

Personal Outcomes as Measures of Quality

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Abstract: The Council on Quality and Leadership in Supports for People With Disabilities (The Council), formerly known as The Accreditation Council, altered its definition of *quality* from "compliance with organizational process" to "responsiveness to people." Council representatives conducted focus group and individual meetings with people who have disabilities to identify priority outcomes they expect from services and supports. The 1993 Outcome Based Performance Measures was used in 447 interviews as part of 54 accreditation reviews. Staff analysis and factor analysis of the outcome interviews using a principle components extraction and varimax rotation resulted in 24 variables loading onto seven major factors (Identity, Autonomy, Affiliation, Attainment, Rights, Health, and Safeguards), which form the basis of The Council 1997 Personal Outcome Measures.

Kuhn (1962) defined a *paradigm shift* as a change in the conceptual framework supporting belief systems. During the past decade, the shifting paradigm has been examined in the fields of management, business, disability, investment, leadership, biology, and physics (Bradley, Ashbaugh, & Blaney, 1994; Ray & Rinzier, 1993; Waldrop, 1992; Wheatley, 1994; Zuboff, 1988). The current attention to paradigm shifts, however, was foreshadowed by Bell (1976) and Toffler (1980).

Bell (1976) noted the increasing competitiveness of the world economy and the proliferation of advanced technologies. He considered the transition from an industrial to postindustrial, knowledge-based society as momentous as was the previous shift from an agrarian to an industrial society. The emergence of knowledge-based societies where the provision of services has replaced the manufacturing of goods is influencing the definition and measurement of quality.

Deming, Juran, Crosby, and Ishikawa have defined *quality* as the continuous discovery and fulfillment of customer needs and desires (cited in Sashkin & Kiser, 1993). The gradual shift

from an industrial to a service economy is resulting in a greater emphasis on defining the customer's desired outcome prior to engaging in the continuous improvement of organizational process.

In service settings, quality is determined at the point of interaction with the customer. Moreover, as Armand Feigenbaum (cited in Sashkin & Kiser, 1993) indicated, "Quality is what the customer says it is" (p. 56). Because the desired outcomes may vary from customer to customer and may change over time for any individual, the service provider must pay continuous attention to customer preferences. Successful service organizations are developing a sharper market focus where they first identify customer outcomes and then customize the service accordingly. Albrecht (1992) stated that "In the customer value paradigm, the primary focus is on outcomes" (p. 41). In contrast to the mass marketing of the industrial era, Peppers and Rogers (1993) emphasized dialogue and interaction with the customer. They suggested that the crucial question is, "What does this [individual] customer really want?" (p. 16).

This concern for the individual definitions

of *desired outcomes* is evident in the quality of life research. Quoting from Flanagan (1978), Parmenter (1992) noted that "the effects on each individual's quality of life should be evaluated in terms of his or her personal values and needs" (p. 251). Taylor and Bogdan (1990) noted that

Quality of life is a matter of subjective experience. . . . people may experience the same circumstances differently. What enhances one person's quality of life may detract from another. (pp. 34-35)

Goode (1994) also noted that "quality of life needed to be evaluated from the subjective standpoint of the individual" (p. vi). Finally, this focus on individual definitions of *quality* is clearly evident in the emerging variations of person-centered planning (Dennis, Williams, Giangreco, & Cloninger, 1993; Mount, 1992; O'Brien & Lovett, 1992; Smull & Harrison, 1992).

The definition of *quality* in terms of outcomes and satisfaction is found in the national debate on managed care. The issue of outcomes dominates the discussion of quality in health, behavioral health care, and, increasingly, in the provision of services to people with developmental disabilities. The managed care outcomes, however, are not personally identified outcomes that people expect from services and supports. In contrast, the majority of outcomes proposed for managed behavioral health care measure broad categories of individual functioning or systems change (American Managed, 1995; Cross & McDonald, 1995; Institute for Behavioral Healthcare, 1996).

The Council on Quality and Leadership in Supports for People With Disabilities (hereafter referred to as The Council) recognized the changing definitions of *quality in services* in the early 1990s. Since its inception in 1969, The Council has designed and published standards in the field of disabilities (Hemp & Braddock, 1990; Gardner & Parsons, 1990). During the 1980s and early 1990s (1984, 1987, and 1990), The Council published standards that defined *quality* in terms of compliance with organizational process. In 1991, however, the Board of Directors of The Council inaugurated the development of a new set of personal outcome measures for purposes of promoting quality enhancement and conducting a national accreditation program.

The Council has always based its accreditation standards on values. For example, the

core principles for the 1990 standards were normalization, age appropriateness, least restriction, and community participation and social integration. The core principles of the Outcome Based Performance Measures are contained in the labels that The Council assigned to the outcomes identified through individual and focus group meetings—personal goals, choice, social inclusion, relationships, rights, dignity and respect, health, environment, security, and satisfaction.

Both the content of the Outcome Based Performance Measures and the interview and information collection methodology of the accreditation review are grounded in the larger principle of informed decision-making. The overriding principles embedded in the personal outcomes orientation are as follows: (a) People define their own outcomes; (b) the process for identifying and defining outcomes is experiential—people experience a range of options from which to make choices; and (c) organizations facilitate outcomes identified by the individual.

These values are embedded in the accreditation review and interview methodology. Prior to the review, The Council identifies a representative sample of people receiving services and supports and obtains their informed consent to participate in an interview. The discovery process begins when accreditation reviewers first meet the person during the interview. In some instances, reviewers discover that the person has verbal skills and can talk about his or her outcomes. In other instances, they find that the individual needs to understand and use different communication systems. There are also situations in which there is very little communication, and the reviewer must turn to staff, family, and friends as key informants.

The Council has identified three dimensions (experience, support, and creativity) that interact to make choice meaningful. Service and support organizations facilitate outcomes when (a) people are given a range of experiences from which to make choices; (b) people are provided with ongoing support while learning from experiences; and (c) professionals, providers, and families are as creative as possible in offering the array of choices.

When professionals and providers experience significant difficulty in traditional communication modalities, they can make the transition from communicating about choice to discovering preferences. Reviewers identify the

preferences that families, professionals, and providers have discovered and ask them how they discovered these preferences. The same dimensions of choice also apply to preferences. Service and support organizations facilitate outcomes when (a) people are given a range of experiences and professionals, reviewers, and families discover preferences; (b) people are provided with ongoing support while learning from experience and indicating preferences; and (c) professionals, providers, and families are as creative as possible in offering an array of experiences and in discovering preferences. In some instances, the discovery period may take months, and the detection of preferences requires creativity and patience.

The application of the Outcome Based Performance Measures during accreditation reviews requires that these three dimensions of choice be present before an outcome is considered present. For example, choosing an outcome related to work or residence without the dimensions of experience, support, and creativity is not considered a real choice.

During reviews, information gathering is conducted at different times and in different locations. Reviewers continue to gather information until there is a convergence of opinions. When there are different perspectives on outcomes, reviewers continue to gather information until convergence occurs. Engaging people to identify their definition of an outcome rather than asking a closed ended question and carrying on the dialogue in two different locations over two different days is intended to minimize the acquiescence response. The data base does indicate, however, that people attain more outcomes when the source of the information is a professional, provider, or a family member rather than the person with disabilities.

The 1993 Outcome Based Performance Measures provides an interview, observation, and document review protocol that enables the user to identify an individual's outcome in each of the 30 outcome areas. People define the specific meaning of each outcome for themselves. The definition of the outcome in each of these areas is subjective. Figure 1 provides an example of the types of questions that can be used to elicit the definition of one of the 30 outcomes. (Although the definition of the outcome is subjective, the determination of whether the outcome is present, in form and extent as defined by the individual, is objective. Figure 2 provides

an example of a decision matrix for 1 of the 30 outcome measures.

The Outcome Based Performance Measures first provides an identification of the individual's priority outcomes, as defined by that individual, and then enables the user to determine whether the outcomes, as identified by the individual, are present. The Outcome Based Performance Measures results in the identification of the individual's definition of desired outcomes in the 30 areas and a determination of whether the outcome is present for the individual. Finally, through this instrument the user is asked to identify the individualized organizational processes that facilitate his or her desired outcomes. These individualized organizational processes are not programs. Rather, they are the individualized actions that organizations take to facilitate the outcome as defined by the person.

The person-centered outcomes create demands on the provider and professional and shift organizing principles from programs to people. Instead of maintaining uniform organizational processes by program, the provider must now individualize process to facilitate the outcome as defined by the individual. Moreover, individualized processes cannot be identified and defined until after the person has identified the individualized meaning of the outcomes.

This individualization of process reverses the traditional total quantity management and continuous quality improvement approach. If all people receiving services and supports defined all 30 outcomes in the same manner, and if all of those same people learned and interacted with other people in the same way, then process might be standardized. However, because different people define their outcomes distinctively, the processes to facilitate the outcomes will vary, which leads to two significant conclusions in quality enhancement evaluation: (a) It is not possible to measure individualized organizational processes without first identifying the outcome around which the process is designed. (b) Measuring individualized organizational process alone after identifying the outcome creates the possibility of measuring a process that is no longer relevant because the definition of the original outcome has changed.

Professionals and providers now confront the dilemma that there may be questionable connections between the outcomes that people

OUTCOME INFORMATION GATHERING

The following is intended as a guide for gathering information from the person and other sources in order to determine whether the outcome is present for the person. The specific activities and some of the questions may need to be modified to accommodate the person's personal preferences and to assist the person to understand the type of information needed.

SUGGESTED QUESTIONS FOR THE PERSON:

- ◆ With whom do you spend most of your time?
- ◆ How often do you have the opportunity to spend time with people other than staff or other people with disabilities?
- ◆ What social contact is involved in your work?
- ◆ Do you enjoy meeting new people?

◆ INTERVIEW THE PERSON:

During the interview with the person, ask about the number and type of interactions that the person has with people who do not work for or receive services from the organization.



◆ INTERVIEW PEOPLE WHO KNOW THE PERSON BEST:

Plan follow-up discussions with the people who know the person best to clarify information, if needed, and find out about supports provided to assist the person.



SUGGESTED QUESTIONS FOR THOSE WHO KNOW THE PERSON BEST:

- ◆ Do you know if the person spends time with people not affiliated with the organization?
- ◆ How do you know that the person's current situation is satisfactory to him or her?
- ◆ Is there anything the person needs to support current relationships or develop new ones?
- ◆ What is the person's preference? Does the person like meeting people and being around others?

◆ OBSERVE INTERACTIONS AND ENVIRONMENTS:

Note any opportunities that are offered to the person to engage in interactions with people outside the service environment in the normal flow of the person's day.



◆ CHECK THE PERSON'S RECORD OR OTHER PROGRAM DOCUMENTATION:

If the person has limited interaction with others, review the person's assessment and individual plan to see how support to expand interactions is addressed for the person.

Figure 1. Example of the questions that can be used to elicit the definition of the outcome measure "People interact with other members of the community."

OUTCOME DECISION MAKING

Based on the information gathered from meeting and talking with the person, interviews with members of the person's formal and informal support network, observations and a review of the record if needed, please answer the following questions about the person's interaction with others in the community:

OUTCOME QUESTIONS:

- 9.1 With whom does the person interact?
- 9.2 Are any of these people not affiliated with the organization?
- 9.3 Is the type and frequency of interaction satisfactory to the person?
- 9.4 If the answers to 9.2 and 9.3 are yes, *the Outcome is present.*
- 9.5 If the answers to 9.2 and 9.3 are no, is this based on personal choice?
- 9.6 If the answer to 9.5 is yes, *the Outcome is present.*

ADDITIONAL CONSIDERATIONS:

- ◆ If the person cannot directly meet others or express his or her choice, then many opportunities to spend time with others should be available.
- ◆ There must be direct social contact between people for this outcome to be considered present.
- ◆ Social contacts that occur during work or other supported activities are considered for this outcome.
- ◆ Family members can be considered *others* with regard to this outcome, if family members enable the person to have many contacts with other members of the community.

ORGANIZATIONAL PROCESS QUESTIONS:

- 9.A Has the organization designed and initiated a process that enables (or will enable) the person to overcome barriers to interacting with others in the community?
- 9.B If the answer is yes, what is the organizational process that enables (or will enable) the person to overcome barriers to interacting with others in the community?

Figure 2. Example of a decision matrix for the outcome measure "People interact with other members of the community."

want and the program processes currently in place. The question becomes, "If you cannot demonstrate a connection between peoples' outcomes and program process, why are you operating the program?" The definition of *quality* has changed from compliance with organizational process to responsiveness to people's outcomes.

Method

In 1991–1992, The Council conducted individual and focus group meetings with people who had disabilities (e.g., mental retardation, severe mental illness, autism, cerebral palsy, and traumatic brain injury). Preliminary drafts of the personal outcomes were discussed with subsequent focus groups of self-advocates, families, and service providers. In the summer of 1992, The Council conducted pilot tests of the draft outcomes at three organizations serving infants, children, and adults with developmental disabilities and severe mental illness in a wide range of services and supports.

The Council published the Field Review Edition of the Outcome Based Performance Measures in September of 1992 and field tested it at nine sites in the United States and Canada between August 1992 and February 1993. The Outcome Based Performance Measures formed the basis for interviews and discussions with 100 individuals. The interrater reliability during the field tests was .82. A factor analysis using SPSS-PC indicated that the 30 variables loaded on seven factors, which accounted for 59% of the variance.

After examining the data from the 100 interviews, The Council decided to enlarge the data base to 450 interviews and conduct an additional factor analysis prior to changing the 30 variables. As such, The Council adopted the following 30 outcomes and published the Outcome Based Performance Measures in 1993.

Personal Goals

1. People choose personal goals
2. People realize personal goals.

Choice

3. People choose where and with whom they live.
4. People choose where they work.
5. People decide how to use their free time.
6. People choose services.
7. People choose their daily routine.

Social Inclusion

8. People participate in the life of the community.

9. People interact with other members of the community.
10. People perform different social roles.

Relationships

11. People have friends.
12. People remain connected to natural support networks.
13. People have intimate relationships.

Rights

14. People exercise rights.
15. People are afforded due process if rights are limited.
16. People are free from abuse and neglect.

Dignity and Respect

17. People are respected.
18. People have time, space and opportunity for privacy.
19. People have and keep personal possessions.
20. People decide when to share personal information.

Health

21. People have health care services.
22. People have the best possible health.

Environment

23. People are safe.
24. People use their environments.
25. People live in integrated environments.

Security

26. People have economic resources.
27. People have insurance to protect their resources.
28. People experience continuity and security.

Satisfaction

29. People are satisfied with services.
30. People are satisfied with their personal life situations.

During the period August 1993 to June 1995, The Council developed a data base on 447 individuals who participated in interviews during accreditation reviews with the Outcome Based Performance Measures at 54 organizations in 16 states throughout the United States. This data base development was funded, in part, through a contract with the Health Care Financing Administration. The interviews were conducted according to the requirements outlined in The Council's (1995) Outcome Based Performance Measures Procedures Manual. The organizations participating in the accreditation reviews represented a broad spectrum of service and support providers, including state-wide family support and respite services and a variety of vocational, day, and residential options. All organizations were licensed in the states in which they operated.

Organization size ranged from less than 10 to over 600 individuals receiving services. Organizations were located in small rural communities as well as suburban and metropolitan areas. In terms of ownership, 83% were private, nonprofit organizations and 13% were public sector agencies. Only 4% were private, for-profit organizations. Only 2% were in operation for less than 5 years, and 90% were in operation for more than 10 years.

People served by the 54 organizations lived in the following situations: independent living (in their own homes without supports), 8%; living with foster family, 5%; living with natural family, 13%; supported living (intermittent supports in various residential options), 18%; supervised living (24 hours of supervision in various residential options), 56%.

Fifty-five percent of the individuals participating in the interviews were men and 45% were women. People under the age of 18 accounted for 16% of the data base, and persons between 18 and 65 accounted for 81% of those interviewed. Almost 80% of those interviewed had a diagnosis of mental retardation; 29% had a designation of severe or profound mental retardation. The remaining participants had a diagnosis of autism (6%), cerebral palsy (6%), mental illness (4%), epilepsy (2%), or other disabilities (3%). The vocational and employment services represented were independent work, supported employment, workshop, and day activity programs. The people involved in the interviews demonstrated a wide range of communication capabilities and modalities. Slightly fewer than half of them used verbal communication. About a quarter were partially verbal. Another 8% used signs/gestures; 6%, staff interpretation; 3%, communication devices; and 12%, other communication systems.

Results

The Final Data Base Report submitted to the Health Care Financing Administration in November 1995 detailed the relations between the characteristics of the people interviewed, the presence of outcomes and individualized organizational processes, and the characteristics of the organizations providing services and supports. The data base analysis did indicate the percentage of people in the sample for whom the outcomes and individualized organizational processes were present (see Table 1).

The outcome and individualized organizational process data from the 447 interviews with the Outcome Based Performance Measures were entered into a data base and analyzed using SPSS-PC. An initial analysis and review by staff resulted in deleting 6 items from further analysis: Item 5 (People decide how to use their free time) was considered a subset of Item 7 (People choose their daily routine); Item 15 (People are afforded due process if rights are limited) was considered a process rather than an outcome; Item 19 (People have and keep personal possessions) was present in over 90% of the sample; Item 21 (People have health care services) was considered a process rather than an outcome; Item 26 (People have economic resources) was present in over 90% of the sample; and Item 27 (People have insurance to protect their resources) was combined with Item 28 (People experience continuity and security).

The resulting 24 survey items were re-analyzed. Construct validity of the instrument was determined through factor analysis using a principle components extraction and varimax rotation. Seven factors were identified through eigenvalues greater than 1.0, which explained a cumulative variance of 57%. The factor scree plot in Figure 3 shows the eigenvalues. Communality values ranged from 0.40 to 0.72 in the final solution for the 24 items. A minimum factor loading of 0.30 was required for a variable's interpretation of a factor.

The seven factors and associated variables are as follows:

Identity: Items 1 (People choose personal goals), 3 (People choose where and with whom to live), 4 (People choose where they work), 13 (People have intimate relationships), 29 (People are satisfied with services), and 30 (People are satisfied with their personal life situations).

Autonomy: Items 7 (People choose their daily routines), 18 (People have time, space, and opportunity for privacy), 20 (People decide when to share personal information), and 24 (People use their environments).

Affiliation: Items 8 (People participate in the life of the community), 9 (People interact with other members of the community), 10 (People perform different social roles), 11 (People have friends), 17 (People are respected), and 25 (People live in integrated environments).

Attainment: Items 2 (People realize personal goals), and 6 (People choose services).

Rights: Item 14 (People exercise rights).

Health: Items 16 (People are free from abuse and neglect), 22 (People have the best possible health), and 28 (People experience continuity and security).

Table 1
 Outcomes Reviews: People With Outcome/Process Present (in %)

Outcome measure	Outcome	Process
26. Have economic resources	94.9	93.8
28. Experience continuity/security	92.5	94.5
19. Have & keep personal possessions	90.8	90.6
16. Free from abuse & neglect	88.9	85.7
8. Participate in community	88.3	87.4
5. Choose free time	88.3	85.5
23. Are safe	87.2	84.9
29. Are satisfied with services	86.8	63.5
21. Have health services	85.5	86.4
20. Decide to share personal information	85.5	80.0
27. Have insurance	83.4	61.0
18. Time, space, opportunity for privacy	82.9	84.9
2. Realize goals	82.3	82.3
7. Choose daily routine	82.3	82.1
30. Are satisfied with personal life	82.3	75.9
12. Connected to natural supports	81.4	81.2
13. Have intimate relationships	79.7	70.8
24. Use environments	75.3	74.6
22. Have best possible health	74.0	78.0
17. Are respected	72.7	71.9
11. Have friends	68.2	61.6
9. Interact with others	65.0	64.8
6. Choose services	64.0	61.6
3. Choose living situation	55.7	64.6
15. Are afforded due process	50.5	49.7
1. Choose goals	44.8	46.1
10. Perform social roles	44.1	40.7
4. Choose work	43.9	46.9
14. Exercise rights	33.9	30.1
25. Live in integrated environments	26.4	37.3

Note. Reviews were conducted from August 1993 to June 1995.

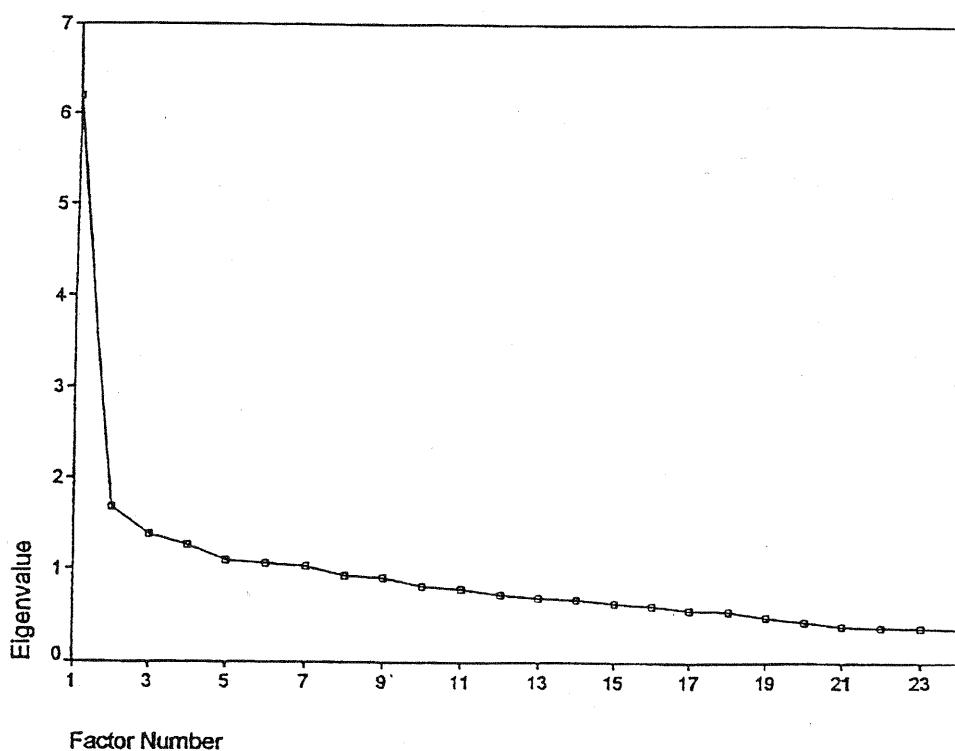


Figure 3. Factor scree plot.

Safeguards: Items 12 (People remain connected to natural support networks) and 23 (People are safe).

All 24 items loaded on the seven factors. Factor loadings and communalities for the 24 items are shown in Table 2.

Discussion

The data analysis and the results of the SPSS-PC factor analysis will be incorporated in the 1997 edition of The Council's revised outcome measures. The 1997 edition will be based on the 24 outcomes clustered in the seven factors.

The Council has demonstrated the feasibility of measuring quality in terms of personal outcomes rather than compliance with organizational process or attaining a score on a standardized outcome scale. The valid and reliable measurement of personal outcomes raises concerns about the continued use of process compliance measurement and standardized outcome scales as a method for assessing quality of services. In a time of decentralization, rapid change, and increased decision-making by self-advocates, quality measurement systems must emphasize a concern for individuality, adaptability, and change rather than the earlier hall-

marks of quality, such as standardization, uniformity, predictability, and conformity.

The relation between person-centered outcomes and individualized organizational process in the Outcome Based Performance Measures represents a significant break with The Council's previous definition and measurement of process. In previous editions of The Council's standards, the required organizational processes were defined. The Council measured organizational compliance with the standards. Hence, uniformity and consistency in implementing the standards resulted in few instances of "noncompliance" and high accreditation scores. The stated assumption was that a high degree of compliance with uniform, consistent, and standardized process yielded outcomes.

The Outcome Based Performance Measures are not based on designated uniform processes that, if implemented, will yield an outcome. These measures contain no standardized policy, procedures, or practices that can be applied to individual outcomes. In contrast, The Outcome Based Performance Measures methodology first requires the identification of the meaning of the outcome as defined by the person. Only after the outcome is defined can organizational pro-

Table 2
Factor Loadings, Communalities (h^2), Percentages of Variance and Covariance for Principle Components Factors Extraction, and Varimax Rotation on Outcome Based Performance Measures Items

Item	Factors ^a							h^2
	1	2	3	4	5	6	7	
29	.75							.62
30	.74							.62
13	.51							.47
3	.44							.57
4	.32							.57
1	.32							.50
20		.73						.57
18		.63						.53
24		.44						.45
7		.35						.51
11			.74					.62
9			.55					.63
10			.51					.59
25			.42					.62
17			.41					.50
8			.40					.61
6				.66				.57
2				.64				.58
14					.70			.55
28						.75		.72
16						.67		.63
22						.30		.40
23							.82	.72
12							.39	.52

^aFactors are, respectively, Identity, Autonomy, Affiliation, Attainment, Rights, Health, and Safeguards.

cess be examined to determine what combination of people, resources, and energy facilitated the outcome. The individualized organizational processes can only be examined in the context of the person-centered outcome.

Table 1 presents the results of 417 outcome interviews conducted as part of the accreditation review. The outcome column indicates the percentage of instances in which each of the 30 outcomes was present for the individual. For any outcome, then, there was a maximum of 417 possible definitions of the outcome. The process column indicates the percentage of instances that there was an individualized process in place to facilitate the outcome for the individual. For any one outcome, the processes differed remarkably. A very reasonable and beneficial process for one person might pose an unreasonable and burdensome demand on another person. Because of the individualized approach to process, there is no standardized set of processes that can stand as proxy measures for, and be identified and measured apart from, person-centered outcomes. The proper interpretation of Table 1 is that there is a very strong correlation between the presence of outcomes and the individualization of organizational process that is directed to the outcome.

Personal outcomes can contribute to the measurement of quality in managed care for persons using long-term services and supports. Personal outcome measures provide self-advocates with greater control and decision-making opportunities in the definition and evaluation of services than does the use of standardized outcome scales. Person-focused outcomes can anchor the managed care definition of quality in people rather than organizational process or outcome scores on standardized scales.

The adoption of person-centered outcomes has challenged The Council. Interacting with people to identify their definition of the outcomes and then determining whether the outcome is or is not present is a more complex and time-consuming task than reading program documentation and checking off compliance with organizational process requirements.

The nuances and challenges of outcome interviews have increased the time and expense of reviewer training and staff development. The skills required for interviewing and learning about people's outcomes are best acquired by meeting and interacting with people. Reviewer

orientation and training now takes place during two to four accreditation reviews when new reviewers first observe, participate, and then lead the interview process. New Council reviewers begin work only when they demonstrate a .90 interrater reliability level. In addition, interrater reliability checks on all reviewers take place on a continuous basis during the year and are a part of each accreditation review.

The concern for discovering people's own definition of the outcomes and accurate measurement of whether those outcomes are present has resulted in new organizational structure and staffing patterns. The Council's data indicate that the discovery of outcomes and reliable and valid measurement would be jeopardized by continuing to hire more and more part-time reviewers who conduct accreditation reviews on an episodic basis. During 1994-1995, The Council conducted 10 field trials to test the hypothesis that volunteers, people with disabilities, parents, peers, and agency staff could conduct accreditation reviews with the person-centered outcomes. The general consensus of the participants was that although they applauded the process, they felt they needed more intensive and ongoing training. The human resource profile of The Council has evolved from part-time surveyors to quality review consultants to organizations. This transition will accelerate as the reviewer-consultants provide organization development feedback to organizations.

Finally, the transition to person-focused outcomes has altered the analysis of information and the feedback to the participating organization. In the past, The Council measured noncompliance with standards and cited individual deficiencies. The focus of analysis was each individual standard. With outcomes, however, the focus shifts to synthesis and understanding of the relation between outcomes and between and among outcomes and individualized organizational process. As a result, The Council recently designed an organizational systems analysis to explain how knowledge of outcomes can lead to staff performance of different work tasks, new work processes, alterations in the organizations' human resources, and different organizational structures. With these changes, The Council's review methodology moves beyond a score-card approach to an analytical model that gives organizations the tools they need to implement change and quality improvement.

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Received 7/18/96, first decision 10/21/96, accepted 11/22/96.

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