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Quality Management as Knowledge Sharing: Experiences of the Napa County Health and Human Services Agency

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Lacking a coordinated effort in utilizing data and tracking program outcomes, one agency developed a Quality Management (QM) division to facilitate and manage more effective data use. To support this process, the agency sought to develop a collective, agency-wide understanding and investment in improving and measuring client outcomes. Similarly, the agency also focused efforts on creating a culture of transparency and accountability, with goals of improving service, increasing agency integrity, meeting regulatory compliance, and engaging in effective risk management. Operationalizing the QM initiative involved developing procedures, systems, and guidelines that would facilitate the generation of reliable and accurate data that could be used to inform program change and decision-making. This case study describes this agency's experience in successfully creating and implementing a QM initiative aimed at engaging in greater knowledge sharing.

KEYWORDS Quality management, knowledge sharing, tracking client outcomes

ORGANIZATIONAL ISSUES LEADING TO THE NEED FOR QUALITY MANAGEMENT

Napa County Health & Human Services Agency (HHSA) has 400 employees and is made up of six program divisions and four administration divisions. The program divisions are Alcohol and Drug Services, Child Welfare Services, Comprehensive Services for Older Adults, Mental Health, Public Assistance–Vocational Services, and Public Health. The four administrative divisions are Fiscal, Human Resource, Operations, and Quality Management. The QM

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group—the newest division to the agency—came into existence in 2006, and helped to launch the agency's quality management initiative in February 2007.

The need for performance-based management and the creation of the QM division was based on the following reasons:[1]

- Insufficient data gathering or monitoring to guide informed decision making (program or systems).
- No consistent development or measurement of goals.
- Lack of agency-wide coordination and planning.
- Over-reliance on 'anecdotal information' for decision making.
- Inadequate accountability to the community.
- Insufficient internal transparency.
- Inadequate accessibility to agency data.
- Need for more effective systems to monitor areas of risk within the agency, particularly in the area of compliance with regulatory requirements relating to federal and state funding of service programs.
  - In this last regard, federal regulators have issued a set of criteria that they will use in investigations of possible violation of federal funding requirements, to determine whether an organization receiving federal funds has exercised appropriate diligence in attempting to adhere to federal requirements. These criteria are referred to as the "Federal Sentencing Guidelines."

An initial effort to address compliance began in 1998. It resulted in a number of important advances and the agency's adherence to regulatory funding requirements improved markedly. However, there was concern that these improvements were largely based on increased training and oversight, rather than institutional changes that would permanently ensure ongoing regulatory compliance.

When the current agency director arrived in 2005, he was given the task by the board of supervisors of creating appropriate administrative structures within the agency to permanently reduce the risk of future regulatory compliance problems. However, the resulting planning process moved past the specifics of regulatory compliance to envision a system that saw regulatory compliance as one important element of a larger goal of quality in service delivery.

An example of an area where service quality and regulatory compliance coincide is the placement of children in foster care with a family relative. The monitoring system developed by the agency reviews all placement cases to ensure that all of the technical requirements are met for the case to qualify for funding under Federal Title IV-E. In so doing, the system also ensures that all placement standards are met to protect the safety of the child, including completion of the background checks for the people living in the home and

licensure of the home itself. The monitoring system includes an ongoing "concurrent review" process through which all cases are monitored as they develop. This process is backed up by a retrospective audit conducted by the QM team to ensure that it is working properly and obtaining accurate results.

In addition, there was no coordination or agency-wide unit overseeing data and reporting functions, nor was there regular reporting or tracking of outcome measures. By creating the QM Division in 2006, HHSA sought to create a culture of transparency and accountability based on objectives of service improvement, increased agency integrity, regulatory compliance, and risk management. HHSA not only wanted to be in compliance with mandated reporting requirements, but also create a collective understanding of the need to improve and measure client outcomes. As a result, today all divisions within the agency are involved in the QM initiative as reflected in this case study.

OPERATIONALIZING QUALITY MANAGEMENT

The first major step of the QM Division was to operationalize how HHSA would implement the QM initiative. Procedures, systems, and guidelines needed to be put in place in order to create a quality management program that could generate reliable and valid data to inform decision making. The structure of the QM division is designed with five positions and as of 2008 included eight staff that fill the following positions: a division director, assistant managers, QM specialists, a staff services analyst, and a senior office assistant. The director oversees all of the functions of the division and also serves as the chair of the QM Committee (to be described later), and the agency's compliance officer. The main role of the QM staff is to support the six program divisions and four administrative divisions in their ongoing reporting, audits, data analysis, and monitoring. They are integral in helping the program divisions create and update their QM plan and often consult with divisions regarding standards, mandatory policies, and best practices, as well as help them research specific regulations and legislative policy. While individual divisions are responsible for meeting state mandates and sending their own mandated reports to the state and federal governments, the QM Division assists each division by reporting state mandated outcomes through the QM program.

Later in the QM program development, HHSA adopted the valid and reliable performance indicator methods created by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF was chosen as a model because some program divisions are considering pursuing CARF accreditation, and after attending CARF conferences the agency felt that CARF's model was consistent with its vision for the QM program. One lesson learned was the need to identify one of the following four "types" or factors when looking at performance measures:

1. *Access*: A clients' ability to get into services.
2. *Efficiency*: Internal processes and structures that assess the relationship between goals and resources; costs, timeliness, cost effectiveness.
3. *Effectiveness*: Impact of services to clients and the nature of program improvements.
4. *Stakeholder Input*: Perceptions of persons served and other stakeholders regarding processes and outcomes.

The CARF factors span four aspects of client services in order to provide a balance between access to services, efficiency of the program, effectiveness of the program, and stakeholder input related to each division's outcome measures.

The outcome measures of each division are part of a formal annual QM plan used to track their goals for the year. In addition to the QM plans, each division has an action plan that is part of the strategic plan for each division. Every item on the action plan is defined along with its rationale for being included (e.g., federal mandate, corrective action, etc.) and the action plans are part of the QM plans.

In addition to staff input in the creation of the QM plans, other items that inform QM plans include strategic plans, action plans, budgeting, and the Office of Inspector General (OIG) Work Plan (audits and investigations performed by the federal government on health and human service agencies). In the creation of the QM plans, the following questions need to be addressed on an on-going basis:[2]

1. What can we measure to address the quality of our services?
2. What should we measure to ensure that staff and management use the information for strategic planning and service improvement?
3. What do we need to know that we don't know and how can we measure it?

The QM Division works with each program division to ensure that the division is able to track the measures they wish to include in their QM plan, collect data on an ongoing basis for that measure, and send the data to the QM Division on the scheduled dates.

Once the measures are chosen, they are defined in three areas: goals, indicators, and targets. An example of a *goal* would be "services are readily available for those who request them." This statement relates to the purpose of the program or services being evaluated and need to include a benefit resulting from the program. An *indicator* shows movement toward the goal or what would indicate success in reaching a goal (e.g., number of QM audit reports completed within the month following the audit). The indicators should relate to the division's action plan, strategic plan, and budget plan. The *target* is the desired percentage to reach the goal (e.g., 100% of QM audit reports completed within the month following the audit).

Division	Program or Service	Type	Goal	Indicators	Target	Source of Service Standard	Risks	Data Source	Collection Frequency	Collector
Quality Management	QM Report Development	Efficiency	The QM Division provides the Agency with timely written reports	% of QM Plan Reports completed within 21 days following collection due date (assuming reports no more frequently than monthly)	100%	QM Division Standards QM Initiative	The QM Division fails to provide timely information to Divisions QM Division reports are not useful to Divisions	QM Division Reports QM data collection data base	Annually (1/31/09)	SSA II Diana Sarsfield
				% of QM Audit Reports completed within the month following the audit	100%			QM Audit Reports QM Audit Schedule and Tracking Spreadsheet	Annually (1/31/09)	SSA II Diana Sarsfield
		Stakeholder Input/ Satisfaction	QM Division Audit Reports receive positive feedback	% of QM Stakeholder Feedback Form responses which are "agree" or "strongly agree"	90%			QM Stakeholder Feedback Forms	Annually (2/28/09)	QM Director Jennifer Yasumoto
	Agency Data Collection	Efficiency	The Agency collects and/or routes data in a timely manner	% of data collected by QM staff sent in a timely manner	100%	QM Initiative	QM process impacted; Decreased efficiency	QM Data Collection Database	Quarterly (4/15; 7/15; 10/15; 1/15)	SSA II Diana Sarsfield
				% of data collected by Division staff sent in a timely manner (Budget Narrative)	100%					

FIGURE 1a QM plan.

Program/Service:						
Review Period:						
Frequency:	☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually					
Type	Goal	Indicators	Target	Results		
				Current	Last	YTD
Background						
Data Description						
Results Narrative or Chart						
Considerations						

FIGURE 1b Components of a QM plan report.

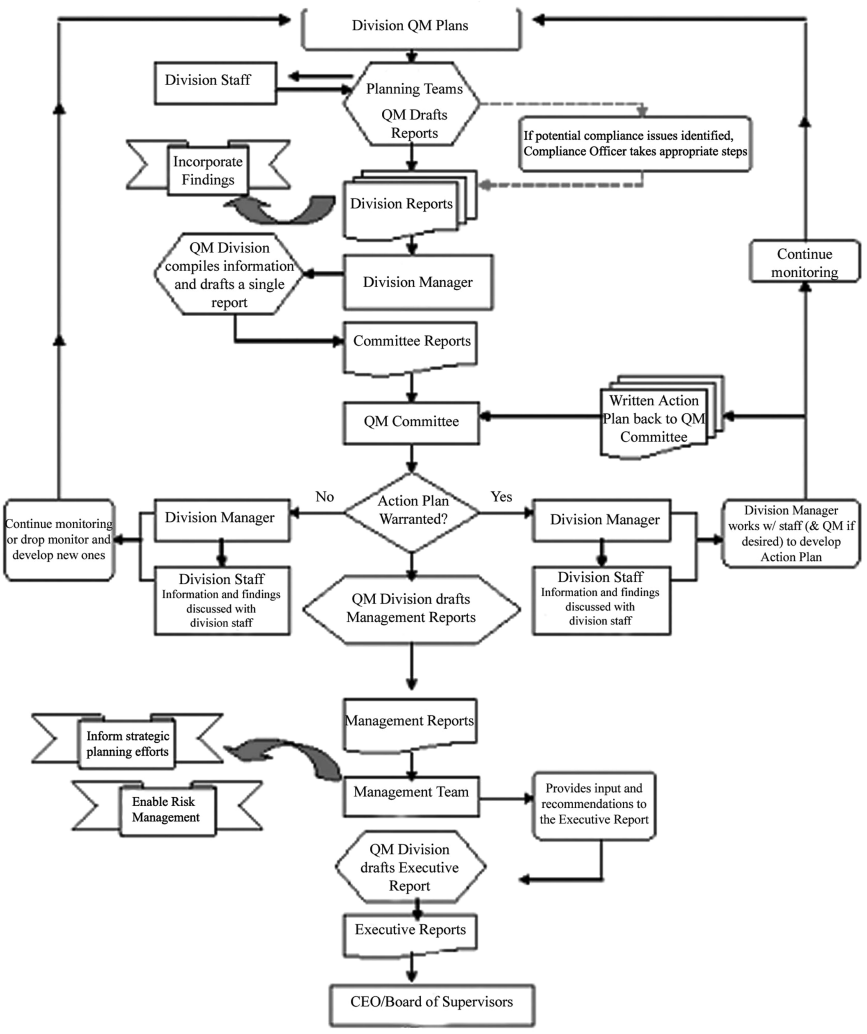

FIGURE 2 Quality management system diagram.

The measures for each division, with their corresponding goals, indicators, and targets are then put into the QM plan (an Excel grid) and mapped with additional information to give a complete picture of what each division is tracking. Each measure has the following data fields in the division QM plan (See Appendix A for a sample of a QM plan):

1. The program or service area (e.g., "QM report development," "customer service," etc.)
2. Goal (desired outcomes, mandates, strategic plan initiative, budget-related, etc.)
3. Indicator (what would indicate that the division was successful in reaching the goal)

4. CARF type (access, efficiently, effectiveness, stakeholder input)
5. Target (percentage)
6. Source of the service standard (specific regulations, funding agreements, compliance mandate, best practice, etc.)
7. Evaluate risks (e.g., "fiscal impact," "program integrity," "loss of accreditation," "repayments," "out of compliance," etc.)
8. Collection frequency (monthly, quarterly)
9. Identify a contact person who is responsible for sending data to the QM Division by the due date indicated in the frequency column.

Once the QM plans are finalized with the program division and QM Division, they go to the Quality Management Committee (QMC) for approval. The QM director is the chair of this committee and consists of seven additional members (the agency director, the agency assistant director, one QM Division staff member, one division manager, one assistant division manager, and two division liaisons). The committee membership rotates annually, except for the agency director, agency assistant director, and QM director. The reason for the yearly rotation is to enable a wide range of HHSA staff to see what other divisions are tracking and how they are performing. This forum provides for knowledge sharing across divisions. The QMC meets on a monthly basis and QM plans are reviewed and approved during these meetings. The manager of each program division is responsible for presenting the divisions QM plan to the QMC for approval and revisions to the plan during the year are presented by the assigned QM staff for each program division.

All HHSA staff can access the current approved plans for each division on the HHSA intranet site under the QM Division section. Current plans, prior plans, and draft plans are also stored as Excel files within the QM Division's network and these versions can be shared amongst staff for planning and tracking purposes. The QM Division maintains the final approved version of all plans as part of keeping the process centralized.

QUALITY MANAGEMENT REPORTING

The staff member identified in the QM plan is responsible for sending division data to the QM team on the specified frequency for that outcome measure. The QM team then creates a report for the division and passes this report back to the division manager for review and feedback. After the QM division receives the final data, they create a report and return it to the division within 21 calendar days. Subsequently, the division manager is responsible for providing feedback in a standardized response form to the QM Division within 5 days of receipt of the report. The response form ensures that the report has been reviewed and processed. They are intended to keep the flow of data moving through the program division and back to the QM division and QMC.

One of the primary purposes of the QM plan reports is to promote continuous service improvement by incorporating the findings into the division's program planning. Each QM plan report uses a standardized format that includes: the division name, program or service being reviewed, the review period, frequency of review, CARF type, goal, indicator(s), target metric, results (current, last reporting period, year-to-date), background information for context, data description, results narrative or chart, and future considerations. (See Appendix A for a sample QM plan report.) Many divisions have created workgroups to review the reports to develop concrete actions for reaching their target goals by addressing the following questions:

1. How can staff and management use the results to identify and initiate quality improvement changes?
2. What steps can management take to further staffs' understanding of the benefit of a QM program?

Before the QM initiative was started, agency data would be disseminated to stakeholders with no process for addressing actionable items. Under the new procedures, the division reviews the report and generates responses that often include action items and target completion dates on the response form, with the program division responsible for tracking action items. The QMC then reviews both the report and the division response and the division staff is invited to attend the monthly meeting to contribute to the discussion.

In addition to the QM plan reports that are tied to the QM plans, there are also QM audit reports that focus on improving services and reducing risks. A monthly audit calendar is created for an entire calendar year, in consultation with division managers and managed by the QM Division. The dates of the audits are also included in the QM plan to ensure all quality management initiatives are located in a central place for each program division and QM Division to track. QM audits began at HHSA in 2007 and 31 audits of eight HHSA divisions were completed by the QM division that year (24 audits were scheduled for 2008, across seven divisions). Some examples of recent audits include reviews of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, General Assistance, Food Stamps, Adult Protective Services, and Relative Home Approvals. A division chooses the program to be audited based on a concern about compliance or needed quality improvement, which may also be of interest to state or federal funders. None of the audit reports are communicated externally as they are all kept within HHSA due to regulatory quality assurance privileges.

As a result of the QM initiative, several program managers noted the benefit of receiving objective, detailed information and analysis of program performance, both with respect to activities relating to regulatory compliance and activities relating solely to service quality. Formal program audits are always conducted with reference to federal or state performance requirements or expectations. They may also include criteria relating to best or

promising practices or other program considerations that managers may wish to take into account as they develop plans to improve services or respond to areas where performance may not be achieving targets. For example, the Public Assistance programs include the administration of applications for coverage under the County Medical Services Program (CMSP). CMSP periodically monitors counties to determine if eligibility staff are accurately determining who qualifies for coverage through the CMSP program. The monitoring and audit activities occurring through the Quality Management system have enabled the Public Assistance Division to track its accuracy rate, enabling it to meet the accuracy requirements of CMSP.

The process for an audit begins with the QM team working with programs in each division to choose the sample size for the audit, design an audit tool, and request access to cases or charts to be audited. The audits are not designed to be full reviews of every case but rather provide a representative picture of the program or cases. Audit reports are created by the QM division and sent to the division manager by the end of the month following the planned audit month (if the audit was planned for June, the report will be sent by the end of July). The format for the audit reports includes:

1. *Executive summary* (highlights of the audit findings).
2. *Background* (background information about the program, relevant regulations, and the audit criteria applied).
3. *Audit sample* (the period covered in the review, the number of items reviewed, and the various types of items reviewed).
4. *Audit findings & analysis* (detailed information about the audit results, including both the results related to the QM plan indicators as well as an explanation of the audit results).
5. *Considerations* (ideas or recommendations for improvements).

In addition to monitoring program activity for the purpose of improving the quality of services and regulatory compliance, the QM program has also proven itself to be a valuable tool in distinguishing situations where apparent quality or compliance issues are in fact technical problems in documentation, information technology, or other systems—and do not present problems of either service quality or regulatory compliance. For example, several social services programs rely on computerized record systems to track cases that include non-computerized activities. These include Medi-Cal and Food Stamp eligibility, Child Protective Services, and the In Home Supportive Services programs. The QM Division regularly conducts audits of these types of programs to determine whether the current profile of the case meets programmatic and regulatory requirements. In some instances, these audits have disclosed apparent variations from standards that trigger a more detailed review or audit of a particular program or activity within a program. Under closer scrutiny, it occasionally turns out that the program activity is being

conducted appropriately but there is inconsistency or inaccuracy in some aspect of the manner in which a case is documented. In a more conventional approach to program monitoring, these situations could easily be misinterpreted as failures to meet service or regulatory compliance standards, rather than as easily correctible technical matters.

Once a QM audit report is completed, it is sent to the division manager along with an audit response form that is to be returned to the QM Division within two weeks of receipt of the report. In addition to the response form, there is also an audit feedback survey sent with the report. Everyone who reads the audit report is asked to fill out the survey to give feedback on the content, clarity, and comprehensiveness of the report. The QMC also reviews the audit reports, response forms, and feedback survey results at their next monthly meeting, in addition to the QM plan reports.

The final tracking mechanism used by the QM Division is called the QM dashboard. This spreadsheet tracks the results from both the QM plan measures and the QM audits to provide a summary snapshot throughout the year that is shared each quarter with the senior management team, the county executive officer (CEO), the assistant CEO, and county counsel. After the QMC reviews QM plan reports and QM audit reports, both report results are entered into the dashboard and are color coded to make it easy for viewers to look at the dashboard and quickly assess the areas of concern using different color-coding. The colors also indicate measures that may need to be taken out of a QM plan or revisited.

The final summary of data collected annually by the QM Division is called the QM Annual Report presented to the senior management team, the CEO, and the board of supervisors. The QM Annual Report summarizes the quality management activities for the year as well as highlights, challenges, and next steps for the QM initiative. For the first year of the program (2007), the annual report noted that there were 10 divisions participating, 217 goals tracked, 63 reports created with 612 individual results reported out with 43% of the results meeting or exceeding their targets.

LOOKING AHEAD

Napa County HHSA continues to refine their QM initiative as they gain experience and knowledge about effective practices in service improvement, increasing agency integrity, regulatory compliance, and risk management. HHSA is aware of the importance of data: the challenges it can present, the benefits of properly managed data, and the time and resources it takes to analyze and report data accurately and precisely. The information reported on and audited by the QM Division needs to be useful and actionable and there is no 'right way' to implement QM programs in order to do what works for the agency. HHSA planned to expand the audit function the following

year to include more research in order to pursue specific questions suggested by the audit outcomes.

Future opportunities for expanding and refining the QM initiative include: (a) increasing automation of data collection and reporting, (b) improving the alignment of the measures with the data, (c) expanding statistical reporting, and (d) developing more complex and meaningful goals. The QM Division is currently implementing a web-based tool to manage the reports that are currently managed in Excel. A web-based dashboard tool would include the QM plans and also expand the capacity to include color-coded graphic representations of each QM measure (a dial to show exceeding the goal target, meeting the goal target, or below the goal target). A more automated tracking system will also free up time for the QM Division and program divisions to strategically plan for ways to improve client services and the efficiency and effectiveness of their teams.

CONCLUSION

As the QM Division of Napa County HHSA entered into its third year (2009) of performance-based management, the agency continued to refine and emphasize the importance of institutional change that permanently ensures ongoing service improvement, increasing agency integrity, regulatory compliance, and risk management. Quality in service delivery remain the focus of HHSA, using technology and effective feedback loops to enhance the impact of QM plans, QM plan reports, QM audit reports, and the QM dashboard. Through the effective and actionable use of data, HHSA will continue to develop its QM Division and provide leadership in continuous quality improvement of services for clients and staff.

NOTES

1. Source: *Quality Management: Health & Human Services Agency's Performance-Based Management Program. Our Journey.* Presented to Napa County Board of Supervisors on September 25, 2007.
2. Source: *Quality Management Operating Manual.* Napa County HHSA, 2008.

APPENDIX A: SOURCES OF INFORMATION

Interviews

Jennifer Yasumoto, Director, Quality Management, Napa County Health and Human Services Agency, CA

Gail Forte, Assistant Manager, Quality Management, Napa County Health and Human Services Agency, CA