



COMMUNITY QUALITY INDICATORS

FLYNN RESEARCH
Measuring Contributions to Society

COMMUNITY QUALITY INDICATORS

Prepared for The Council on Quality and Leadership

by FLYNN RESEARCH

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On November 20, 2003, The Council on Quality and Leadership's board of directors met in Baltimore, Maryland to consider the value of developing community quality indicators to measure the broader environment within which the disabilities community exists. The idea is motivated by the recognition that personal well-being is influenced by community well-being for all of us in society. The availability of health care, a strong employment base, good public transportation systems, crime-free neighborhoods, and support, tolerance, and diversity within local communities are just as important as direct services in the promotion of quality of life. Such an initiative holds the potential to more clearly illuminate the complex inter-relationships between individuals with disabilities, the organizations that provide needed supports, and the broader community in which people live.

Toward this end, The Council engaged FLYNN RESEARCH to help steer and design the initiative. This entailed identifying key stakeholders, posing specific questions to be answered, envisioning and articulating success, defining core elements, and designing a conceptual framework for the community quality indicators. The conclusions were integrated into The Council's *Quality Measures 2005*, an anthology to promote both basic assurances and quality of life.

For further information, please visit The Council's website at www.TheCouncil.org or contact:

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APPENDIX 1: THE COUNCIL ON QUALITY AND LEADERSHIP

The Council on Quality and Leadership originated in the late 1960s in an effort to stop the abuses and inhumane treatment in large public institutions serving people with intellectual disabilities. During the 1970s and 1980s, The Council (known then as The Accreditation Council) served a leadership role in developing national consensus standards for such institutions. The standards reflected the principles and values of professionals, families, provider organizations, and government agencies. The Council's standards were subsequently incorporated into federal court rulings, Health Care Financing Administration Medicaid standards, and numerous state licensing requirements.

In 1991, The Council's staff and board began work on a set of *Personal Outcome Measures* that reflects what people with developmental disabilities, chronic mental illness, brain injury, and physical challenges expect from the services and supports received. A wide group of people helped inform the design of the new measures, including individuals with disabilities, their families, friends and neighbors, as well as employees of organizations providing services. The research methodology included focus groups, pilot testing of the draft metrics in two states, the incorporation of ongoing feedback from the field, and field trials in ten sites in the U.S. and Canada.

The *Personal Outcome Measures*, first released in 1993, provide the basis for assessing personal quality of life in the field of disabilities. The initiative reflects a significant shift in thinking among practitioners during the last quarter of the 20th century from a focus primarily on organizational process standards (i.e., organization-level measures) to a focus on responsiveness to individual client needs and desires (i.e., person-level measures).

The purposes of the *Personal Outcome Measures* are two-fold: (1) to learn how people with disabilities live their lives and set their own priorities and (2) to improve the formal and informal service and support systems in ways that assist individuals achieve their personal outcome goals.

The 25 measures are grouped into seven categories: identity, autonomy, affiliation, attainment, safeguards, rights, and health & wellness.

The success of the *Personal Outcome Measures* prompted the leaders of The Council to considering an expanded approach to measuring quality. The Council recognizes that personal quality of life takes place within communities of concerned and supporting people. Hence, the next phase of The Council's work will focus on the social or community context within which the disabilities community exists.

The effort builds on the concept of social capital, that is, the ties and trust that we have with other people, including our families, friends, neighbors, social groups, colleagues, and service providers. Strong social capital enables all of us to live healthier and happier lives, to increase our community affiliations, and to be able to exercise choice and self-determination. The theory provides the conceptual footing to move from a person-centered approach when working with people with disabilities to a community-centered approach.

Factors associated with quality of life include, for example, the availability of health care, a strong employment base, reliable transportation systems, and crime-free neighborhoods. The Council's experience demonstrates that these variables are just as important as direct services in the promotion of quality of life for all of us.

The successful design of community indicators of well-being will help The Council redefine the emergent roles and functions of support and service organizations in today's environment. Perhaps the analysis will encourage the re-shaping of the human service system so that traditional organizations become mediating structures that facilitate the full participation of people in community. By initiating and hosting such a dialogue, The Council will build allies among practitioners, scholars, donors, and policymakers interested in an expanded view of societal well-being while at the same time meeting the emergent service needs of the disabilities community.

In the end, it is the hope of The Council that this new effort will contribute to our collective understanding of the relationships between people in society, the human service system, and the broader communities in which we live.

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