Eden and Beyond:
Quality Management Isn't as Tough as It Looks

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The Eden Alternative, Wellspring, the Pioneer Movement—everyone has heard the names and drawn their own conclusions about these novel approaches to long term care. However, whatever one thinks about these models, the reality is that when programs such as the Eden Alternative are effectively introduced into a community, there are impressive results. For example, data from research conducted by Southwest Texas State University indicated a 50% reduction in the incidence of decubitus ulcers; a 60% decrease in difficult behavioral incidents among residents; a 48% decline in staff absenteeism; and an 11% drop in employee accidents. Clearly, Eden and similar programs seem to impact favorably on both resident and staff alike.

What's It All About, Eden?

Assessments about what such movements are really all about seem somewhat premature. Some have seen Eden as a program focused exclusively on nursing facilities, with limited relevance to other forms of facility-based care. The impression of others has been that Eden is a fringe philosophy consisting of little more than the integration of plants, pets, and children into the facility environment. That is possibly what led to early skepticism among nursing home administrators, who frowned on

the movement as impractical and expensive. What they failed to comprehend is that the "livestock"—as some derided the use of animals—was simply a *result* of program implementation, not one of its essential components.

These pioneer movements, however, all share common values. They are resident-centered; they look to what concerns the patient: the loneliness, the sense of helplessness, and the boredom. They all empower front-line staff to deal with those patient concerns and to make decisions regarding patient care and the environment in which that care is delivered. In short, they all share a customer focus—a determination to look at care from the resident's perspective and to empower staff to determine what will most satisfy each individual resident (whether that means birds, dogs, flowers, or something else).

However, premature assessment does not entirely fall to the pioneer movements' critics. In some ways, many of the movements' advocates seem to be unsure of what they have gotten into by aligning themselves with these programs. One called for a "change of heart" when it comes to changing long term care in this country. If this nation is going to improve the quality of old age in America, he argued, "we cannot rely solely on CQI [Continuous Quality Improvement]." However, CQI is *exactly* what leaders in this industry have to rely on; and that is the "change of heart." For CQI is precisely what the advocates of the Eden Alternative have gotten right. I am reminded of what one of my mentors in LTC argued when she talked about resident-centered care.

Business buzzwords like CQI and TQM reflect nothing more or less than customer-oriented management. It's what makes Nordstrom unique or Ritz-Carleton an example to be emulated and what leads people to flock to Disney for management training.

There is little doubt that quality management is a critical (if not *the* most critical) component in managing a successful long term care community. But many in the industry have assumed that it involves such a level of complexity and expense that they have feared placing it on an already overburdened list of "things to do." What's more, they just might have lost sight of the supposed beneficiary of these efforts: the resident "customer."

Sharpening the Resident Focus

In the economic environment in which *nursing facilities* operate these days, perhaps it was inevitable that *they* might lose their "resident-centered" focus. With essentially only one payer for the services delivered—the government, usually via Medicaid—it perhaps is understandable that many nursing homes would confuse the payer (government) with the customer (resident).

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In a true market-driven economy, however, it is the customer *receiving* the service who is in the best position to determine what that service should look like. By allowing the government to assume the role of customer, nursing homes guaranteed only that their product would meet government—not customer—expectations. Many would agree that the result has not been a happy one.

Assisted living has no such excuse; and ALFs have an opportunity to assess customer need and do so in concert with the customers themselves. That's really what quality management (QM) is all about. With an understanding of three basic principles and a respect for three related caveats, QM's implementation need not be that difficult at all—in nursing homes *or* in assisted living.

Tackling Quality Management

Quality management goes by any number of names, but Total Quality Management (TQM) and Continuous Quality improvement (CQI) are the most common. Additionally, there are specific to the nursing home profession the Eden Alternative, the Pioneer Movement, and Wellspring models. No matter the name, they all share basic principles; and they all begin (and end) with the customer.

Therein lies their relevance to long term care. In seniors housing and care, resident-centered care is really the only kind of care that has staying power. It's certainly the only type of care that can elicit customer and, by inference, political support. Therefore, a customer focus becomes the first and most critical principle of quality management.

The second principal of care is that facilities don't provide care. People do—adequate numbers of people possessing the necessary competencies. This calls for people working within well-understood systems and adhering to accepted standards established by management. And, most critically, it requires people imbued with a culture of caring functioning as empowered members of a *team* that reflects that same culture, that same customer focus.

Without the underlying concept of a multidisciplinary team, meaningful services cannot be delivered and successful programs cannot be

achieved, no matter what the geriatric setting is. Home care, adult day care, assisted living, nursing facilities—they all cry out for application of the principles of teamwork. To speak of the need for teamwork in long term care is to speak of the need to apply the geriatric model of service delivery. This must consider the unique nature of the elderly patient and the peculiar needs that separate him or her from other recipients of health care services. In *any* senior care setting, the team is the very reflection of the needs of the *geriatric patient*. It is a necessary function of the unique needs of the person *receiving* care, not of the setting in which that care is delivered.

However, the team cannot function without knowledge. This leads to the third principle: the need for customer-focused data with measurable and achievable management goals as their primary focus.

It all adds up this: Quality management relies on a staff, working as a team, empowered and motivated to achieve measurable goals that are focused on achieving customer satisfaction. Quality management is not quality management unless it reflects:

- a customer focus
- a reliance on data
- an empowered staff

All three are critical. None can be ignored.

Starting Over

So, where do we start? The need for quality teams seems to be a logical beginning. Addressing customer satisfaction with empowered staff teams is a hallmark of quality management. Equally, it reflects that companies have embraced "culture change" as a critical force driving quality and, by inference, value as perceived by the customer.

Different companies approach team-building for quality improvement from different perspectives. Some replicate the quality improvement team from the existing management team. The advantage to this is that it reduces meeting frequency and the resulting imposition on staff time. The disadvantage is that it won't and can't bring into the loop employees who would not normally participate in management team meetings. Those left out are typically front line staff who can be the most valuable resource in constructing quality improvement strategies.

While a combination approach can work (ie, management team meetings supplemented by teams at other organizational levels), care must be taken that facilities and interdisciplinary team leaders don't create the impression of a "two-tiered" system, where the "lower-level" teams are looked on as mere window dressing, leaving all major deliberations in the capable hands of senior management. Remember, the purpose of the quality improvement team is two-fold: the obvious initial goal of improved outcomes and customer satisfaction *and* development of a process that, conducted correctly, will *itself* improve corporate culture.

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Remember, the value formula—what customers value in a culture—rests on the twin concepts of quality and price. Improving quality helps improve perceived value—that is, the customer will notice and evaluate improved knowledge, skills, and attitude displayed by staff. Any process that by its very existence noticeably improves staff attitude will contribute as much to perceived value as the more tangible benefits of the caregiving process itself.

No Leaders, No Teams

It is impossible to talk about "teams" without addressing "leadership." For *teams* to function effectively, leadership is essential. Egalitarian societies are wonderful conceptually; their only drawback is that they don't work very well. Accepting the reality of leadership and designating a team leader does not violate the concept of an empowered staff, any more than a quarterback's play calling violates the concept of a football "team." The key to team success is how well the leader fulfills his or her responsibilities.

Team leadership comes in many flavors. It can be *self-centered* or it can be *inclusive*. The team can be *directed* or it can be *motivated*. It can *mandate activities and processes* or it can entail the techniques of *team problem solving with one-on-one coaching, as needed*. It is clear on which side of this ledger true culture change will occur.

One of the most effective (and enjoyable) methods for a leader to create a quality management culture within the team is to start with the development of vision and mission statements. Absent consensus on who the customers are and what their needs might be, the team is unlikely to achieve its goals. One approach would be to distribute a simple matrix among team members and ask them to describe at least three customers and what their expectations might be. This can bring real focus to one of the basic tenets of quality management, ie, a company has multiple customers—both internal and external—whose needs, at least initially,

might appear to be at cross-purposes with each other; and difficult decisions must be made.

A next step in the process might be to establish domains of care and service. What do leaders want to measure? What is it important to measure and why?

Improving Service

Management's ultimate purpose is to improve services, including the resident's sense of satisfaction with those services. Therefore, to the extent possible, the domains of service and care should be areas of need as perceived by the resident, not by management. That leads to caveat number one: A customer focus means just that. Facility priorities should be closely tied to customer perceptions. Management's involvement is important, but not preeminent.

A third step in the process consists of defining objectives that need to be met within the domains of service if the organization's vision and mission are to be realized. These objectives must be measurable in terms of both meeting expectations and time lines. An objective might be as broad as retaining customer loyalty or as narrow as reducing the wait time for service in the dining room. The criteria might be as broad as a decreased number of voluntary departures from the facility or as narrow as fewer minutes elapsed between seating and service during lunch. Achieving improvement might involve as major a step as establishing a meaningful resident council or a minor one such as changing staff assignments in the dining room.

After any attempted remedial action, the results must be measured, analyzed, and fed back into the goal-setting process so that further refinement or newer goals might be developed. (Remember, quality management is not a *project*; it is a *process*.) Good data is the key. The severity of a problem and the success of its solution can only be ascertained by generating clearly ascertainable data.

An effective quality management process operates at three levels:

- Community and corporate leadership, whose primary role is to understand and support the concept
- A quality committee, whose primary function is to oversee the process, provide appropriate resources (including training and data), and facilitate implementation of the remedial actions
- Quality teams, where the heavy lifting is done

All three levels are critical, but the consistent and unflagging support of leadership is at the basis of everything. Through its quality management commitment and strategy, management expresses its commitment to staff and—through staff—to the customer. Many have described such thinking as more fad than philosophy, pointing to examples of enterprises that have allegedly installed quality management systems only to see them fail. Failures *have* occurred—and research has shown that the primary cause was almost invariably shallow and/or sporadic management support. In short, team leadership will be the primary factor determining a community's culture and, as an offshoot, the quality team's success in achieving customer satisfaction and community profitability.

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Role of Data

It is impossible to implement and maintain quality management without data. Do you know whether resident complaints have been more pronounced recently in the dining room? How happy are your residents with housekeeping services? Where has line staff, which is closest to the customer, indicated a need for improvement? Have you used marketing focus groups or surveys of potential customers? Have they isolated areas requiring increased attention? Do you have data in *any* of these areas? Have you used *any* of these processes?

And, as important as data are in selecting *areas* of focus, they are equally critical for establishing appropriate *benchmarks*. If facilities are going to establish objectives within certain domains of service and care, how are we to judge them? Where have they been? Where are they now? Where do they want to be? By when? How do they know when we're there?

Certainly, in the nursing home industry (and particularly with respect to clinical indicators) government provides many of the tools for effective benchmarking. The Minimum Data Set (MDS) can be a real boon to quality management.

Assisted living has no such uniform tool, nationally or locally. But even the MDS has its limitations. Though we do need to know what is happening to the customer clinically, perhaps of even greater importance is to know how the customer *perceives* what is happening to her. Both are essential. Rosalie Kane, one of the nation's most respected students of long term care, sees this propensity of the MDS to "bypass" quality of life (as opposed to quality of care) as one of its greatest flaws.

While it might assess rates of bedsores and even risk-adjust them appropriately, it "misses what interests

ordinary people," she writes. Chuck Chakrapani (author of *How to Measure Service Quality & Customer Satisfaction*) says it best when he suggests that to measure outcomes absent customer satisfaction is "to measure something without context." *Especially* in long term care, resident satisfaction is at least as important as clinical and service outcomes.

This is where many assisted living communities have taken the lead. Much more so than nursing facilities, they have pioneered the measurement of customer satisfaction. This is no small task, as customer satisfaction can be *difficult* to measure in any care setting. There are numerous questionnaires available purporting to be the definitive approach to doing so. They are produced by academicians, consultants, providers, and the associations that represent them. The challenge is distinguishing between those whose primary purpose is marketing and those whose critical focus is management. (That, by the way, is caveat number two.)

Everyone has seen survey results that "demonstrate" astronomical levels of resident satisfaction. Indeed, they may help in keeping the facility fully occupied, but they are of little use to a management team looking for areas on which to focus its quality improvement efforts. For that, it is important to find out what makes the customer unhappy or dissatisfied. Only then can ALFs work on improving levels of resident satisfaction.

Remember, important as data are, however, this information is only a tool (albeit an essential tool) in the quality management process. Ultimately, the successful quality management program is a part of the very culture of the facility. It must be a critical facet of all its policies and procedures. It must be interwoven within the very fabric of the enterprise. A customer-focus is not just the responsibility of social services. Data-driven management is not just the responsibility of nursing. Staff empowerment is not just the responsibility of housekeeping.

All of these activities are everyone's responsibility. The only way to make that absolutely clear—to make it a part of the *facility's* culture—is for senior management to demonstrate regularly that it is a part of *their* culture as well. This is where quality management often has failed.

This leads to caveat number three: Paying lip service to quality management is to sentence it to an untimely death. Staff is intelligent, and they know when words are just words. They also know when management actually is committed to those words as reflecting something of real significance.

QM is More than Feeling OK

After all, quality management is more than just a "feel good" concept. It is just as much in line with *fiduciary* responsibilities. The pioneers of quality management (W. Edwards Deming, Joseph M. Juran, and Philip B. Crosby) did not see themselves as altruistic social innovators. They were businessmen looking to create tools for improving business results. For them, profitability was not a dirty word. They looked to quality management primarily as a means of *improving* profitability.

Critical also is the recognition that quality management is not a *project*. Rather, it is a *process*. That is to say that it never stops. It functions as a continuous loop. AL facilities and their leaders determine priorities based on customer satisfaction. They measure. They empower staff to stimulate improvement. They reexamine priorities. And they measure again. But they must begin the journey by returning to a system that places people—the customers—first. ALC

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From the Editor

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malpractice cases allows a first-hand view of these issues, providing the foundation for developing quality practices for one's own facility. In this issue of ALC, Dr. Scott M. Bolhack and his colleagues emphasize the importance of developing policies and procedures that are consistent both with residents' rights and their medical safety within an ALF.

Utilizing a resident-centered approach that requires a closer clinical focus on the part of ALFs produces positive outcomes for all involved. This approach can greatly increase the comfort and well-being of residents, whether from improved vision, elimination of urinary incontinence, or a delay in the progress of dementia. In addition, ALFs benefit by a significant increase in their occupancy, through attracting residents to the facility, as well as maintaining residents in the facility longer through improved health outcomes. This has been demonstrated by hard results in the resident-centered models that have shown 50% reductions in geriatric clinical issues in the areas of decubitus ulcers and behavioral incidents.

Of course, health outcomes are not the only items improved by a resident-centered focus—staff absenteeism and incidents such as employee accidents also are positively affected. By providing resident-centered care through a quality-driven interdisciplinary approach, everyone can benefit. However, the trick is doing more than just writing and talking about being resident focused, but really doing it as a team. ALC

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