Chapter 17: Quality Management/Program Improvement (QM/PI) for Healthy Start Providers and Coalitions

Introduction

Quality management is a systematic approach to continuously assess and improve the overall quality of a program or service by identifying positive and negative program processes, services, and outcomes. The quality management process is facilitated through measurement and analysis of performance measures and contract deliverables, and should include active staff participation. Periodic measurement and evaluation of program outcomes provides assurance that agency and program practices are consistent with established standards, guidelines, and procedures. The ongoing monitoring of services, outcomes, and processes impacting service delivery are key factors for achieving quality maintenance and quality improvement.

> **Quality maintenance** is defined as assuring the continuation of services and processes that are meeting high quality standards. Ongoing monitoring of factors that positively or negatively influence a service or process is important to sustain high quality standards.
> **Program improvement** is defined as the process by which services not meeting quality measures or processes that could be streamlined or improved are evaluated and changed to obtain better results.
> **Quality management** is a continuous and dynamic process that encompasses both quality maintenance and program improvement.

The implementation of an ongoing, program-specific QM/PI process is necessary to assure that services are:

- provided in a manner that meet the needs of participants, and the requirements of the program, including negotiated performance measures,
- of high quality and consistent with current standards of practice,
- accessible and acceptable to the community and to the participants, and
- delivered in a timely manner.

Standards and Criteria

Standard 17.1 A written QM/PI process will be implemented by all Healthy Start providers.

Criterion:
The process must designate the frequency that reviews will be conducted and the data components that will be reviewed. The provider will use the designated data components to analyze and document program strengths and weaknesses and to identify areas for both quality maintenance and program improvement.

Examples of Data Components
Client records, data reports, financial indicators, customer satisfaction results, staff interviews, and fact finding phone calls are all examples of possible data components.

Standard 17.2. All contracts executed by Healthy Start coalitions for Healthy Start services will include a statewide core set of outcome and performance measures based on the current Healthy Start Standards and Guidelines. Coalitions and their subcontracted providers shall incorporate at a minimum the applicable core outcome and performance measures for the contracted services. Additional outcome and performance measures may be negotiated between the provider and the local Healthy Start coalition and included in the contract.

Criteria:
17.2. a Measurement, tracking, and analysis of core outcome and negotiated performance measures will guide providers and coalitions in the development of service delivery plans that address areas for program maintenance and improvement. This analysis should be completed at least quarterly.

17.2. b Each performance measure should include baseline data when available and a specific goal measurement to be achieved and maintained.

Standard 17.3 A Performance Improvement Plan (PIP) will be developed by the provider and approved by the local Healthy Start coalition, or initiated by the coalition based on review of quarterly deliverables in the event that core outcome or negotiated performance measures are not being met.

Criteria:
17.3. a The PIP is ideally developed by the provider and submitted to the local Healthy Start coalition. If the provider does not develop a plan, the coalition will initiate the PIP. The coalition will review the submitted PIP and either approve the plan as written or return the plan to the provider with feedback for further revisions.

17.3.b The plan must delineate services and processes that should be maintained and those that need improvement. For services or processes that are not meeting the established performance standards, the plan should define strategies and process changes designed to directly improve performance outcomes.

17.3.c The coalition will provide the Department a copy of the approved PIP in the quarterly deliverables to the Department.

Standard 17.4 The PIP will be updated quarterly and submitted to the coalition for approval or further revision. The coalition will submit a copy of the approved, updated PIP to the Department as part of the coalition's quarterly deliverables.

Criterion:
The PIP contains at a minimum: 1) the status of performance achievement, 2) the status of progress toward full implementation of strategies and their impact on the performance outcome, and 3) discussion of additional strategies that will be attempted or of strategies found to be ineffective that will be discontinued.

Guidelines for Providers

This chapter provides an overview of the following essential components (steps) for developing a quality management program and improvement process (QM/PI):

1. Assess program strengths and weaknesses.
2. Establish performance measures through negotiation with the supervising coalition.
3. Develop a Quality Management /Program Improvement plan.
4. Develop a Performance Improvement Plan that defines strategies designed to directly improve performance outcomes of services or processes that are not meeting established performance measures.
5. Assure ongoing measurement, tracking, and analysis of the performance measures and solution strategies in the PIP.
6. Report progress to the supervising Healthy Start coalition and other stakeholders.

Six Steps to Developing a Quality Management/Program Improvement Plan

Step 1. *Assessing a Program's Strengths and Weaknesses*

An effective assessment of a program's strengths and weaknesses:

- Is data driven,
- Includes and encourages staff involvement,
- Examines program components and processes rather than individuals,
- Includes an emphasis on the consumer, and
- Is part of an ongoing process focused on quality management.

The Healthy Start program is comprised of a number of service components including outreach, risk screening, initial contact, assessment, ongoing care coordination, and tracking. Additional Healthy Start services include nutrition counseling, tobacco education and cessation, breastfeeding education and support, parenting support and education, psychosocial counseling, childbirth education, interconception education and counseling, and community outreach. Important process related components include coding, leveling, case management, development of community linkages, appropriate cessation or transition of care, and thorough documentation of services and outcomes.

Within the quality management process the identification of both strengths and weaknesses are of equal importance; therefore, the assessment process should be structured in a manner that will serve to identify both. Identification of successful components within a program will allow continued allocation of resources toward the maintenance of services that are shown through data to have a positive impact on core outcome measures and program goals.

To assess a program's strengths and weaknesses, it is essential to address each component of service delivery contained in the service contract and identify the critical questions that help to define the services. It is important to consider the provider's infrastructure and position within the provider's agency (such as with the County Health Department), as well as the provider's position within the community's larger maternal and child health network of care. Based on input from coalition representatives and service providers across the state, a list of critical questions has been developed for

each of the components of Healthy Start. These critical questions are provided in the QM/PI standards matrix at the end of this chapter.

Example
When examining "contact with the client" as a component of Healthy Start, the first question in the QM/PI standards matrix that a program might consider would be the number of women contacted who score a 6 or more and number of infants contacted who score a 4 or more on the Healthy Start screen or were referred into the program for reasons other than score. The first step in the assessment of this component is to determine the average number and percentage of clients contacted.

A data source for this information as well as other program component data is the Healthy Start Executive Summary Report. This monthly report provides the number and percentage of women and infants who have been contacted by Healthy Start. Additional process and service indicators can be tracked through other Healthy Start Reports available on the Department of Health website at: http://www.floridacharts.com/hs/hslogon.asp . Other data sources include the local CHD case management module or data aggregated from provider logs and participant records. In order to achieve a reliable average, more than one quarter of data should be reviewed to determine if the program has met the established threshold. It is also helpful to collect and review data over a period of time to avoid reacting prematurely to a single data point. When possible, the program component should be evaluated for both quantitative and qualitative achievement.

Note
A prerequisite to using any data is assuring that the data are accurate. This is accomplished through local monitoring of reports, logs or records, and the reconciliation of data as needed.

After collection, individual data results should be compared to a standard. Standards may come from legislation, the Healthy Start Standards and Guidelines, National Standards such as Healthy People 2010, practice standards from professional organizations such as The American College of Obstetricians and Gynecologists (ACOG), or may be set by the community. A standard that may be used to assess quantitative program outcomes is a comparison between the actual percentage of participants contacted and that prescribed by Florida statute.

Example
The statute states that all women who score 6 or more and infants who score 4 or more or are referred into the program must be contacted. If the number and percent of women contacted is lower than the comparative standards, in this case 100 percent who score 6 or more, this program component might be selected for improvement.

Assessing the *quality* of this service component is equally important in the evaluation of the strengths and weaknesses of a program. The issue of quality is addressed with critical questions for each program component in the QM/PI matrix and at the end of each component chapter. A good data source for determining the quality of a service is through record review. A sample of records should be reviewed each quarter as part of ongoing quality maintenance activities. A guideline for numbers of records to be reviewed is at least 10 records or 100 percent of all records for a program with very

small numbers and five to ten percent of the total case load for programs serving larger numbers.

Example
The assessment of the quality of a contact might include the timeliness and the nature of the contact. Record review of participant contacts allow staff to see if the contact was attempted and facilitated within the established timeframes, what risk factors were discussed, if appropriate referrals were facilitated, and if thorough documentation of the client's response to or decline of services is noted.

Peer record reviews performed by a team of staff members are highly recommended as a mechanism for identifying issues related to service delivery, and as a venue to share best practices and encourage support among staff members. Team problem-solving sessions that examine the program staffing patterns, outreach and referral processes, and barriers to care often identify systems problems and solutions, rather than individual staff or client issues.

For those providers contracted to provide a large array of services, the QM/PI section of each chapter and the critical questions included in the QM/PI matrix should be used to focus and prioritize the program areas identified as potentially needing improvement.

Assessing a program's strengths and weaknesses is typically a process that occurs internally within the provider agency and does not involve the participation of the Healthy Start coalition. However, once problem areas have been prioritized and selected for program improvement, goals should be established collaboratively with the coalition as part of the coalition's responsibility in providing oversight. After an initial assessment of program strengths and weaknesses, the ongoing process of monitoring through team record reviews and systems evaluation may include the participation of the coalition.

The problem-solving process begins with the establishment of a goal for improvement. This goal is typically negotiated and agreed to by the provider and the Healthy Start coalition in the form of a performance measure, which is the next step in the QM/PI process.

Step 2. *Establish Performance Measures*
Performance measures may be initially negotiated on standards that are in statute, rule, or commonly agreed upon standards set by the community. Performance measures might also be negotiated following a provider's assessment of program strengths and weaknesses. In either case a performance measure goal should be determined and agreed upon by the provider and the coalition. Goals should be defined quantitatively as a performance measure statement with a specified baseline measure when available and appropriate. The QM/PI matrix at the end of this chapter provides examples of performance measure statements for each component of Healthy Start. Each statement includes a measure for a selected program component's current status or baseline as well as a goal for improvement.

Examples

Measures negotiated at the onset of a provider contract may look like this: "90 percent of pregnant teens will receive an assessment of interconception education and counseling needs in addition to postpartum family planning

counseling using the BRAIDED method within two weeks following the cessation of pregnancy."

If the number and percentage of prenatal contacts in a program are below the established threshold, the performance measure statement might be written as: "The prenatal contact rate will increase from 75 percent in the 4th quarter of 2006 to 90 percent in the 4th quarter of 2007."

If record reviews reveal that contacts did not include documentation of all appropriate information, an additional performance measure might be written as: "The percentage of records with documentation of all appropriate information on individual risk as well as pre-evaluation of need will increase from 30 percent in the 2nd quarter of 2006 to 90 percent in the 4th quarter of 2007."

Once the current status or baseline of a program component has been established and a goal for improvement has been selected, a decision should be made regarding how long it should take to improve the program components. This is typically negotiated between the provider and the Healthy Start coalition and should be based on the significance and complexity of the problem, as well as an expected strategy to be implemented to resolve the problem. This is the next step in the QM/PI process.

Step 3. *Developing Solution Strategies for a Performance Improvement Plan*

A provider who is not meeting a negotiated performance measure will need to determine contributing causes and potential strategies for problem resolution. In large agencies, the use of QM/PI teams can be very helpful. The following guidelines, however, are appropriate for individual QM/PI coordinators in small agencies as well. There are several types of QM/PI teams including "functional teams," "project teams," and "quality circles." This chapter will address only the basic elements of teams.

Note:
For more information on how to create and organize appropriate teams and methods for problem solving, a good reference is *The Team Handbook,* 2nd ed., by Peter R. Scholtes, Brian L. Joiner, and Barbara J. Streibel.

QM/PI teams are typically made up of internal staff members who are familiar with the program components and processes, and who have a good general understanding of how the program operates. A QM/PI team or coordinator should implement an evaluation process that involves data-driven decision making, using both quantitative and qualitative information. Steps in this process include: review of relevant data (as discussed in the above section), identification of problem causes, and the development of solutions.

Identification of Problem Cause
Following the evaluation of appropriate and verified data, many techniques can be used to assist in the identification of the correct causes of a problem. Team members directly involved in the process have significant insight into the roadblocks. A team leader can use a variety of brainstorming techniques to solicit this information. Further data collection, interview of staff or participants, and/or direct observation of a process can also help to identify both causes and solutions. It is important at this stage to test and confirm the identified causes of a problem before developing solutions. In special cases,

additional information may be needed to clearly define the causes of the problem and refine or narrow the focus for improvement efforts. Before embarking on a special study, it is helpful to consider and test several potential causes of a problem.

Examples
A county may discover, through record reviews, participant interviews, coalition feedback, etc., that too few women are being contacted in a timely manner. The project team may use a record review to test and confirm the cause of the problem by answering questions, such as:

- *Who are the staff currently attempting the contacts?*
- *What are the methods being used to make contact?*
- *Are the screens received by the care coordinator in a timely manner? etc.*

Another example might be that the administrator has discovered that the care coordination team has provided only half the services contracted for the first six months of the year. The project team may use a record review to test and confirm the cause of the problem by asking questions such as:

- *Are some groups of participants taking more time to serve than expected?*
- *Are participants not getting into care coordination until pregnancy is almost complete?*
- *Are too many participants open who do not really need services? .*
- *Is service coding accurate? etc.*

Developing Solution Strategies
Once the cause of a problem is identified, the next step is to develop solutions with the best potential to correct the problem and a plan to implement these solutions. There are a number of factors to consider in this process. The first task is to develop an operational or measurable definition of the problem.

Example
If the problem is that clients have expressed dissatisfaction about waiting too long for an appointment, you must define what constitutes an *excessively long waiting period* for the specific activity? 30 minutes or 3 days?

Use brainstorming techniques to generate alternatives for improvement and resources needed for implementation. Encourage the generation of ideas that range from the simple to the extraordinary. Even if an idea seems impracticable, it may be that with some refinement it can work well. Ensure that the team includes a variety of staff and personnel that are impacted by or have impact on the service you are evaluating. After brainstorming solutions your team will need to evaluate the feasibility of implementing the intervention as well as the potential for the intervention to impact the problem. Financial and administrative staff are often helpful at this stage. A thorough assessment of impact can avoid future derailment of a solution.

Examples
Be sure to include fiscal information as you consider each alternative, such as:

- *What fiscal resources are available? Is there potential for a grant or outside funding source?*
- *How much might proposed staffing changes cost or save?*
- *Might additional third-party reimbursement funds be used in changing our current practices?*

Consider which people or departments are currently or will be involved in a proposed solution and note what impact implementation of the solution may have on the organization and client:

- *How will change affect the current process*?
- *Will the change impact other systems within or outside my organization?*
- *How will the solution affect our clients?*

Next you should consider the resources you would need to implement a potential solution:

- *Do you have systems in place to support the change?*
- *Is there leadership support for the change?*
- *Can this be implemented with existing staff or will it require additional human resources?*
- *What skills, training, education, and resources will be required?*

Are there other avenues you should consider as potential solutions?

- It may be that the solution is not to change a current process, but that the terms of the contract or MOA need to be changed to reflect more realistic time and cost estimates.

It is important to remember that change is often difficult and incorporating a culture of ongoing performance management takes practice and persistence. The more your staff are included in the entire process, the more they will be invested in making change work. Try solutions on a small scale initially to help in planning for subsequent full-scale implementation.

Step 4: ***Developing a Performance Improvement Plan (PIP)***

Once a solution strategy has been selected for implementation, each step of the strategy must be delineated and documented in a Performance Improvement Plan (PIP). An example of a PIP format can be found after step 6. A PIP should include a sequence of the major steps for each solution strategy. Consider carefully all steps that will need to take place to successfully implement your plan.

Example
If your outcome goal is to increase the early identification and intervention of developmental delays in HS infants, and your performance measure states that "90% of all Healthy Start infants will be formally assessed for developmental delays at 6, 12, 18, 24, and 36 months of age," you would need to complete several steps before the first child is screened. Your plan should delineate steps to assure a foundation for success, such as:

- Form a team to evaluate at least 3 evidenced based developmental screening tools to determine cost, required staff skills and training needs, and potential for incorporation into existing program for all clients
- Secure adequate funding
- Develop policies and procedures including consent and follow up
- Identify referral options for children needing follow up
- Develop client education materials
- Train staff to use the chosen tool and program policies
- Develop a process to verify staff proficiency for using the tool

- Develop program performance measures

You will also need to identify a leader who will be responsible for overseeing the process and individuals who will be involved in carrying out each step, a date to begin each step, and an estimated end date for completion of implementation. When developing a performance management plan format, the appropriate performance measure statements, which are the desired outcomes, should be included for each solution strategy. It is recommended that these performance measures be tied to an overall outcome indicator as well.

It is imperative to keep the objectives of the action plan strategies in mind and tie the development and implementation of solution strategies directly to these outcomes.

Step 5: _Checking the Progress of Implementation and Impact_

Effective implementation is critical to the success of a solution strategy. As implementation begins for each of the action steps, it is necessary to monitor the process to assure that the strategy or action steps are being implemented as intended.

Example
In the above example of improving developmental screening, there are many steps that need to be assessed:

> Each staff member needs to be trained on the new developmental screening tool. If this "training" action step has not been implemented fully and effectively, the desired outcomes will not be met. If referral options and procedures have not been established, clients and staff will be frustrated when intervention is needed.

The next task is to measure the impact the strategies are having on the intended outcome or target population. The overall outcome should be "checked" or evaluated annually using the same criteria used in the initial assessment and establishment of performance measures. Additional data collected within a provider agency population or other population data may also be identified during the implementation process as lending important information. This information can be added to your data set.

Example

> In the example above, you would want to measure the number of children enrolled in your program who receive services according to the schedule you have developed. You may also want to monitor the number of children found to be at risk using your chosen developmental screening tool, the number of children who were referred and obtained additional assessment, the percentage of those referred for additional assessment who were found to have actual delays, and the percentage who received appropriate intervention. This data would give you insight into whether your screening efforts were leading to the early identification and intervention of children with developmental delays.

When evaluating an outcome, if the population is defined as those participants served by the provider, a source of information about those specific participants must be used to measure impact. Sample record reviews are a recommended source of provider specific data. This would assure that the selected outcomes are documented in all records. It is recommended that, whenever possible, the population be defined as those

participants served by the provider agency, as this is a more valid measure of the impact.

Analysis of strategies should begin early in the implementation process to identify which strategies are working, and which may need refinement in order to maximize the potential for obtaining the desired performance outcomes. This information can be obtained through monitoring the implementation and impact of strategies with data collection tools such as record reviews, surveys, interviews, and/or observations. This process should be ongoing with more frequent checks and corrections occurring at the beginning of a process to avoid ongoing adherence to processes that are not effective or disruptive. If a strategy is not working, either because the implementation of the strategy is too difficult or it simply has had no impact on the outcome, it may be necessary to revise the original solution strategy or to delete it and implement an alternative strategy.

It is important to remember that change is difficult and many new strategies will take time to implement with maximum efficiency. In addition, the desired impact may not be seen immediately; many solutions may simply need more time for the strategy to work. You will need to use your professional judgement and skills to balance 'tweaking" a process for maximum efficiency with actually changing solution strategies in order to achieve your desired outcome.

The process described here of planning for, implementing, and evaluating program improvement is cyclical in nature. It requires continuous planning, implementing, and evaluating to assure quality services and service delivery. A simple way to remember the process is:

PLAN - DO - CHECK – ACT
If each of these steps is followed as part of an ongoing cycle, significant quality program improvements can be accomplished and overall outcome goals achieved.

Step 6. *Reporting to the Healthy Start Coalition and Other Stakeholders*

Reports to the Healthy Start coalition and other stakeholders are critical to quality management to identify best practices. Reports of progress include the status of performance achievement. In the event that a provider consistently and significantly falls short of a performance measure or goal, only the *goal* of a statewide core performance measure may be renegotiated. Core *performance measures* must remain consistent throughout the state. However, both the performance measure and goal of a *locally* negotiated performance measure may be renegotiated. In either situation, a PIP may be required. The PIP should include a report of progress of implementation of solution strategies, as well as progress in achieving the goal performance measure. As mentioned above, measuring and reporting the status of implementation is important to ensure that the solution strategy has been carried out as it was intended.

Example

The coalition has identified repeat teen births as a risk factor for infant mortality in the community and a provider has assessed its Healthy Start program and determined that their high-risk pregnant teens are not all receiving postpartum family planning counseling, and that during their infants' first year of life they are receiving fewer than one or two encounters. A solution strategy might be to include Interconception Education and Counseling activities with each teen client

during the postpartum period, increase postpartum family planning counseling, and increase the number of encounters with postpartum teens and their infants. The strategy might also include referrals to a new peer counseling program established by the coalition to prevent repeat births. In this strategy one of the action steps might be that all Healthy Start staff will receive training and education on the new requirements for high-risk pregnant teens and their infants. Monitoring the implementation of this strategy would include interviews with staff to ensure that they are aware of the new requirements and understand them.

Another action step for this strategy might be to either develop or ask the coalition for brochures about the new peer counseling program to disseminate to teens. Monitoring might include interviews with teens to determine:

- If they are participating in the new program,
- If so, how they like the new program, and
- If they are learning about how to prevent repeat pregnancy.

If staff haven't been trained and teens aren't participating in counseling, it is unlikely that this strategy will have an impact. Reporting the status of implementation should include quantitative and qualitative information that can substantiate that the action steps are properly in place and having the intended impact on the performance measure.

It is necessary to monitor and report the impact of the selected solution strategies on the negotiated performance measure and to monitor the impact on the overall outcome as well.

In the example used above, monitoring the impact of the strategy on the performance measure would include a review of high-risk teen/infant records to assess the percentage of records that indicate postpartum family planning and referrals/follow up to peer counseling, and the average number of encounters with infants of high-risk teens. This would include an assessment of the content and quality of the encounters as well.

A periodic report to the coalition would then include the number and percentage of records that indicated the performance goal was being met or some indication that progress toward the goal was being achieved, along with supporting data. The overall outcome goal, in this case the repeat teen pregnancy objective, should also be monitored annually even though impact on overall outcomes may not occur until one or more years after implementation of the solution strategy. If after an appropriate length of time (e.g., one year), the data collected as part of monitoring indicate that either the strategy has not been fully implemented or the performance measure has not been met, the report should reflect that the strategy is being revised or deleted or should include a rationale for continuing the strategy.

Example

The average number of encounters for postpartum teens is still less than one or two after one year of implementation, and it has been determined upon further analysis that staff do not have enough time to visit their high risk teen or infant participants with appropriate frequency because of high case loads.

The strategy is then revised to include a restructuring of staff to accommodate this high-risk population and special efforts are made to appropriately close cases that need no further services, thereby reducing caseloads.

These new action steps would then be included in an "updated" performance improvement plan, which then continues to be monitored and reported to the coalition as well as any other stakeholders. It is recommended that a performance management plan format be used for reporting that simply includes statements of the status of implementation and impact at the end of each set of selected strategy action steps. This standardized format allows the provider and coalition to continuously monitor the progress of program improvement in an effective and efficient way. Frequency of reporting is recommended to be no less than annually and no more than quarterly, as it takes time to implement a strategy effectively. These reports may then be used to report performance information to the Department of Health through the coalitions' progress reports, which completes the circle of continuous quality management.

To evaluate overall performance status, the provider should also include the following in their PIP reports to the coalition:

- Current program caseload numbers
- Current numbers of enrolled clients by level
- Results of record reviews including evaluation of wrap around services
- Progress of all performance management action steps
- Client survey summary and plan of action

The Department of Health also has responsibility for oversight of all providers of Healthy Start services; when possible, the coalition annual site visits should be coordinated to coincide with the state Performance Management site visits to avoid unnecessary duplication of monitoring activities.

As a final note, when negotiating a proposal for a Performance Management Plan as part of a contract or MOA with the local coalition, it is important to remember the following:

- Program successes should be reported to emphasize all the positive aspects of the program and services that are being provided!

Healthy Start Provider Performance Improvement Plan /Progress Report

Overall Outcome Objectives: These are measurable statements with baselines and goals typically stated in the coalition's service delivery plan. The statements are population health status indicators that are selected based on the community needs assessment; the data for countywide indicators typically comes from Vital Statistics CHARTS. If the provider's population is used to measure impact on overall outcome, the data typically comes from sample record reviews (e.g., To reduce the percentage of repeat teen births from __ percent to __ percent in 2007).

Process Performance Measure Statements: These are measurable statements typically related to program process with baselines and goals. These statements may be based on a problem analysis that identifies root causes of program weaknesses that have an impact on overall outcomes. For example, a provider or coalition may have identified repeat teen pregnancies as a health problem in the community and a problem analysis by the provider has revealed that their pregnant teen population has a high rate of repeat pregnancies. One solution strategy is to increase the average number of face-to-face visits with their postpartum teen clients and assure they receive interconception education and counseling during the postpartum period. The overall outcome objective is to reduce the rate of teen client repeat births from __ in 2006 to __ in 2007. The performance measure statement negotiated between the coalition and the provider might be the average number and percentage of face-to-face encounters with postpartum teens and infants determined to need face-to-face encounters will increase from the current average of two in 2006 to five in 2007 and at least 75 percent of teens will receive interconception counseling and education.

Strategy: These are brief, general statements that describe a strategy which will be used to impact an overall outcome and the negotiated performance measure.

ACTION STEPS	PERSON(S) RESPONSIBLE	BEGIN DATE	END DATE	MONITORING TOOLS/REPORTS	COMMENTS (OPTIONAL)
Steps taken to accomplish the strategy: 1. Training & education of staff on new care coordination requirements for teens and provision of interconception education and counseling; 2. Develop brochures on Peer Counseling Program; and/or 3. Track participation of teens who receive interconception education.	1. Healthy Start Care Coordinator; 2. CHD Care Coordinator and Coalition Director; and 3. Care coordination staff.	When the action step is initiated.	When the development of the action step is completed.	Describes when, how, and what will be measured to monitor progress of implementation and impact (e.g., for implementation – interviews with staff and teens; to monitor impact – record reviews of teen clients including the number of repeat teen births)	General comments about circumstances surrounding the implementation of action step(s)

Status of Implementation: This is typically a brief statement of the progress in implementing the action steps/strategy; the statement should include data collected as specified in the Monitoring Tools/Reports column above to demonstrate that the strategy is being implemented as designed (e.g., interviews with staff indicated all had been trained, understood the new requirements, and were increasing encounters with teens and referring to peer counseling; interviews with teens indicated participation in peer counseling, of 15 interviews 11 said they liked the program).

Impact: This is a statement with supporting data that demonstrates the impact of the strategy on the Performance Measure. For example, in a review of 20 teen records in the first six months after implementation of the strategy, 20 records indicated that at least four encounters had occurred with postpartum teens when appropriate and all had received interconception education and counseling. At the end of a year, the impact on the outcome would be reported. For example, a review of 75 records revealed that no teens had a repeat pregnancy within one year.

Healthy Start QM/PI Standards Matrix — Service Delivery/Impact Committee Framework

Component	Critical Questions For Service Delivery	Performance Measures (Examples)	Data Needs Data Source	Frequency of report to Coalition and/or Others
Screening System	QUANTITY 1. The # or % of women/infants screened (women –offered and consenting OK)? 2. The # or % of women who scored 6+? 3. The # or % of infants who scored 4+? 4. The # or % of women who scored less than 6 but were referred in at screening? 5. The # or % of infants who scored less than 4 but were referred in at screening? 6. The number of cases referred in only for classes? 7. The number of screens received out of county? 8. The number of cases referred in but not captured on reporting system (*referred in without screen)?* 9. The # or % of women/infants consenting to participate in Healthy Start? QUALITY 1. Are screens accurate? 2. Are screens processed in a timely manner? (accurate as well as inaccurate) 3. The # or % of sample records for participants, referred for score only, with no screens present in record? 4. Are number of screens commensurate with provider caseloads? 5. Are out of county screens received in a timely manner? 6. Are some ZIP codes not being captured?	1. The infant screening rate will increase from __% in 200_ to __% by 200_. 2. The prenatal screening rate will increase from __% in 200_ to __% in 200_. 3. The # or % of records of participants referred at time of screening, for score only, with no screen present in the record, will decrease from __ to __ by the end of the fourth quarter 200_.	Executive Summary Report Screening Report Sample Record Reviews Staff Interview Observations	No more than quarterly, no less than annually
Initial Contact	QUANTITY 1. The # or % of women contacted who score 6 or more? 2. The # or % of infants contacted who score 4 or more? 3. The # or % of women contacted who score less than 6 (rate of referral based on other factors)? 4. The # or % of infants contacted who score less than 4 (rate of referral based on other factors)? 5. Number of cases contacted with no screening form (referred in with no screen)? 6. Number of cases contacted for classes only? QUALITY 1. Are attempted initial contacts timely, within 5 days of receipt of screen? 2. Are standards of care issues provided (eg., HIV)? 3. The # or % of sample records without documentation of explanation of risk and pre-evaluation need?	1. The prenatal initial contact rate will increase from __% in 200_ to __% by __quarter in 200_ for women scoring 6 or more. 2. The average contact time will decrease from 2 weeks in the first quarter of 200_ to 5 days in the 4th quarter of 200_. 3. The # or % of records with documentation of contact, with explanation of risk and pre-evaluation of need, will increase from __% in 200_ to __% by __quarter in 200_. (Pre-requisite baseline needed from record review data)	Executive Summary Report Sample Record Reviews Staff Interviews Observation	No more than quarterly, no less than annually

HEALTHY START QM/PI STANDARDS MATRIX
SERVICE DELIVERY/IMPACT COMMITTEE FRAMEWORK

COMPONENT	CRITICAL QUESTIONS FOR SERVICE DELIVERY	PERFORMANCE MEASURES (EXAMPLES)	DATA NEEDS DATA SOURCE	FREQUENCY OF REPORT TO COALITION AND/OR OTHERS
ASSESSMENT	QUANTITY 1. The # or % of women/infants determined to need assessment? 2. The # or % of women/infants assessed? QUALITY 1. Are assessments timely, within ________? 2. Is assessment documentation present in sample records with evidence of use of recommended tools, procedure which further identifies risk and individual lack of resources to address risk (provided by appropriate professional)?	1. The infant assessment rate will increase from __% in 200_ to __% in by __quarter in 200_. 2. The # or % of records with documentation of assessments will increase from __% in 200_ to __% by __ quarter in 200_.	Executive Summary Report Sample Record Reviews Staff Interviews Observation	No more than quarterly, no less than annually
CARE COORDINATION TRACKING AND NON-FACE-TO-FACE SERVICES	QUANTITY 1. The number of women/infants who received any Healthy Start service? 2. The # or % of women/infants who received tracking services? 3. What is the average number of encounters per client? 4. The # or % of cases receiving tracking and non face-to-face services in a non-clinical setting? QUALITY 1. Is service delivery timely within ____days of assessment? 2. The number of sample records w/o documentation of tracking consistent with the level of need?	1. The average number of encounters per woman who is determined to need tracking services will decrease from __ in 200_to __ by 200_. 2. The average time between assessment and service delivery will decrease from __ days in 200_ to __ days by 200_.	Executive Summary Report GH330 Report Sample Record Review Client Satisfaction Surveys Staff Interviews	No more than quarterly, no less than annually

HEALTHY START QM/PI STANDARDS MATRIX
SERVICE DELIVERY/IMPACT COMMITTEE FRAMEWORK

COMPONENT	CRITICAL QUESTIONS FOR SERVICE DELIVERY	PERFORMANCE MEASURES (EXAMPLES)	DATA NEEDS DATA SOURCE	FREQUENCY OF REPORT TO COALITION AND/OR OTHERS
CARE COORDINATION FACE-TO-FACE SERVICES	QUANTITY 1. The number of women/infants who received any Healthy Start service? 2. The # or % of women/infants who received face-to-face services without an FSP? 3. The # or % of women/infants who received face-to-face services with an FSP? 4. What is the average number of encounters per client? 5. The # or % of cases receiving face-to-face services in a non-clinical setting (e.g., home visits)? 6. The # or % of cases receiving non face-to-face services in a non-clinical setting (e.g., home visits)? QUALITY 1. Is service delivery timely, within ____days of assessment? 2. The number of sample records without documentation of face-to-face and non face-to-face service consistent with the level of risk/need? 3. Are clients satisfied with their services?	1. The percentage of women who receive face-to-face services without a FSP will decrease from __% in 200_to __% by the 4th quarter 200_. 2. The average number of encounters per woman who is determined to need face-to-face care coordination services will increase from __ in 200_ to __ by 200_. 3. The average time between assessment and service delivery will decrease from __ days in 200_ to __ days by 200_.	Executive Summary Report GH330 Report Sample Record Review Client Satisfaction Surveys Staff Interviews	No more than quarterly, no less than annually
OTHER HEALTHY START SERVICES	QUANTITY 1. The number of women/infants who received services (broken down by services)? 2. The number of services provided (by service)? 3. The number of services per client (by service)? QUALITY 1. Is service delivery timely, within ___ days of assessment? 2. Is service documentation present with evidence of participation/follow-up consistent with level of risk/need? 3. Are clients satisfied with their service?	1. The # or % of women who complete psychosocial counseling, who are determined to need counseling, will increase from __% in 200_ to __% in 200_. 2. The # or % of sample records without documentation of participation in Healthy Start service classes will decrease from __% in 200_ to __% in 200_.	"Other Healthy Start Services" Report GH330 Report Sample Record Review Client Satisfaction Surveys Agency/Staff Interviews Observation	No more than quarterly, no less than annually

Healthy Start QM/PI Standards Matrix
Service Delivery/Impact Committee Framework

COMPONENT	CRITICAL QUESTIONS FOR SERVICE DELIVERY	PERFORMANCE MEASURES (EXAMPLES)	DATA NEEDS DATA SOURCE	FREQUENCY OF REPORT TO COALITION AND/OR OTHERS
CARE COORDINATION SYSTEM LINKAGES/ TRANSISTION OF CARE	QUANTITY 1. Is a written QM/PI plan in place? 2. Are interagency agreements in place? 3. The number of referrals made to other agencies? QUALITY 1. Do all program administration/staff participate in the QM/PI process? 2. Do interagency agreements provide accessible services? 3. Do interagency agreements assure services provided by credentialed professionals? 4. Do interagency agreements assure appropriate utilization of client satisfaction surveys? 5. Do interagency agreements include the appropriate use of FSPs?	The # or % of clients who report being satisfied with the transition process and services will increase from __% in 200_ to __% in 200_.	Administrative records Administrative/ Staff interview Client satisfaction surveys	No more than quarterly, no less than annually
CLOSURES	QUANTITY The number of participants who do not have services coded for a specified amount of time (indicating need for closure)? QUALITY All closure activities are completed at the time of closure?	The number of participants who do not have service codes for a specified period of time will decrease from __% in 200_ to _% in 200_.	Executive Summary Report	No more than quarterly, no less than annually
UNABLE TO LOCATE	QUANTITY The # or % of Unable to Locates? QUALITY The number and types of attempts (sample)?	The # or % of Unable to Locate will decrease from __% in 200_ to __% in 200_.	Executive Summary Report	No more than quarterly, no less than annually

Healthy Start QM/PI Standards Matrix
Service Delivery/Impact Committee Framework

Component	Critical Questions For Service Delivery	Performance Measures (Examples)	Data Needs Data Source	Frequency of report to Coalition and/or Others
Healthy Start Coding and Data Collection	Quantity 1. The # or % of coding forms (e.g., encounter forms), based on a sample of forms that are coded incorrectly? 2. The # or % of coding forms, based on a sample of forms that are entered into HMS incorrectly? Quality 1. Is data entry timely? 2. Is ongoing coding training available to new employees?	The # or % of sample coding forms with errors will decrease from __% in 200_ to __% in 200_.	Periodic sample coding and data entry quality control studies	No more than quarterly, no less than annually
Variation in Services Delivery Sites	Quantity The number of non-clinical visits (e.g., home visits) provided by risk level? Quality Are home visits conducted with a written plan of care?	The # or % of sample records without a plan of care or written agenda with follow-up documentation of progress for home visits will decrease from __% in 200_ to __% in 200_.	Sample record reviews Data reports	No more than quarterly, no less than annually
Community Education, Outreach, and Recruitment	Quantity 1. The number of women/infants identified and referred for services? 2. The number of classes conducted, speaking and media engagements? Quality Was case referral consistent with level of risk/need?	The number of "found" cases in zip code _____ will increase from __in 200__ to __ in 200_.	Administrative records Administrative/ Staff interview Data reports	No more than quarterly, no less than annually
SOBRA Care Management				
Explanation of Program	Attempt to contact enrollee within 5 working days? Are special needs identified?	% of enrollees with an attempt to contract within 5 days will increase from __% in 200_ to __% in 200_.	Record review/SOBRA Information System	No more than quarterly, no less than annually

COMPONENT	CRITICAL QUESTIONS FOR SERVICE DELIVERY	PERFORMANCE MEASURES (EXAMPLES)	DATA NEEDS DATA SOURCE	FREQUENCY OF REPORT TO COALITION AND/OR OTHERS
PRENATAL CARE COUNSELING	PROVIDED WITHIN 5 WORKING DAYS OF ENROLLMENT?	___% of auto assigned enrollees will receive three documented attempts to contact.	Record review/SOBRA Information System	No more than quarterly, no less than annually
HEALTHCARE PROVIDER APPOINTMENT	COMPLETED WITHIN 30 DAYS OF ELIGIBILITY? WAS APPOINTMENT FACILITATED?	___% of the enrollees successfully contacted will be enrolled with their chosen health care provider in 30 days.	Record review/SOBRA Information System	No more than quarterly, no less than annually
HEALTHY START SCREENING	COMPLETED WITHIN 30 DAYS OF ENROLLMENT? WAS HEALTHY START PROGRAM INFORMATION PROVIDED TO ENROLLEE?	__% of the enrollees who had a Healthy Start screen completed within 30 days of enrollment.	Record review/SOBRA Information System	No more than quarterly, no less than annually
NOTIFICATION AND FOLLOW-UP ON HEALTHCARE APPOINTMENTS	NUMBER OF WOMEN RECEIVING FOLLOW-UP FROM THE PRENATAL CARE COUNSELOR		Record review/SOBRA Information System	No more than quarterly, no less than annually.
FACILITATE WIC	NUMBER OF WOMEN RECEIVING INFORMATION ABOUT WIC SERVICES	___% of contacted enrollees who received WIC information.	Record Review/SOBRA Information System	No more than quarterly, no less than annually.
ASSISTING WITH HEALTHCARE COVERAGE AND SELECTION OF HEALTHCARE PROVIDER FOR NEW INFANT	NUMBER OF WOMEN ASSISTED TO ACCESS HEALTH CARE COVERAGE FOR THE INFANT		Record Review/SOBRA Information System	No more than quarterly, no less than annually.

Notes

Self Study Questions: **(Answers to these questions may be found in Appendix H)**

1. How is "quality maintenance" defined for the purposes of Florida's Healthy Start program?

2. How is "program improvement" defined for the purposes of Florida's Healthy Start program?

3. How is "quality management" defined for the purposes of Florida's Healthy Start program?

4. Why is the implementation of an ongoing, program-specific QM/PI process necessary?

5. At a minimum, what must all contracts executed by Healthy Start coalitions for Healthy Start services include?

6. What needs to happen in the event that core outcome or negotiated performance measures are not being met?