against the nine LCRC communities," says Coburn. Each month, the communities submit data and can run reports using numerous parameters. For example, the control charts reveal important quality data for each quality indicator. "You can slice and dice the data anyway you want, which makes these reports truly meaningful as we look to continually enhance our care and services." Each quarter, Coburn provides LCRC's Corporate Compliance Committee and board with a benchmarking report.

Two out of five Florida-based LCRC organizations have received the prestigious Gold Seal designation, awarded as part of a state-run program designed to showcase those facilities with exceptionally high standards of care, financial stability and quality of life. "Our communities are very competitive," says Coburn, "and the quality reports prompt them to strive for even better outcomes." The tool has also enabled LCRC to save time in assessing quality. "As we continue to progress in understanding the diversity of the software and apply the principles of quality improvement, we are beginning to see positive responses to our interventions, and that's extremely rewarding."

** EQuIP, software developed by the New York Association of Homes and Services for the Aging.*

lutionizing and revitalizing concepts of quality. It is not surprising that, with so many different entities attempting to enhance quality and ultimately transform a field in distress, there has been conflict. Ironically, only in recent years has the "consumer voice" been audible amidst the din of widespread wrangling about how to ensure high-quality care for a vulnerable population. Until these factions identify common incentives, they will be hard-pressed to create solutions that will effectively impact the field.

A Tarnished Image: Perception is Reality

An administrator once recounted the story of a young and somewhat green nurse she heard crying in a bathroom stall. When the nurse was prompted to explain why she was upset, she replied, "A resident and patient I was very close to just died. No one trained me for this aspect of my job. I don't feel like I'm being a very good nurse right now." The administrator responded by saying she had been, and was being, the "perfect nurse" by demonstrating extraordinary compassion while delivering high-quality care.

Unfortunately, these moments are not the ones the media spotlights. For every time a CNA works well into the night to care for, comfort and

Quality Indicators Across the Aging Services Continuum

Best Practices asked Deborah Wilkerson, chief research and education officer at CARF, her thoughts about quality aging services continuums today and in the future.

Q: What are the core components of an aging services continuum?

A: I think part of our challenge is that there is not yet universal agreement about the answer. Some would assert that, at a minimum, a full 'aging services continuum' would include access to independent living, assisted living, and skilled nursing, while others might feel that hospice and home health are inherent to that minimal structure. In theory, a full aging services continuum would be able to accommodate someone from a place of healthy independence to a place of extreme fragility and everywhere in between as his or her health needs change. It would be flexible and fluid enough to enable someone to move easily through it and progress wherever he or she needs to be as his or her conditions deteriorate or improve. And it would be transparent for consumers as they search for the right housing and services.

Q: Is it possible to develop quality indicators that would address the full continuum?

A: Yes, at some level I believe it is, but it depends on what you're measuring. If, for example, you want to measure how dignified a person feels in his or her care setting or his or her perception of how timely services are delivered, you could do that in each component that comprises the continuum. It wouldn't matter whether the individual was living independently or soaking in the last moments of life in hospice. There are certain domains you can apply universally.

If, however, you wanted to gain a more in-depth and broader assessment of a component's quality, such as assisted living, you could not apply that data set across all areas. The frequency of decubiti, for example, may be highly relevant in measuring quality in skilled nursing settings but not very meaningful in independent living.

There's a gap between where we are today and where we need to be in the future in measuring quality across the continuum. We might have a handful of generic data specs to apply to a full continuum, but these specs will not necessarily render the most accurate snapshots of more detailed views of quality in every component. I believe a combination of both uniform and specialized indicators is likely to be needed.

Q: What do you think are the biggest obstacles to measuring quality across a continuum?

A: Assessing quality is multifaceted, and providers are bombarded with hundreds of tools to help them do it. The end result is that we lack standardization, and we don't know which quality oversight entity should be responsible for leading the way and providing consistency to the field. Who is best equipped to develop these tools, and how are these entities going about it? Are consumers given ample opportunities to voice their preferences in focus groups? How do proprietary data systems impact these efforts?

Q: How can the field address these challenges?

A: It's important for the field to participate in discussions around where there might be commonalities in how we look at quality across settings or pieces of the continuum and keep an open mind about how we can cut to the core concepts using language understandable to all. It is also important for each component of the continuum to define in a uniform way those more specific quality indicators peculiar to that setting. For example, while being involved in one's own services, being treated with respect, and having choice are universals from independent living to hospice, these should be augmented with specialized indicators that may be relevant to only one component. This might include frequency of participation in the community at the independent living end and relief from pain at the hospice end.

graciously serve a frail and perhaps dying elder, the press is quick to showcase an instance when—to put it bluntly—the system failed. In turn, the public often does not associate quality care with aging services, and yet increasingly demands it.

Quality Solutions

Great leaders realize that, however difficult a situation seems, there are always ways to turn grim realities into exhilarating futures. Many would probably agree that the current state of quality assessment in aging services is well-intended and frequently successful, but ultimately lacking in consistency and cohesion.

Given this reality, how can providers embrace principles of quality assessment and foster superior outcomes in their organizations?

- *Find common ground.* Actively work with quality oversight organizations, regulators, insurers, consumer advocacy groups and other providers to define a common language to discuss quality.

- *Collaborate.* Help inform the standards, rules and codes quality oversight organizations develop so they are truly meaningful for your residents. Insist that you are at the table during these critical moments.

- *Mine gold together.* Break down perceived barriers of competition with other providers and band together to find solutions to common problems.

- *Focus on those you serve.* Emphasize notions of quality outcomes by focusing on those you serve as well as your employees. Sign the AAHSA Quality First Covenant and formally commit to this model of excellence.

- *Go beyond the Minimum Data Set.* Galvanize your troops and prompt them to find the leading edge in your quest for quality. Seek out respected accreditation programs and a quality assessment tool that best meets your organization's needs—all of which will prompt continuous improvement.

- *Educate consumers.* Arm consumers and consumer advocacy groups with information about your organization's commitment to quality in service.

- *Befriend the media.* Showcase living, breathing examples of quality in your organization before local and national media. Develop positive relationships with reporters in your area and don't wait to share your success stories. No one can tell them better than you.

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