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# The Numerous Facets of Quality Care

## *Les nombreuses facettes des soins de qualité*

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### **Abstract**

The concept of quality care is viewed from several different perspectives: those of society, the professions, the client and family, the client's immediate community, the employer, the funding agency, the referral source, and the professional. The consequences of failing to provide quality care are discussed. Various strategies for measuring quality are outlined with the main focus on Quality Improvement. Changes associated with Quality Improvement are presented, including self-directed teams and product line management. In the final section, factors potentially influencing quality care in the next decade are discussed, with emphasis on the greater use of supportive personnel, the right-sizing of management personnel, family centred intervention, personal special needs funding, and indirect costs associated with services.

### **Résumé**

*La notion de soins de qualité est envisagée selon plusieurs points de vue différents : celui de la société, des professions, du client et de sa famille, de l'entourage immédiat du client, de l'employeur, de l'organisme de financement, du médecin référant et du clinicien. Les conséquences découlant de l'absence de soins de qualité sont abordées. Le document traite de diverses stratégies d'évaluation de la qualité des soins en mettant l'accent sur l'amélioration de la qualité. Des changements susceptibles d'améliorer la qualité des soins sont énoncés, telle la mise en place d'équipes autonomes ou encore celle d'un système de surveillance des produits. Dans la dernière partie sont abordés des facteurs qui pourront influencer sur les soins de qualité au cours des dix prochaines années, notamment l'utilisation croissante de personnel de soutien, la réduction du nombre de cadres, l'intervention axée sur la famille, le financement des soins spéciaux et les coûts indirects associés aux services.*

*Warning! Reading the Following Article May Challenge Your Internal Perceptions of Quality. Extensive Discussion With Your Colleagues is Advised!*

On a more serious note, the reader is advised that many of the statements made in this article represent the author's personal views. Very little has been published in our field discussing

perceptions of quality care. As a result, interpretations presented in this article reflect the world as seen through one person's eyes. The only feeble justification offered to excuse such conceit is that the author has been around for a long time - twenty years since becoming president-elect of the Canadian Speech and Hearing Association (now CASLPA). So, having established the right to be called an "old bird," the reader is left to decide (preferably after reading the article) whether the modifier "wise," "misinformed," "alarmist," or some other descriptor should be added to the author's credentials. Whatever the reader's decision, it is hoped that everyone will agree that the topic of quality care is of vital importance to our profession and deserves our immediate energetic attention.

For those of you into self appraisal, reflect upon the following: How do you internally define quality care? Have your perceptions changed over time? What are the external benchmarks you use to make judgements of quality? Before reading on, you may wish to turn to the Appendix and complete the questionnaire as a pretest. One year from now, review your answers and see what has changed!

### **Definition of Quality Care**

From our earliest memories as students entering our first practicum, each of us has been committed to the concept that we should provide the highest calibre of care to each and every client we serve. Even those clinicians who may have become jaded over the years with the day by day task of devising new strategies to motivate clients to approximate more closely that elusive goal in therapy, would maintain strenuously that they still strive toward the highest quality of care. Throughout our professional education we are taught that, in general, no effort is too great if it will provide better service to the client. The ethical expectations of our colleagues and our professional organization also exhort us to maintain the highest standards of care. Quality is accepted to mean a degree of excellence. But what is quality care? Are there parameters that can be identified to assist in recognizing what constitutes quality?

### Society's Definition of Quality Care

Personal experience over the last three decades suggests that society has distinct expectations as to the parameters of quality care. Discussions with colleagues and with politicians verify these beliefs. Society has an expectation that each person referred for services will receive a comprehensive evaluation of his/her needs and that these needs will be met in a timely, efficient, and effective manner. Society has an expectation that those clinicians who are hired to provide services are at the forefront of knowledge in the field. Society acknowledges that there may be situations when a second opinion may be desirable, but there is an expectation that the local clinician will recognize when referral to a specialized facility is called for and that the local clinician always has the skills and equipment necessary to provide appropriate intervention. Over the last decade society has also become considerably more sophisticated regarding specialized services that have an impact on quality of life and learning. Therefore, society expects equal access to services regardless of geographic location. Unfortunately, society's increased awareness of services that should be provided has not been matched by an awareness that the services provided may not result in an end product of normal function. The major elements of society's expectations regarding quality care are summarized in Table 1.

**Table 1. Quality care: Perceptions of society.**

<ul style="list-style-type: none"><li>• comprehensive evaluation of needs</li><li>• needs met—timely, efficiently, effectively</li><li>• highly knowledgeable clinicians</li><li>• needs met locally</li><li>• equal access regardless of geographic location</li></ul>
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### The Professions' Definition of Quality Care

Our professions also dictate elements of quality care through standards related to ethical practice. Implicit in membership in the Canadian Association of Speech-Language Pathologists and Audiologists is an agreement that we will abide by the ethical standards of the Association. The CASLPA Canon of Ethics (May 1992) begins by emphasizing that "the preservation of the highest standards of integrity and ethical principles is vital to the successful discharge of the responsibilities of all members" and "the ethical responsibilities of the members require that the welfare of those served professionally be considered paramount."

The Canon is separated into three sections. The first is related to duties and responsibilities to the client and public. It includes a requirement that members provide only those services for which they have been adequately prepared and not

misrepresent their qualifications; that members must adequately supervise students and supportive personnel; that members must not discriminate in any facet of their professional relationships; that members must respect the intrinsic worth of their clients and not exploit relationships with them; that appropriate referrals should be made to ensure comprehensive service to the client; and that information must not be shared without the implicit consent of the client.

The second section of the Canon relates to duties and responsibilities to the profession, including not accepting compensation for making a referral; avoiding a conflict of interest; not engaging in clinical practice for any commercial manufacturer; avoiding advertisements that might mislead or misrepresent; promoting harmonious relations with professional colleagues; not dishonouring the reputation of the professions; seeking to advance services for our clients; disseminating research and developments through professional channels for comment prior to disseminating it to the public; and advising and cooperating in dealing with any violations of the Canon. The last section of the Canon is headed "General" and states, "No member shall engage in conduct or an act relevant to [the] practice of speech-language pathology or audiology that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional."

Over the years there have been several changes to the Canon of Ethics. This is to be expected as the scope of our activities changes and as society's values change. However, some basic principles remain the same and serve as an excellent means by which to monitor our skills and performance. In many ways the Canon reminds us of what we should *not* do rather than delineating what we should do. The major elements of CASLPA's Canon of Ethics as it relates to our professions' expectations regarding quality care are summarized in Table 2.

### A Practical Perspective on Quality Care

Comparing the parameters of quality care as perceived by society and by our profession (Tables 1 and 2) shows that there is relatively little overlap. Quality is a term that relates to internal perceptions. As with all perceptions, it becomes a question of "in whose eyes?" Each different category of consumer with whom we interact will have a different perception of what constitutes quality. It is therefore necessary to examine the question from a variety of perspectives: the client and family; the client's immediate community; the employer (of the professional); the agency which funds the services; the person who makes a referral for services; and the professional. On a daily basis these are the consumers who are most involved with the product of service delivery.

**Table 2. Quality care: Perceptions of the professions.**

<p><b>CASLPA Canon of Ethics</b></p> <ul style="list-style-type: none"> <li>• abide by ethical standards</li> <li>• highest standards of integrity</li> <li>• no unprofessional conduct</li> </ul> <p><b>Duties and Responsibilities to Client and Public</b></p> <ul style="list-style-type: none"> <li>• only provide service wherein adequate preparation</li> <li>• no misrepresentation of qualifications</li> <li>• adequate supervision of students and supportive personnel</li> <li>• no exploitation of relationship with client</li> <li>• respect intrinsic worth of clients</li> <li>• ensure comprehensive service through appropriate referrals</li> <li>• client consent required prior to sharing information with others</li> </ul> <p><b>Duties and Responsibilities to Professions</b></p> <ul style="list-style-type: none"> <li>• no compensation for making referrals</li> <li>• avoid conflict of interest</li> <li>• no clinical practice on behalf of commercial manufacturer</li> <li>• no advertising which might mislead or misrepresent</li> <li>• promoting harmonious relationships with colleagues</li> <li>• no dishonouring the reputation of the professions</li> <li>• advancing services for clients</li> <li>• disseminating research and developments through professional channels</li> <li>• advising and cooperating whenever ethics are violated</li> </ul>
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### The Client and Family

Clients and families come to the clinic with a set of preconceived notions. They will judge the quality of the services they receive based on those notions. Notions can be modified to some extent through client and family education, which is an on-going aspect of service. However, notions are seldom eradicated, and the perceived success of outcomes will always be coloured by the initial set of expectations. Despite the results often reported from satisfaction surveys, few clients and families feel sufficiently secure to be able to give honest responses to questions related to their levels of satisfaction with the services provided. Most people who respond to surveys are content with what they have received, and even those who have some concerns feel constrained to mask their true feelings. Most people feel their answers should be positive for some of these reasons. First, they are dependent on the professional's goodwill if they desire an on-going relation-

ship. Second, they believe that professionals are probably doing the best they can "under the circumstances." Also, the professional may convey an impression that education and expertise are the only valid parameters in the disposition of services. Finally, the parent/family wish to be seen as being cooperative and willing to do whatever is necessary to assist the client.

If it were possible to glean honest responses from clients and families, we would probably find that they are dissatisfied when the waiting period for service exceeds a few days. They are also dissatisfied when the evaluation merely confirms what they had already identified as the problem and, without elaboration, they receive assurance that "it will go away" or are not offered the opportunity of immediate remedial action. Being placed on a waiting list has a detrimental effect on motivation and increases frustration levels for all parties concerned. On average, clinic waiting lists are an inevitable fact of life. All these potentially negative reactions are possible even before the client is actually seen for treatment. If the above statements regarding potential dissatisfaction are true, then few of our clients will be happy with the services we provide. As professionals we must explore the families' expectations and attempt to meet them. If families' expectations are unrealistic, we must assist them by providing opportunities for them to see that their expectations cannot be met.

Patient satisfaction data frequently are collected for marketing purposes in American hospitals and health care facilities. However, this information is seldom used as the basis for developing health care protocols or making changes to improve quality of care (Prehn, Mayo, & Weisman, 1989). Prehn et al. (1989) suggest that patient satisfaction should be considered in all aspects of service delivery that relate to "affective content," for example, the attentiveness and courtesy of staff, and the comfort of the facilities, but patients' evaluation of the technical aspects of care (such as predetermined protocols) may not be relevant. Prehn et al. also comment that patients can provide valuable insight into whether they were given adequate information to make choices. Satisfied patients are more likely to cooperate with their caregivers and to follow their recommendations, which has a direct impact on quality care (Donebedian, 1980).

What would it take for clients and families to feel that they had received quality care? Frank responses to such a question would probably include statements such as:

- the family's request for service should be the only referral required;
- the evaluation should be scheduled within a few days of the referral;

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- the evaluation should be quite informal (many clients and families react negatively to the unexpected two hour battery of tests which we frequently undertake); after all everyone can talk, so families believe that it should be relatively simple to identify the cause of the problem and "fix" it;
- the fix should be available immediately and not take longer than a couple of sessions to implement;
- and the clinician should be responsible for the intervention process because family members do not have the necessary professional skills.

The preceding statements do not cover all clients and families. However, the statements probably reflect the expectations of the majority of clients that we serve. These expectations are summarized in Table 3.

**Table 3. Quality care: Perceptions of the client and family.**

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| <ul style="list-style-type: none"><li>• direct referral privileges</li><li>• waiting period for appointment should not exceed a few days</li><li>• immediate feedback and reassurance or "action"</li><li>• attentiveness and courtesy of staff</li><li>• sufficient information to make choices</li><li>• informal setting, short sessions</li><li>• clinician as intervenor, not family member</li></ul> |
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## The Client's Immediate Community

The perceptions of people in the client's immediate environment (friends, teachers, aides, social workers, or other caregivers) will probably be quite similar to those of the family. The major differences will probably be that caregivers are likely to be more aware of the actual impact of a communication disorder on daily interactions and that external assistance (from a speech-language pathologist or audiologist) offers the opportunity to provide hope to the family. Familiarity with the service delivery system may increase caregivers' tolerance of waiting lists, provided a firm date for evaluation or treatment is given. Promoting access to an external authority, such as a Speech and Hearing Clinic, also may be a way for caregivers to deflect some of the inappropriate expectations families harbour in their hearts. But in the final analysis, caregivers' judgements about the quality of services provided are likely to be based on values similar to those of the client and family.

## The Employer

The agency that employs speech-language pathologists and audiologists will evaluate the quality of services from a different perspective than those of the professional or the client and family. The judgements of clients and families will always be of paramount importance to the employer, but seen from a collective rather than an individual perspective. Employers generally regard waiting lists as a justification for service rather than as a hindrance to access. Employers place great emphasis on verification of a professional's qualifications and previous employment experiences as a mechanism to ensure on-going quality. Employers require confirmation that the services offered are in compliance with the mission statement of the agency and that intake and discharge criteria are consistent with services offered throughout the agency. Employers require documentation that services are being provided in an efficient manner, which compares favourably with the workload statistics of sister agencies. The ability to work harmoniously and productively with other professionals (internal and external to the agency) also is used frequently as a yardstick of quality.

Grants, publications, presentations, positive reporting by the media, and all other forms of external recognition count significantly towards perceptions of quality. The ability to maintain a full complement of staff with low levels of absenteeism for sickness and low turn-over rates, combined with the ability to operate within budgetary constraints established for the year, also are perceived as important components of quality. For many employers, a department that operates without the need for frequent guidance from Administration is a department that has competent leadership and is providing consistent and appropriate service. Unless the department is perceived as having a high value within the organization, frequent proposals for innovations are likely to be received negatively rather than positively. The parameters that indicate quality care from an employer's perspective are summarized in Table 4.

## The Funding Agency

The majority of audiology and speech-language pathology services offered in Canada are funded by provincial governments, usually through the departments of Health and/or Education. It is only relatively recently that a mandate for providing services has been established. As an example, in 1988 "speech therapy" services were mandated for the residents of Alberta with the funding and coordination of services being assigned to Alberta Health. Prior to that time jurisdictions had the prerogative to provide services at their discretion using existing funds. Based on their knowledge of the state of

**Table 4. Quality care: Perceptions of the employer.**

- general satisfaction of consumers
- waiting lists justification for service
- verification of clinicians' qualifications and previous experience
- services in compliance with mission statement
- admission/discharge criteria consistent across agency
- comparable workload statistics with sister agencies
- harmonious relationships, internal and external
- external recognition (grants, publications)
- low absenteeism, low turn-over rates
- operation within budgetary constraints
- frequent proposals for innovation may be negative

the economy, the Alberta Government determined the level of funding that could reasonably be allocated to speech therapy services. The dollars designated as available were pro-rated according to Alberta's population figures, thereby establishing target ratios of service. Target ratios of service exist in other provinces (e.g., British Columbia has targets for the preschool population, for school aged children, and for the general population). Most government agencies hasten to clarify that the target ratios established do not reflect their perceptions of the ideal level of service, but rather are a direct reflection of the monies that have been designated for the service. It is hoped that these monies will be supplemented over time, but the economic climate in conjunction with public pressure will determine year by year whether funding levels increase or decrease.

What are the parameters that provincial governments use to determine whether quality care is the outcome of the funds they have invested? In order to define these parameters it is necessary to identify why governments fund services in any area. The public elects representatives who are charged with monitoring the use of public funds (i.e., taxes) to ensure that monies are expended wisely to secure those services (be they garbage collection, protection of the environment, medical, or educational services) that the public has determined are necessary to a desirable quality of life. The wisdom demonstrated by each elected representative in voting for, and supervising, the use of public funds (in the manner that the public decides is appropriate) will determine whether each representative can hope to be elected again. Because most provincial elections occur every five years, government tends to plan in five year cycles. The fact that "speech therapy services" have been authorized as a necessary expenditure (i.e., mandated) in provinces such as Alberta is a tremendous step forward for our profession. One of the motivating forces behind the mandate

was the volume of both requests for service and complaints about inadequate access to service. Public interest was identified as being sufficiently high that government included services to people with communication disorders as one of the priorities for the use of public money. At the same time government is under continuous pressure to restrain the level of funding provided for health and education. The end result is a constant need for accountability. Governments must be able to demonstrate in tangible ways that money was well spent. One of the challenges to government is that they allocate funds to agencies to provide services, but each agency is administered by an independent board (as in health clinics, school boards, and hospital boards). As a result, the actual control exerted by government is one step removed.

Bearing in mind those factors that carry significance for government, quality care will be evaluated according to the following parameters. Equality of access to services is of vital importance to governments; all stakeholders expect to be able to benefit from publicly funded services regardless of their geographic location. The explanation that "the health unit has been unable to hire a replacement speech-language pathologist for the past twelve months" is not acceptable to the residents of small remote towns. Public satisfaction with the services provided is measured by the lack of complaint about services rather than by the rare accolades received about the excellence of service. Quality care tends to be measured in terms of workload statistics—the number of clients seen and the number of client attendance days averaged across the number of professionals employed to provide the service. The length of waiting lists only becomes significant when it generates complaints from consumers (either clients or those referring clients for service). Proposals for innovative programs are more likely to receive positive attention if it can be demonstrated that the program will expand services to those currently unserved or reduce the amount of time clients spend in therapy so that greater numbers of clients can be served. Governments seldom fund programs whose sole purpose is to incorporate changes at the "cutting edge" of knowledge unless there are grounds to believe there will be an associated significant reduction in cost. Providing services in a better way may not be interpreted by funding agencies as being a parameter of quality care. Table 5 summarizes the factors that are typically considered by funding agencies as demonstrating quality.

**Table 5. Quality care: Perceptions of the funding agency.**

- equality of access to services
- public satisfaction equated to few or no complaints
- volume of clients discharged
- strategies to service unmet needs, expand volume or reduce costs

### **The Referral Source**

The nature of the relationship between those who make referrals and those who provide service will alter significantly the factors that are considered when determining if quality care exists. For example, if services are provided in an acute care environment in which the daily findings of the audiologist influence the surgical decisions of the otolaryngologist, then perceptions of quality will be directly related to the professional competence and thoroughness of the audiologist. On the other hand, a family physician who makes less than five referrals per year to the speech-language pathologist at the local health unit will probably base his perceptions of quality on the length of time his patients had to wait for an appointment rather than on the specific competence level of the clinician.

People who make frequent referrals to audiologists and speech-language pathologists also equate quality with the conciseness of the report. If the report is received promptly and contains information relevant to the referral in an easily readable format, then quality is likely to be perceived. A long comprehensive report is viewed negatively, particularly if the referral agent sees the content as irrelevant or of minimal importance. A long comprehensive report that arrives six months after the referral is likely to be perceived as doubly negative ("if only they would do what they were asked rather than covering the waterfront, they would not have such long waiting lists").

Most referral agents are interested primarily in the identification of the problem. Esoteric intervention strategies are regarded as irrelevant. The needs of the person receiving the report are of paramount importance, and there are other places in the file where it is possible to document what is important to successive clinicians.

### **The Professional**

As discussed earlier, the professional enters clinical practice with many expectations about quality care already firmly embedded in her/his mind. Superimposed on these expectations are the realities of daily practice. Many new graduates have unrealistic expectations of themselves and may fail to value the client's participation in determining outcomes. There is a tendency for estimations of self worth to be closely tied to what is achievable when viewed under the microscope of quality. The reality of clinical practice is that waiting lists prevent immediate access to service, clients may not be scheduled for the optimum intensity or duration of therapy, insufficient homogeneity of caseload eliminates the potential for group work, families may become dissatisfied with the serv-

ices provided and official complaints are made, and so on. It is unmanageable factors such as these that cause many clinicians to perceive that they have failed to provide quality care to their clients. Many of those who enter the helping professions tend to be naive about what can be achieved in a practical sense, particularly when the client is not making direct payment for the services s/he desires. If a local acute care hospital directs its occupational therapists to diagnose and meet the communication needs of their stroke patients, the profession's voice raised in concern will not magically create the monies necessary to fund a position for a speech-language pathologist. Such frustrations can erode the energy levels of clinicians and cause them to be highly dissatisfied with their own levels of performance.

### **External Factors That Currently Influence Quality Care**

In situations in which funding does not support adequate levels of service or in which manpower shortages restrict an employer's ability to fill vacant positions, quality care will be compromised. Across jurisdictions in Canada the volume of potential clients far exceeds the capacity of agencies to provide services. As a result, some populations, either because of geographic location or type of disability, are denied access to service. Even in areas where services are relatively plentiful, restrictions are invoked so that available resources are spread in the most equitable manner. In such scenarios, clinicians frequently must compromise their perceptions, of the ideal therapeutic environment. To many clinicians, any form of compromise automatically impedes their ability to provide quality care.

The mission statement of an agency and its policies regarding the type of care to be provided may also limit a clinician's ability to offer a full spectrum of service. Clinicians frequently lament that their employer does not have the funding flexibility to authorize them to provide the frequency or duration of treatment and the followup they believe their clients require. An inability to provide followup is particularly stressful when alternate services are not available in the community. For example, this type of situation occurs when a hospital has funding to provide services to inpatients but does not have funding to extend those services to outpatients. Under such circumstances clinicians may respond by recommending that clients continue in an inpatient program beyond the point at which the client is ready to face the challenges of returning home. While this situation may allow the client to receive the necessary therapy that could not be provided in the community, quality care is violated for the client, for members of the professional team assigned to the program, and for those clients awaiting admission to the program.

While society at large has become much more sophisticated regarding the need to provide services to people with communication disorders, the general level of understanding is still superficial. Even colleagues that we work with on a daily basis seldom appreciate the scope of communication disorders or the pervasive negative influence communication disorders can exert over many aspects of interaction. The consumers of our services (used in the broadest sense) are consistently amazed that intervention for most communication disorders spans months rather than days. In many instances, the nuances of change we are able to facilitate may not be perceived by naive audiences as changes in language skills but rather as changes in self confidence and group interaction skills. With only a small proportion of the clients we serve are the changes dramatic. Does this mean we should restrict our services to the 0.05% of the 10% of the population who exhibit communication disorders who are likely to achieve dramatic improvement? If we did restrict our client load in this way, it would certainly make it easier to demonstrate quality care both to our consumers and ourselves. But we believe that many clients with various types and degrees of communication disorders are able to benefit from, and deserve, access to service. Any denial of access to evaluation implicitly compromises quality care. If we are to continue to offer services to the broad spectrum of persons with communication disorders, then the need for more dynamic, continued education of all consumer groups is imperative. In addition, we have a professional responsibility to explore alternative cost effective strategies to provide services to those groups who may be denied traditional treatment.

## What are the Consequences of Not Providing Quality Care?

As new graduates, many of us tend to concentrate on the immediate act of working with our clients. Having secured a position that, we hope, will allow us to expand our knowledge base in those areas that are of the greatest interest to us, we tend not to look beyond the here and now. But it is becoming increasingly important to focus on broader professional responsibilities and on our perceived image in society. In the past we have tended to downplay the concerns of administrators to demonstrate successful outcomes from specific intervention strategies and programs, and the most efficient and effective use of our resources. After all, we *know* that our clients and families need us, and we *know* what is best for them! Does our conceit know no bounds?!

As the competition becomes increasingly fierce for the education or health care dollar, we must be able to demonstrate vividly that what we do works (i.e., is effective), that what we do is done efficiently, and that we are the best people to do

it. Phrased in another way, we must develop mechanisms that dynamically display the quality of care we offer. As if that were not a sufficiently ambitious challenge, we must also be prepared to demonstrate that the services we offer are an efficient use of the public dollar (or the client's dollar for those in private practice). We are ethically bound to pick up this challenge. Each one of us as a professional has as great a responsibility as any elected government official to ensure we are not squandering the funds that have been entrusted to us to provide a service that society has deemed to be important and necessary.

For our professional survival we must also pick up the challenge of accountability, the challenge of demonstrating effective, efficient quality care. There have been many jurisdictional battles between audiologists, hearing aid dispensers, and otolaryngologists. To date, speech-language pathologists have been less challenged by people working in associated areas, but we should be aware that our arena of professional practice spans a broad area. Some of the other professionals who work in those areas are beginning to challenge our right to be there. Who should take the lead in working with children whose language deficits are causing learning problems in school? Who should take the lead in identifying clients who may aspirate while eating? Who should take the lead in intervention for the client who has a functional voice disorder? I predict that the competition over disputed areas of practice will increase rapidly. We must be secure in our own minds that we have a significant role to play in these disputed areas and that we have completed the necessary ground work to do so, so that the public and our employers will be equally convinced that we have skills and knowledge to contribute.

## The Measurement of Quality Care

It is no longer sufficient to have internal standards of quality. We need to measure the effectiveness of our outcomes. We must devise effective ways to measure tangibly what we mean by quality care. The mechanisms used to demonstrate quality must also be meaningful to our consumers. We need long term, more effective survival skills to succeed in a competitive and cost-driven system (Taubman & Frittali, 1992). Over the past decade, hospitals and some professional groups have shown a concern for quality, which has been monitored through Quality Assurance (QA) programs. QA programs have evolved in many different ways, some of them being dynamic, while others tending more towards retrospective audit. In many programs the emphasis has been on verifying that the practitioner complied with established protocol. In the last couple of years however, the emphasis has changed to the process rather than the practitioner. The focus has now changed to one of what can we do that will improve the outcome, reduce the

duration of intervention, and increase the number of people we can serve? This new perspective is known as *Total Quality Management (TQM)* or *Quality Improvement (QI)*. As Carol Frittali<sup>1</sup> expressed it, "Rather than managing quality to discipline those practitioners on the extreme left [of the bell curve], today's objective is to move the entire bell curve of quality to the right." One of the reasons that TQM and QI have come into vogue is the new wave of reduction or elimination of management positions that is being experienced throughout industry of every type. (For readers who would like to explore the practical and emotional impacts of such change, Scott and Jaffe [1991] is recommended reading.) TQM requires total acceptance by the whole organization. Because most of us are not in situations in which we can decide what the whole organization will adopt, the more manageable concepts of QI will be presented.

### A Quality Improvement Cycle

A quality improvement program bears close resemblance to the quality assurance activities with which many of us are familiar. The sequence followed is outlined in Table 6. The major difference in focus is that attention is directed towards the process and outcome rather than upon the activities of a specific practitioner in meeting a set of standards.

Externally created standards of quality tend to elicit defensiveness and resentment. If standards of quality are derived internally, then each individual identifies with the process and is committed to perform at that level or higher. If the group (or team) sees itself as mutually dependent, then the challenge becomes one of finding ways to assist colleagues in removing unnecessary barriers to the activities that need to be performed.

A QI program can have a direct effect on the way in which services are offered or cultivated to meet the needs of specific environments. The QI program offers an avenue in which new ideas can be evaluated and implemented. The direct results will be determined by the projects selected. However, there are a number of associated changes which may, or may not, be directly attributable to the QI program.

**Table 6. A Quality Improvement cycle.**

1. Obtain group consensus and commitment to a Quality Improvement program. Identify who will have primary responsibility for coordinating the process and ensuring effective communication.
2. Determine which parameters will be encompassed under the QI program, e.g., characteristics of clients, disability groupings, services provided, by whom, etc.
3. Determine which aspects of service will be monitored, e.g., high volume activity areas, areas where there is greatest concern for complications, or known problem areas.
4. Identify quality indicators that have the greatest meaning to staff, i.e., measurable variables that relate to structure, process, or outcome of clinical care. Establish realistic thresholds for compliance with these indicators. [N.B. A threshold is different from optimal standards of care.]
5. Determine appropriate data sources, data collection, sampling, and analysis methods within a specified time frame.
6. If a satisfactory threshold level has not been achieved, data should be reviewed to determine whether there are opportunities for improvement, e.g., trends over time, peer review of specific instances against accepted standards, and experience.
7. If appropriate, an action plan is developed specifying the parameters of change expected, assigning specific responsibilities and strategies and determining when it should occur. The action plan is then monitored to evaluate changes and document improvement. As thresholds are met they may be increased to continually strive towards improved quality of care. Relevant information from this cycle should be communicated to appropriate levels of the organization.

*Adapted from "How to Establish a Quality Improvement Process: A Ten-Step Model" developed by the American Speech-Language-Hearing Association Committee on Quality Assurance, draft June 1991.*

### Self-Directed Teams

Many of us work in environments in which we function as a member of an interdisciplinary team. Typically in these situations, we are responsible to a department for our professional expertise and to a team for the daily management of clients. One of the outgrowths of a QI perspective is that the team identifies where changes in process should occur. In that sense, it is the team that authorizes change and monitors compliance. The team gives authority to various members to implement change and serve as a spokesperson if necessary. There is no automatic tie-in with departments per se. Taken

<sup>1</sup> Carol Frittali, Ph.D., Director, Health Services Division, Professional Practices Department, American Speech-Language-Hearing Association, in her presentation at ASHA's Quality Improvement Workshop, Indianapolis, 1991.



to its logical conclusion, self-directed teams will select and hire those people whom they feel will fit in with the values and culture developed by the team.

Self-directed teams will impact on our perceptions of quality care. The perception of quality will take on a more global perspective. Issues related to communication disorders will be weighed against issues related to all the other aspects of the client's needs. As long as the clinician can verify internally that no aspects of the Canon of Ethics are being compromised, the client should be served equally well. When members of the team find themselves in disagreement, the clinician may find it a greater challenge to convince the team than it would have been to convince one's colleagues within the same professional discipline.

### **Product-Line Management**

As self-directed teams become more autonomous, the value of departmental affiliations might be in question. Organizations will ask whether a program-based structure is more efficient than one that is departmentally-based. This system has been adopted in part by a number of hospitals in the United States. Some of our American colleagues now have a dual role, for example, director of the Department of Communication Disorders and co-director of the Stroke Program. In this scenario, the other co-director frequently is a physician who retains clinical responsibility for patients enrolled in the program, while the speech-language pathologist or audiologist, who is co-director, is responsible for the business/administrative aspects of the program. The next question becomes how long will it be desirable to retain a Department of Communication Disorders. The implications for quality care are very similar to those related to self-directed teams except that clinicians may feel a greater sense of isolation from the professional discipline under this new form of organization.

### **Quality Care in the Next Decade**

Reflecting upon the changes that have occurred within society over the last five years, it seems that the next ten years will be a time of even more rapidly escalating changes. Many of the changes to come cannot be predicted. We only know that they will require us to review our value statements frequently and modify our approaches to match society's expectations. However, there are some changes currently evolving that may have a dramatic impact on who we are and what we do, particularly in terms of the definition of quality care.

### **Supportive Personnel**

The use of program assistants will increase. As budgets become more constrained, programs will be forced to explore ways of providing the same level of service with fewer dollars. Agencies will find themselves under increasing pressure to reduce the number of professionals and supplement their numbers with lower cost supportive personnel. As this occurs we will find ourselves posing additional questions about quality care such as:

- how many program assistants can be supervised by one clinician without jeopardizing quality care?
- what type of educational preparation is necessary for a program assistant and by whom should that be provided?
- what strategies can clinicians develop to allow them to feel comfortable with the quality of care provided when their role becomes more consultative and supervisory, rather than direct-service oriented?
- what distinctions will be made between a clinician with a bachelor's degree in Speech-Language Pathology and an assistant with a two-year college program in Communicative Disorders post a non-specific B.Sc. and what distinctions should be made to families so that they understand the respective quality of services being offered?

### **Right-Sizing of Management**

In concert with QI programs and the establishment of self-directed teams, many hospitals have undertaken significant restructuring. In many instances the supervisory level has been severely curtailed, and in some instances it has been totally eliminated. The elimination of supervisory positions has removed one of the clinician's primary sources of feedback regarding the quality of her/his care. Clinicians, accustomed to having a supervisor evaluate their performance, may find that their own self-evaluative skills have become dormant. In this new era, the whole area of performance appraisal and self evaluation of quality will become each clinician's responsibility. Clinicians not only must become their own evaluators, but also evaluate their peers, a potentially uncomfortable situation for people who instinctively look for the positive in everything they encounter! There will probably be many task forces established over the next few of years to assist clinicians in developing new strategies and new methods for devising mutually agreeable self-appraisal standards. These changes may be equally uncomfortable for administrators because their own perceptions of quality care and the mechanisms for monitoring it also will require significant change.

### Family Centred Intervention

There is a move towards making the client's constellation the focus of service rather than the individual client. An integral component of this approach is that the client and family determine what intervention will be received. The clinician's role is to provide information about the options available and alert the family to effective strategies to obtain the assistance the family feels is most appropriate at that time and place. Clinicians may find themselves in conflict when families select options the clinicians feel are not in the client's best interests. There may be situations in which a clinician feels s/he is being denied the opportunity to provide quality service. There are many subtle role changes necessary for all parties if a true family focus is adopted.

### Personal Special Needs Funding

There is a movement towards giving families greater control in the selection of services for people with special needs. Should this become reality, families may be able to select which types of services they wish to purchase from which agencies. This level of control over the funds allocated by government to address special needs for individuals may result in very different patterns of clinical intervention. Agencies and practitioners will become much more dependent on the public's perceptions of the quality of their services. Demonstrable positive outcomes from intervention will be imperative. The families' involvement in the intervention process may become much more dynamic in that they will have a greater sense of ensuring that their money is well used.

### Indirect Costs Associated With Service

In a competitive market for providing services, large institutions may find themselves at a disadvantage. The overhead costs associated with multidisciplinary teams may be much greater than the cost of service provided by a single practitioner. In the field of Education there already has been a move toward a more consultative approach in Speech-Language Pathology, partially triggered by the realization that staffing levels are inadequate to provide direct intervention to all children with communication disorders. Direct intervention can be provided at less cost if the overhead is lower, potentially leading to a greater proliferation of private practice options. If intervention by single practitioners escalates, then the need for coordinated case management will become paramount. But who will be there to pick up the case management function? In the ideal world the family assumes this role, but its successful consummation may be beyond the abilities of the many dysfunctional families with whom we interact.

### Summary

There are several challenges facing us as professionals. We need to review our perceptions of quality care in the light of consumer expectations and our professional obligations and responsibilities. We need to see what can be changed so that it is easier for us to live with ourselves, so that the public can readily perceive how we contribute to the welfare of clients, and so that, at the same time, we do not compromise our ethical standards. For if we are not comfortable with the way in which we offer service, if we are unable to believe in ourselves, then how can we expect others to believe in us. This internal review process will be a constant re-evaluation in concert with the escalating changes in our environment. As long as we continue to monitor our compliance with our ethical standards and our basic values, the welfare of our clients will not be compromised.

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## Appendix Quality Care Concepts - Self Appraisal

Consider each of the questions listed. Several response options are listed, but these are not meant to be exclusive (or even "correct"! ). Place a check mark against those which match your opinion. Insert alternatives if they more accurately reflect your ideas.

1. *How do you decide whether a client has received quality care?*
  - the evaluation was provided promptly
    - within one week of referral
    - within one month of referral
    - within three months of referral
    - other (define) \_\_\_\_\_
  - the evaluation correctly identified the diagnosis and prognosis for improvement
  - if needed, treatment was initiated promptly (define how long you feel it is acceptable for a client to wait for therapy) \_\_\_\_\_
  - it was possible for the client to be scheduled for the optimum frequency and duration of treatment
  
2. *What other factors come into play when you consider quality care from the perspective of the individual client?*  
 \_\_\_\_\_  
 \_\_\_\_\_
  
3. *In what percentage of cases do you feel that you provide quality care to individual clients?*  
 \_\_\_\_\_  
 \_\_\_\_\_
  
4. *What are the factors which you feel prevent you from being able to provide quality care?*  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. *How do you decide if the family believes that the client has received quality care?*
  - by the family's willingness to follow therapy suggestions
  - by asking the family to complete a satisfaction survey at the termination of contact
  - by casual comments made during the course of treatment
  - other (describe) \_\_\_\_\_
  
6. *Do you seek anyone else's opinion to assist you in deciding whether you are providing quality care?*
  - feedback from colleagues
  - feedback from referral sources
  - feedback from employer
  - other (describe) \_\_\_\_\_

what type of comments do you hear/request?  
 \_\_\_\_\_  
 \_\_\_\_\_
  
7. *On an annual basis, how would you rate your overall satisfaction with your performance in terms of providing quality care?*
  - completely satisfied
  - adequately
  - completely demoralized
  - reasonably content
  - unhappy/concerned
  
8. *Assuming that you have been in practice for several years, has your satisfaction level in terms of providing quality care changed?*
  - satisfaction has increased
  - satisfaction has decreased
  - satisfaction levels have fluctuated
  - N/A - first year of employment

what factors do you believe influenced the change?  
 \_\_\_\_\_
  
9. *What are the essential features of quality care?*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  
10. *Do you anticipate that any of the above features may change over the next ten years? In what ways? Why?*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_