Chapter 6:
Continuous Quality Improvement/Quality Assurance

Vision: The statewide system has established criteria for quality assurance and has a system to ensure adherence to these criteria. The statewide system collects data for program planning and evaluation purposes.

I. Introduction

In the business world, change is vital. This is true for non-profits as well. Healthy Families America programs are increasingly being looked upon by funders, policy makers and the general public to prove the quality of their services and demonstrate results. The systems to measure and disseminate these results, Quality Assurance (QA) Systems, should work in conjunction with technical assistance, training and evaluation to ensure quality services. The road to improving quality can be a difficult one, as there tends to be a resistance to change and self-examination. The key is not only developing a meaningful and effective quality assurance process, but also to have the buy-in of key stakeholders. This can make the difference between a stagnant state system and one that inspires innovation, values quality, and continually works toward improvement and results.

What are quality assurance and continuous quality improvement?
Quality assurance is a mechanism to evaluate appropriateness and efficiency of services by ensuring the delivery of high quality services. It provides a means to identify and resolve problems in order to pursue continuous quality improvement and it provides a means for dissemination of information regarding the quality of services.

Continuous quality improvement is a philosophy that allows a state system to look at its sites’ activities and performance and create plans for improvement. The process is never punitive towards any staff, individuals, or sites, and is solution focused.

What are the benefits of quality assurance/continuous quality improvement?
There are a multitude of benefits associated with quality assurance and continuous quality improvement measures. Some of the benefits include:

- Improving functioning and communication across the system.
- Improving outcomes as a result of refocusing on and revisiting program goals, policies and procedures, and through analysis of patterns in service delivery.
- Identifying system strengths and areas needing improvement.
- Increasing staff morale and communication through empowerment.
- Providing a signal to the interested public (i.e., funders, stakeholders, etc.) of the system’s willingness to improve and continue learning.
- Facilitating the determination of program effectiveness and tracking of program integrity.
• Aiding in the refinement of service delivery.
• Identifying new programs and program components.
• Increasing capacity to secure funding.
• Creating marketing opportunities (i.e., promotional materials, annual reports, funding requests, and requests for third party payer monies, etc.)

III. Guidelines for Continuous Quality Improvement/Quality Assurance

1. Develop a quality assurance plan that includes providing and evaluating technical assistance to sites around data collection, quality assurance, and/or credentialing. The development of a quality assurance plan should involve representatives of the major stakeholders in the state system and should focus on both administrative and program areas. This plan should include the following components:

   • A description of the system’s mission/purpose, goals, and objectives;
   • A description of the scope of services;
   • An outline of the steps taken to develop the plan, and;
   • A description of how quality assurance information will be disseminated, identified timeframes for completing tasks and a description of how activities will be evaluated.

Once the quality assurance plan is developed it should serve as a blueprint for operation of the quality assurance system and should be reviewed by key stakeholders on an ongoing basis (at least annually for its continued effectiveness).

2. Implement a system (manual or electronic) that enables all sites to collect data in a confidential and consistent manner. The state should have a system in place to regularly collect data from sites on the measures identified in the system’s evaluation to ensure they are following best practices. The data management system should meet the data and reporting needs of the system and allow it to manage the volume of data given the size and complexity of the system. Regular reports should be generated to provide feedback to sites on their performance. There are a variety of data management systems available to states. The following are examples: PCA America’s software package, Program Information Management Systems or PIMS (http://www.healthyfamiliesamerica.org/research/index.shtml#data) or other independently developed software and standardized tools such as Excel or SPSS.
A Note on Confidentiality

Precautions should also be implemented to ensure that participant and staff information is secured so that only authorized personnel have access to this information. This includes using locked file cabinets to store paper files or for database users, utilizing a password protection system. Procedures should also be implemented to ensure that former database users no longer have access to data. It is recommended that this include a plan for periodically changing passwords. Database security systems should also include password protection on screensavers.

3. Designate staff and procure adequate technology to meet the data management needs of the state. The system, whether it be automated or manual, should be able to provide current and historical perspectives for both the system and each site operating within the system. It is important that those individuals who are responsible for data management fully understand how crucial their role is in ensuring high quality service. Devising a system to ensure data is collected and entered accurately and in a timely manner will have tremendous pay-offs in demonstrating program effectiveness. The number of staff assigned to monitor and manage the system’s database will depend on the size, complexity, and resources of the system.

Multi-site Credentialing:

The multi-site credentialing process was developed to respond to the changing structure and needs of home visitation programs. The original interpretation of the credentialing standards for individual sites did not capture the complexity and variety of the multi-site systems in the network. The process was modified to accommodate multi-site systems while retaining the existing foundation of research-based principles and best practice standards. After a review of existing state and multi-site systems and the quality assurance literature in human services administration, recommendations were developed for refining the credentialing process to reflect the differences in multi-site systems.

A Healthy Families America multi-site system is defined as multiple sites providing direct service (i.e., assessment, home visitation, and supervision) to sites providing services in more than one geographic location and following a set of common program policies determined by a central administration. The central administration ensures the quality of each site and the entire system through quality assurance, training, technical assistance, and evaluation services. These functions may be provided directly by the central administration and/or through a sub-contractor. While policies are the same, local procedures and funding streams may differ.

There are many similarities between multi-site systems and state systems. The main distinction between the two is that while state systems are comprised of individuals with different roles within Healthy Families America, multi-site systems are also comprised of program sites and are most specifically focused on the process of credentialing.
Who is eligible for multi-site credentialing?

Entities that choose to complete the multi-site credentialing process do not have to be part of a state system. A collaboration of sites within a state may consider itself a multi-site system and choose to complete the credentialing process together as long as they meet the definition listed above.

The trend toward devolution of social programs to the states provided a unique opportunity to develop large state Healthy Families America multi-site systems. Multi-site systems share many of the incentives and complexities of other multi-institutional systems such as hospitals.

In reviewing the literature on the structure and governance of these systems, two recommendations stand out:

1. The site providing service delivery must provide input to the central administration. Because the central administration is far removed from the communities and populations served local input is critical. A committee of Healthy Families America program managers should be established in every multi-site system to make recommendations and policy decisions.

2. Flexibility on the part of everyone involved is necessary. The structure among multi-site systems varies widely. This variation can make the credentialing process confusing, not only for reviewers, but also for the sites and systems themselves. The credentialing process must also be flexible to accommodate these needs.

Flexibility in completing uniform and specific policies established by a central administration is the basic premise of the definition of multi-site credentialing. This definition allows for creative implementation of policies that stem from the broader criteria of the twelve critical elements.

III. Examples from the states

Several state systems in the network have implemented quality assurance systems to ensure the quality of services at the program site level. An overview of the quality assurance systems for Arizona and Indiana states systems is highlighted [http://www.healthyfamiliesamerica.org/ssdg/](http://www.healthyfamiliesamerica.org/ssdg/) or in Appendix B.

IV. Continuous Quality Improvement/Quality Assurance Resources

Credentialing staff: [http://www.healthyfamiliesamerica.org/home/contact_us.shtml](http://www.healthyfamiliesamerica.org/home/contact_us.shtml)


CARF (Commission on Accreditation of Rehabilitation Facilities) is an independent, not-for-profit organization which focuses on ensuring services received meets consumers needs for quality and the best possible outcomes. CARF reviews and grants accreditation services nationally and internationally on request of a facility or program. Their standards are rigorous, so those services that meet them are among the best available. Website: www.carf.org.

Council on Accreditation of Services for Families and Children, Inc. (COA) is an international, independent, not-for-profit, child-and family-service and behavioral healthcare accrediting organization. Founded in 1977 by the Child Welfare League of America and Family Service America, COA promotes standards, champions quality services for children, youth, and families; and advocates for the value of accreditation. Website: www.coanet.org.

HCQA: Health Care Quality Alliance, a non-profit organization of health care consumers, providers, and industry representatives who promote the quality of health care by increasing public attention, sharing perspectives and information, and fostering consensus on critical policy issues.

NCQA: National Committee for Quality Assurance, an independent, non-profit organization that accredits managed care organizations. In 1996, they developed HEDIS 3.0 (Health Plan Employer Data and Information Set), a set of standardized performance measures designed to provide information to employers and the public that reliably compares the performance of managed health care plans. Web site: www.ncqa.org.

JCAHO: The Joint Commission on Accreditation of Healthcare Organizations, a non-profit organization that serves as the primary accrediting body for health care organizations such as hospitals, ambulatory settings, long-term care facilities, sub-acute settings, etc. Accreditation is a nationally recognized standard for health care organizations obtained through site surveys and reviews every three years. Web site: www.jcaho.org.

QInet: An organization composed of Quality Improvement/ Quality Assurance departments from voluntary family service agencies dedicated to sharing information in order to enhance users’ ability to provide the highest level of service for the children and families. QInet was the first group to create an organization like this in Quality Improvement for social services and have continued to be leaders others follow and learn from. By using the discussion groups to ask and answer questions, the membership list to make connections and the other resources on these pages, services can be improved to families and children. www.qinet.org