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Defining, assessing and improving quality in long-term care in the community

Workshop with representatives of home care providers and volunteers
Celje, Slovenia  | 11 April 2017
Overview

• Definitions
  – Quality and “long-term care”

• Trends in selected European countries

• Methods and tools to assess, analyse and improve quality in long-term care

• Recommendations
Background


"Quality is the decent delivery of a mutually agreed product or service"

- How do the various stakeholders assess what is meant by ‘decent’?
- Who is involved in ‘mutual agreements’?
The specific challenges of long-term care

**Social care system**
- Services
- Residential care
- Providers
- Professions
- Methods
- Legal Framework
- Policies

**Health care system**
- Hospitals - Services
- Providers - Professions
- GPs - Methods
- Legal Framework
- Policies

**Volunteers**

**The formal – informal care divide**

**Long-term care**
- linked-in, co-ordinated, integrated?

**Identity - Policies - Structures - Functions - Processes - Resources/Funding**

**Users**

**Informal carers:** family, friends …
Quality in long-term care

- A complex network of stakeholders
- Barriers to communication, hierarchies, ‘taylorised’ division of work with not always well-defined competencies (distribution of tasks)
- Missing tools and methods to describe complex service delivery
- Subjective vs. objective perceptions of reality

She asks for help, because she lost her self-confidence and dignity.

She asks for help, because she does not want to make any effort. This is how she shows her power.

She asks for help, because she wants somebody to consider her needs.
Quality issues to be addressed

- Safety vs. autonomy: is there a right to risk in LTC?
- Responsibilities (across providers, professions, family ...)
- Care planning, care coordination (case management)
- Management of interfaces, handovers
- Clinical indicators and Quality of Life
- Skills and grade mix, multi-professional team work
- Relationship with family members and volunteers
- Relationship with other local resources in the community
- Quality assurance within the organization and by third party (audit)
How is quality in LTC ensured in selected European countries?

- Finland
  - Municipalities (almost exclusively public providers):
    RAI – Minimum Data Set, clinical indicators

- The Netherlands
  - Health Care Inspectorate: yearly reports, inspection, accreditation and certification; since 2006: Quality Framework Responsible Care (public reporting) but currently being revised
  - ‘Buurtzorg’: The Omaha System (clinical outcomes)

- Sweden
  - Accreditation guidelines for all providers of home care
  - Home help as a separate open market
How is quality in LTC ensured in selected European countries?

- **France**
  - Shifting boundaries between home care and home help (voucher system)
- **Austria**
  - Inspection by *regional governments* (structures and processes)
  - **Quality assurance visits at home**: about 20,000 beneficiaries of the LTC allowance are visited by nurses (organised by the farmers’ social insurance institution)
  - **Voluntary quality management** by providers, in particular in home care (ISO, EFQM, E-Qalin, RAI-HC etc.) depending on provider and region
  - **Voluntary ‘National Quality Certificate’** - care homes only
Key trends in quality assurance and quality management in LTC

• Moving from inspection to self-assessment and certification by third parties
• Fostering transparency: public reporting of performance indicators
• Embedding quality management in care professionals’ job profiles
• Looking for quality assurance across the care pathway (‘chain of care’)
• Shifting from minimum standards to models of excellence?
• Shifting from the definition of structural and process quality criteria to result-oriented indicators?

Source: Nies et al, 2013
Quality management by result-oriented indicators: The challenges

Visions & Mission statements

Methods & Know-how

Legal requirements
National, regional, local

Structural quality

Process quality

Quality of results

The most challenging area for research and policy
A tool to address the challenges:
The E-Qalin quality management model

- Developed by managers, trainers, care staff, quality managers and other relevant stakeholders (also for home care organisations)
- User and staff orientation:
  - Values, needs and participation
- Organisational development:
  - Improve from where you are now!
- Further training:
  - E-Qalin Process Managers and Moderators
- Self-assessment and certification by third parties
- Reflecting upon quality of structures, processes and results
The E-Qalin Model 4.0

48 Criteria (50%)
PLAN – DO – CHECK – ACT – INVOLVE

24 Sub-results (50%)
Performance Indicators

PERSPECTIVES
• Residents
• Staff
• Leadership/Management
• Social context
• Learning organisation

Structures & Processes

Results
Self-assessment from different perspectives

- Respecting all perspectives by involving
  - different professional groups
  - different stakeholders (staff, users, family members, purchasers, partner organisations)
  - different hierarchical levels
  - “I assess what is relevant to my role!”
Results as a starting point for reflecting among stakeholders

- Quality of (clinical) care
  - Share of residents with decubitus ulcers, falls, dehydration, weight loss etc.
- Quality of life
  - Subjective assessment, satisfaction surveys (residents, family, staff)
- Leadership and Management
  - Staff turnover, sickness, overtime, legal requirements etc.
- Economic performance
  - Costs per user, occupancy rate, etc.
- Social context and ‘learning organisation’
  - Volunteering, image, further training
How to work with performance indicators towards improvement

### Quality indicator
Share of users with dehydration

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**Steering 1 (Jan 2015)**
- Target value defined
- Regular control, a special focus during care planning

**Steering 2 (July 2015)**
- New distribution of responsibilities, exchange of practices between teams, awareness raising measures with staff, users and family members
Caveats and wrong incentives: Who is interested in quality?

- The ‘regulation dilemma’
  - Constraints and prescriptions (‘minimum standards’)
  - What kind of incentives?
  - Public reporting

- Measuring ‘quality of life’
  - “Users are always satisfied”

- Measuring outcomes of health and social care work
  - Quality management as part of the job or new types of bureaucracy?

- Dialogue between funders, regulators and care professionals
  - Budgets for quality improvement and transparency
Improving quality does not always cost more: The “Buurtzorg” example

• Social innovation by user-oriented support to self-care, re-mobilisation
  – Activation and integration of local resources in the user’s vicinity

• Organisation of local, autonomous teams of ‘community nurses’ and assistants
  – Teams manage their own schedules, training needs and working times, supported by a small back-office

• ‘Buurtzorg’ reports lower costs than traditional home care organisations
  – Transparency by quality management (OMAHA System)
  – Reduced overhead costs due to ‘flat hierarchies’
  – Satisfied staff (grown from 2007 to 2016 from 10 to about 10,000)

• The community nurse and new organisation principles are key
  – Holistic working in partnership
Recommendations: Enabling continuous improvement by involving all relevant stakeholders

- Self-evaluation accompanied by certification (third party)
- Quality management as ‘part of the job’
- Consider all relevant perspectives
- Establish continuous improvement by establishing a culture that allows for ‘learning from errors’ with appropriate indicators
- Focus on quality of life: further research is needed …
- Links between outcomes and funding to establish new incentive structures: ‘bundled budgets’ rather than ‘fee-for-service’
Further information and contact

• Further information
  – www.euro.centre.org/interlinks
  – www.euro.centre.org/progress
  – www-e-qalin.net

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