Assessing & Enhancing The Quality of Services

A Guide for the Human Services Field

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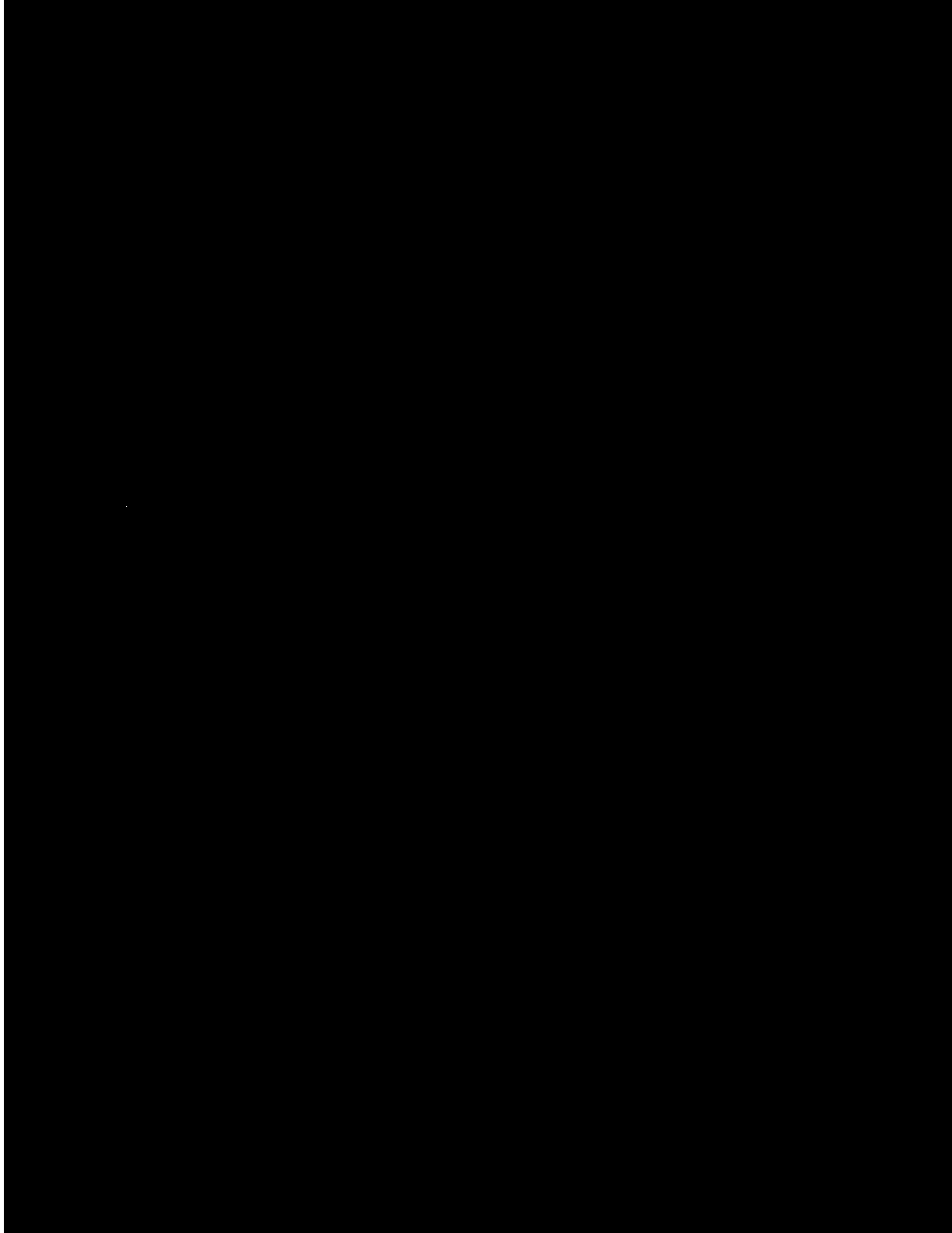

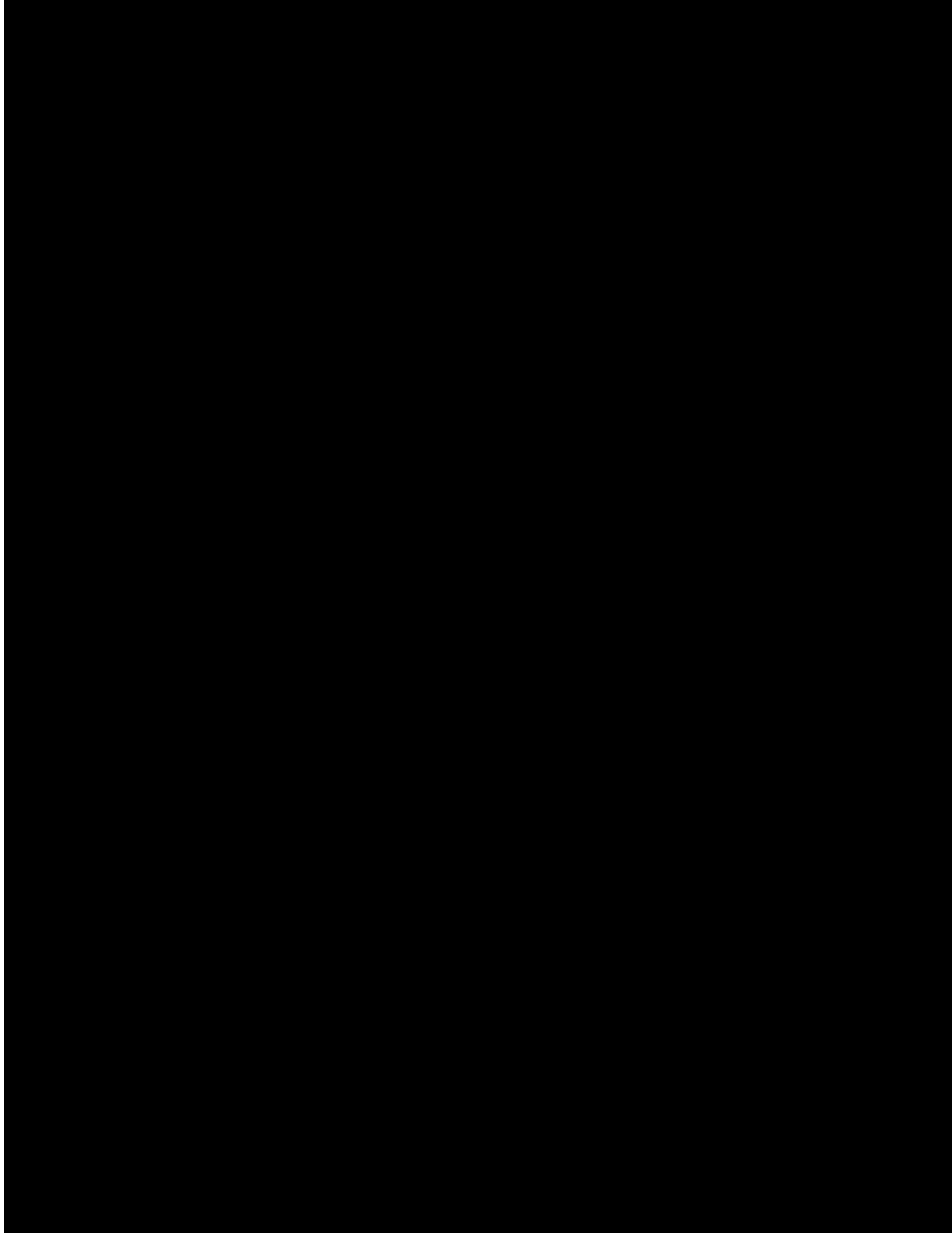

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Our initial work was overseen by an advisory committee, the members of which have considerable knowledge and interest in the improvement of human service quality assurance methods. Committee members include state and county administrators of a range of human development services, directors of private philanthropic organizations and representatives of voluntary associations. Their names are included in the Appendix.

Members of the advisory committee volunteered their time to review quality assurance methods identified by the project directors, to advise the project directors on which methods appeared most promising, and to suggest which methods might best be packaged and disseminated for use by state and local level administrators.

We would also like to thank those federal officials from each of the OHDS divisions who took the time to review and comment on the utility of these methods.

Finally, we would like to acknowledge the dozens of agencies whose quality assurance methods were considered for inclusion in this report, and who so generously provided us with the information needed for selection and documentation.

Preface

Devising quality assurance mechanisms in an era of shrinking resources may seem to some to be akin to polishing the brass rails on the Titanic -- why should we be concerned with improving the quality of social services when the primary concern of many providers is holding their heads above water? Though this initial reaction seems in keeping with the times, a more thoughtful assessment suggests that now, more than ever, responsive quality assurance mechanisms are necessary to ensure that the most effective and efficient services survive funding cut-backs. Without adequate information regarding the quality of services, the process of allocating scarce resources will lack foundation and will be too easily swayed by political pressures.

In addition to the importance of information about program quality to decisions on budget priorities, quality mechanisms are also important to the protection of client well-being in times of limited funding. As financial support becomes constrained, service providers may be forced to cut corners in order to meet continuing demand. If this process is not carried out in a rational and conscientious fashion, the interests of particular clients may suffer.

Further, as social services have proliferated and decentralized, the ability of public agencies to monitor such providers in the traditional ways (e.g., periodic on-site reviews characteristic of licensing, certification, etc.) is declining. Formal licensing and accreditation procedures, though useful in assuring a minimum capability to provide quality services, do not address actual performance, nor do they ensure that client well-being is effectively protected. As the number of providers has grown in proportion to the number of public licensing staff, the process of monitoring providers has

slowed and in some instances has become more of a hindrance to service delivery than a help. Given the importance of such monitoring, it will be necessary to explore less costly, more versatile, and more affirmative methods for accomplishing these ends. Quality assurance mechanisms built on more innovative and less bureaucratic models must be investigated including those that involve citizens, consumers, and consumer advocates.

The Social Services Block Grant also provides an impetus for designing more locally responsive quality assurance mechanisms. Because block grants are accompanied by a diminution of federal regulation and the enforcement of uniform standards for provider performance, states and localities will have to craft alternative monitoring techniques that are consistent with their unique needs and that preserve public accountability.

The following report is an attempt to analyze the shortcomings of current quality assurance approaches, to investigate the state-of-the-art in quality assurance, to present examples of innovative methods currently in practice around the country, and to describe a systematic approach whereby state and local human service agencies can put these methods to use. Our hope is that this report will lead those responsible for assuring the quality of human services to reevaluate their practices, and where it makes sense, to adopt more practical, effective, and dynamic methods.

Chapter I
Introduction

Over the past several years, the shape and content of the system providing social services to the elderly, to children, to the disabled and to other disadvantaged groups has undergone a significant metamorphosis. The primary hallmarks of this change are decentralization of services, diminution of the segregation of social services clients, reduction in the role played by large congregate care facilities, reinstatement of local control over service delivery, and -- as a means of accomplishing the above ends -- a dramatic expansion in the use of the private sector to provide social services. While this near revolution substantially changed the service landscape, the infrastructure of the system including public quality assurance mechanisms changed very little and in fact was allowed to atrophy in some instances due to shortages of staff, a failure to keep pace with evolving service technology, and the difficulties involved in monitoring services in a decentralized system.

Because the expansion of services outpaced the development of administrative support systems, the past several years have witnessed a frenetic scramble on the part of many states to regain control over what some would call a runaway system. Unfortunately in their rush to take the reins, some public social services officials opted for quality regulating methods aimed solely at policing the system rather than developing a balanced oversight structure that included quality enhancing techniques as well. The result in some states has been an increasing alienation of the public overseers from the private providers, and the development of a relationship

more akin to a commerical arrangement between "purchaser" and "vendor" than a public/private partnership devoted to collaboration and service improvement.

The major casualty of the rigidification of relationships between the public and private sector in the social services field is the ability of state officials to transmit programmatic policy to the service system. The communication of a vision of what the service system should be is blocked both by the adversarial character of the relationships and by the narrow focus of much of public monitoring (e.g., on fiscal irregularities, inadequate record-keeping, etc.). Ironically, the ossification of the channels of policy transmittal between the state and the private sector may lead to the same state of affairs that precipitated the initial wave of reform -- a static delivery system devoid of innovation and geared to the lowest common denominator.

The following manual provides a new way of viewing quality assurance mechanisms and presents a variety of concrete methods for enhancing service quality while also regulating provider accountability. The purpose of the document is to assist public officials, social services professionals, consumers, and their advocates to design and install quality assurance techniques that are cost-effective, utilize existing resources (e.g., volunteers, parents, etc.), respond to client interests, and stretch the capabilities of social services agencies to their maximum potential. Before outlining some of the techniques that can be employed, the remainder of the introduction desribes the evolution of the manual and guide, the major findings that underpin its design, and the rationale for the organization of the material.

History of the Study

This report reflects the culmination of a five year collaborative effort directed by the Human Services Research Institute (HSRI) and including Berkeley Planning Associates (BPA) and the Urban Institute (UI). Funds to support this exploration have come from the Office of Human Development Services in the Department of Health and Human Services -- initially from the agency's "cross-cutting" grant program and subsequently from the discretionary grant fund. Over the project period, the study has gone through several stages and has generated numerous analyses and reports.

The first phase of the study was devoted to the conceptualization of quality assurance principles and approaches. Our task was to ascertain how "quality" should be defined in the social services arena and to explore the literature to determine the range of techniques available to measure and assess this elusive concept. Though no single definition of quality was found to be adequate by the study team, we were able to describe the dimensions along which quality could be assessed (i.e., input, process, output, and outcome), to differentiate the levels at which particular forms of quality assurance information are required (i.e., policy level versus operational level), and to assess the efficacy of particular quality assurance techniques (e.g., outcome monitoring, accreditation, etc.).

The substance of the analysis relied heavily on information gained from the health literature because of the breadth of experience in that field. It was also greatly assisted by two advisory groups -- one comprised of academics and theorists interested in the field of quality assurance and the second consisting of social services practitioners. The report from that phase of

the project, Assuring the Quality of Human Services: A Conceptual Analysis (Ashbaugh, Bradley & Stoddard, 1980), was useful to a range public and private social services providers and officials interested in assessing the relative merits of various approaches and in designing quality assurance systems.

The findings of the first phase led to a recognition of the limitations of broad-scale, complex quality assurance systems. Such limitations were in part the result of inadequate technology (e.g., inability to devise reasonably-priced outcome monitoring techniques), overly ambitious expectations (i.e., a desire to know more about services than the information processing system could reasonably be expected to transmit), and rapidly diminishing budgets for quality assurance activities. The initial assessment of quality assurance techniques also pointed out the inability of conventional oversight techniques to ensure ongoing client well-being and to prevent abuse and exploitation.

Persuaded, therefore, that any further exploration of large-scale, mechanistic quality assurance schemes would be counter-productive, the study team turned its attention to more innovative, moderately priced and responsive mechanisms. With the help of a wide range of human services organizations, the study team advertised in numerous journals and newsletters for exemplary quality assurance methods. The result was the identification of over 50 techniques -- all of which were followed up either through site visit or by phone. The utility of the methods uncovered was reviewed by another project advisory group, this time comprised of public officials, representatives of national organizations, agency directors, and consumer representatives. The result of this phase was the preparation of a report titled Overview of Methods for Assuring the Quality of Human Services Currently Operating at State and Local Levels (Ashbaugh, Harder & Stoddard, 1981).

The final phase of the project has involved the formulation of a new orientation toward quality assurance in human services that builds on the work in the first two project phases and that grows out of organizational management principles that have been receiving increased attention over the past few years (e.g., use of positive incentives and encouragement, elimination of rigid hierarchical structures, mutual participation and collaboration, etc.). It is also premised on a recognition that every quality assurance system must include regulatory or control-oriented mechanisms (e.g., auditing, licensing, etc.) as well as capacity- enhancing techniques (i.e., technical assistance, self assessment, etc.). The nature of the balance between these two poles is discussed in more detail in the section that follows.

Critique of Current Quality Assurance Approaches

A review of quality assurance systems around the country suggests that most are only partially effective and in some instances counterproductive. The problem stems from an inadequate balance between the aims of quality regulation and quality enhancement. This lack of equilibrium can be seen in the of the following characterization of traditional quality assurance systems.

Minimum vs. Model

By and large, the standards used to judge social services are static and represent minimal compliance threshholds. Standards are relatively static in that they change little with the state-of-the-art or the development of the service system. They are minimal in that they are more concerned with floors

than ceilings. Clearly, there are basic requirements that all services should meet and that are unlikely to change over time including minimum health and safety standards. However, those standards that pertain to the conduct of programs should not be immutable since the "art of service" changes over time. Further, standards should not only mark minimal achievement, but should contribute to the dynamic character of a system by constantly exhorting providers to higher levels of attainment.

Thus, while most conventional standards guarantee that crucial health and safety protections are available to social services consumers, they also tend to build mediocrity into the service system by aiming at the lowest common denominator. This latter phenomenon is understandable given the importance of standards in determining eligibility for federal and/or state funding. If standards are set too high, funding bodies run the risk of eliminating a large segment of the provider community from the system. There is no reason, however, why minimum <u>and</u> model standards cannot be developed -- minimum standards to ensure client well-being, and model standards to serve as a target for increasing levels of performance and as a way of infusing the system with new ideas.

An instance of the failure of minimum standards to move the service system to maximum performance levels was observed by the study team during one of the state site visits. In that particular state, the division of developmental disabilities devised a set of standards to be administered by site review teams made up of providers, state officials and consumers. In the initial stages of the peer review process, according to a number of program administrators interviewed, providers benefitted by their exposure to the new standards and to the experiences of their peers. However, after a few years, most providers had achieved compliance and there was nothing left to learn

from the process. There was also no incentive to move beyond the standards, only sanctions for non-compliance. Eventually, what had begun as a challenging and stimulating quality assurance scheme became routinized and was seen as superfluous by many providers. Though the standards continued to provide a floor under the service system for developmentally disabled persons, the rules became increasingly irrelevant since many providers had moved beyond them.

Burden of Documentation

A second characteristic of most quality assurance systems is the extensive amount of written documentation needed to satisfy "quality assurers" that standards have been achieved. In order to understand why such informational demands are placed on the service system, it is necessary to review the bases that underlie conventional standards. The two most pervasive theories on which standards are based are: 1) management systems theory (Johnson, Kast & Rosenzweig, 1973), and 2) rational casework theory (Wood, 1978). Both of these theories are derived from the systems approach to service management and differ only in the purpose for which they are applied.

Systems management theory was originally developed with large complex organizational structures and tasks in mind (e.g., missile construction, computer production, etc.). It stressed the importance of articulating formal purposes or goals and objectives, implementation strategies, time-tables, and standing operating procedures. It also stressed the importance of documenting these plans or formal statements of anticipated courses of action. Such procedures were necessary to keep complex undertakings on track by making them more manageable.

The importance of written plans and procedures is also stressed in rational casework theory which calls for the development of individual or case plans that address agreed upon client goals and records of goal achievement, and the design of principles to govern the delivery of services. An example of the influence of this theory can be seen in the standards developed by the Accreditation Council for Services to Mentally Retarded and Other Developmentally Disabled Persons which contain no less than three dozen requirements for standing plans (AC-MR/DD, 1978). These written standing plans or procedures are intended to guide staff in lieu of ad hoc, personal management directives.

The convergence of systems theory and rational casework theory in the design of standards for social services has resulted in a monitoring system that relies heavily on documentation of paper policies and procedures (e.g., written plans, standard operating procedures, formal objectives, etc.). Though the need for formal and predictable routines is unarguable, the question is how many of the policies and procedures need to be committed to paper. In a large and complex organization, such formalization and routinization is essential to efficient operation. However, many social services agencies are small and the program management and case management processes are not that complex. Good managers in these settings can and do handle a range of situations on a case-by-case basis.

To a large extent, documentation requirements for social services programs are designed more to satisfy quality assurance requirements than to bolster internal management. Under these circumstances, one must ask: 1) to what extent is such documentation needed and justified? 2) would it be more efficient to devise a less burdensome and "paper-laden" means of monitoring social services programs and client performance? In other words, does

extensive documentation contribute to service quality or has it become a hollow and inordinately time-consuming exercise? A quote from a prestigious provider that appeared in a recent report on purchase of service reinforces the latter possibility: "I could be running a zoo here and they wouldn't care as long as I filled in the little blocks (on the forms)" (Massachusetts Taxpayers Foundation, 1980).

Reactive vs. Positive

The third tendency of traditional quality assurance systems is to employ techniques that are more reactive than "proactive." Proactive mechanisms involve continually monitoring and assisting programs for the purpose of improving practice to the point where it surpasses minimum standards, and heading off potential problems before they develop. Reactive mechanisms are designed to investigate service quality problems post facto. Proactive mechanisms are by nature positive and forward looking, while reactive mechanisms are generally negative and targeted to past practice.

A quality assurance system that is characterized by reactive approaches is aimed primarily at past performance and is geared to finding fault or non-compliance. When site visitors appear from state licensing authorities, they are usually looking for irregularities, not for positive achievements. Further, techniques such as grievance mechanisms are aimed at uncovering and investigating past wrong-doing rather than building future consumer protections. Clearly, ferreting out abuses in service delivery is an important activity in any quality assurance system. The problem arises when the system becomes dominated by negative oversight and sanctions.

Proactive mechanisms are those elements of quality assurance that move the system to higher levels of performance and include such things as

interdisciplinary review of client progress, provision of training and technical assistance to provider staff, and active involvement of case managers, parents and others in overseeing program operations and advocating for program improvements. Proactive techniques seek to encourage and reward performance and to equip social services staff with the tools and capabilities needed to do their jobs properly. It is through these techniques that social services officials communicate their expectations for system development and renew their connection to the delivery of services.

Without the proper balance of positive proactive procedures, alienation between overseer and provider intensifies and the transmission of programmatic vision is jammed. Social services administrators come to see the public monitors as adversaries concerned only with finding fault and without anything more than a technocratic vision of program content. Conversely, quality assurance officials increasingly treat the provider at arm's length since the absence of positive approaches diminishes the collaborative aspects of the public/private service partnership. As a result, the mutual support and cooperation conducive to service quality is undermined.

Conclusion

The previous discussion points out the one-sided character of current quality assurance systems in the field of social services. The imbalance stems from an over-reliance on mechanisms that are static, that fail to reward superior performance, that entail burdensome documentation requirements, and that are oriented to fault-finding rather than capacity enhancement. This critique is not meant to suggest that such quality assurance mechanisms are inappropriately applied in the field, but that they are applied to the exclusion of other techniques. Without the leavening of quality enhancement

mechanisms such as technical assistance and training, the exclusive reliance on more negative quality regulating approaches may ultimately frustrate the very ends they are meant to achieve -- the maintenance of a responsive and dynamic social services system for vulnerable and disadvantaged citizens.

Overview of the Manual

Guiding Concepts

In order to understand the way in which this report is organized, it is necessary to set out some governing principles and categories for the discussion. First, in designing the manual, the study team identified five fundamental governmental responsibilities or purposes that should be served by a quality assurance system and component methods: 1) to assure that providers of human services have the capability to provide an acceptable level of service; 2) to assure that client services are provided consistent with accepted beliefs about what constitutes good practice; 3) to assure that a given commitment of resources produces a reasonable level of service; 4) to assure that the services that are provided have the intended effect; and 5) to assure that the limited supply of services is provided to the clients most in need.

There are two additional ends to which specific quality assurance methods lend themselves that cut across the major objectives mentioned above and that help to further define and catalogue quality monitoring approaches -- quality regulation and quality enhancement. As noted earlier, quality regulation seeks to ensure that services meet minimum standards, that financial and programmatic irregularities are detected, and that basic procedures are

documented. Quality enhancement seeks to maintain the momentum of the system toward a programmatic ideal and to equip service providers with the skills necessary to keep in step with changes in the art of service. As will be seen in Chapter III, some methods by their nature are either quality regulating (e.g., licensing) or quality enchancing (e.g., technical assistance), while others are basically neutral and take on the coloration of one or the other aim depending on the purposes to which they are put.

Further, quality assurance techniques are usually comprised of three elements: 1) standards and measures -- these terms represent the expected levels of provider competency or performance (i.e., in terms of input, process, outcome, and/or outputs) and the corresponding indicators used to gauge their achievement; 2) monitoring and evaluation -- these activities involve the actual measurement of service provider competence and/or performance and the communication of this information to the quality assurance organization; 3) control mechanisms -- this term encompasses those procedures and techniques involved in initiating corrective action or any action necessary to bring actual competency or performance in line with what is expected.

Whether one is intent on the overhaul of existing state or local quality assurance systems or simply on the improvement of a particular method, one must keep these purposes and key elements in mind. Because of their significance, the study team has organized the discussion of the state-of-the-art quality assurance according to these concepts.

Organization of the Manual

As noted, the layout and substance of the manual is intended to underline the concepts that should govern quality assurance activities and to emphasize

the importance of a balance between quality-regulating and quality-enhancing techniques. The initial discussion of the state-of-the-art in quality assurance in Chapter II is organized according to each of the five areas of responsibility and includes an assessment of the capabilities and limitations of existing quality assurance methods relative to each governmental responsibility. The discussion highlights some of the most troublesome problems and constraints that plague quality assurance endeavors and provides a useful backdrop for the discussion of specific techniques that follows in Chapter III. It should be noted, however, that this section of the manual is somewhat theoretical and abstract. If the reader is more interested in particular applications of quality assurance techniques, skimming Chapter II to pick up the major themes may be advisable.

The analysis of specific techniques is organized according to the auspices under which innovative quality assurance activities can be carried out and the categories of techniques that can be employed. The description of each approach includes an assessment of its uses and limitations in terms of the fundamental quality assurance responsibilities, the applicability of the technique to specific services and target populations, and the ways in which the three key elements of quality assurance techniques (measurement, monitoring, and control) are manifest. The discussion also notes whether or not the approach is by nature quality-regulating or quality-enhancing, or whether its purpose is dependent on the context in which it is used. Some of the methods that are discussed in Chapter III represent alternatives to the more reactive federal and state quality regulating measures currently in use. Other methods can be put to more positive purposes and can be employed to rectify the current imbalance described earlier.

Chapter IV of the manual is intended for state and local officials and

private funders of human services looking for more than a short-term solution to immediate quality assurance problems. It describes a systematic procedure for analyzing and redesigning quality assurance systems to bring about a balance between reactive and proactive elements, and for managing the implementation of major system changes.

Chapter V includes a description of the quality assurance methods described in the text. The discussion is divided into the following components: purpose, scope; implementation history, monitoring process, analytic process, control process, strengths, and limitations. Each method also includes the name of a contact person for further information.

Chapter II
State-of-the-Art

Growth in Public Quality Assurance Systems

Prior to the growth of large publicly funded human service networks, the definition and assurance of quality was largely a private and informal matter between service recipient and provider. As the size and complexity of the human service bureaucracy has grown, the role played by the individual consumer in assuring the quality of services has declined.

Morgan (1974) suggests two explanations for the growing reliance on formal quality assurance mechanisms:

> One is our change to a society which is technically specialized, in which the ordinary citizens have neither the expertise nor the access to inspect for quality and safety, and must rely on the authority of the state for protection. The second is the change to a society in which people have become more mobile, more likely to be strangers to one another with the result that informal community supervision cannot be fully relied upon. (p. 22)

A third, and perhaps more important explanation is the increasing role of the government and other third party payers in the service system which has resulted in a diffusion of the provider's sense of accountability to the individual consumer.

Although the individual consumer may participate in the monitoring and evaluation of service quality, quality control is largely left to a public or private "quality assurance" agent or agency. Collective quality assurance entities, both public and private, are motivated variously by the protection of consumer and/or community interests, promotion of good and efficient

practice, and prevention of the misuse of public funds.

Levels of Quality Assurance Systems

Two levels of decision making and associated quality assurance activities can be characterized within a social services delivery system: (1) policy level, and (2) operational level. At the policy level, the decisions are strategic and complex in nature, encompassing a relatively broad program scope and geared to a long versus short term purpose. Decisions at this level apply to the overall delivery system, and are primarily concerned with the relative cost effectiveness of alternative service designs (i.e., programs).

At the operational level, the decisions are tactical and less complex in nature, more focused on present rather than future concerns, and less concerned with service design alternatives than with the efficient implementation of a given design. These decisions are directed at individual providers.

Policy Level

By definition, the prime quality concern at the policy level is with service outcomes or the assurance of effectiveness. This characteristically entails the comparative evaluation of services or providers in terms of selected outcome measures. Scientific research and statistical methods are employed to ensure that the findings are reasonably valid and reliable. Such information is important at the policy level to assist in designing larger service strategies. Design activities entail a determination of what services, new or existing, will have a more beneficial outcome at a lesser cost (i.e. cost/outcome, cost/benefit, and cost effectiveness evaluations).

For example, is adoptive care more beneficial than foster care? -- Are community-based residential and day programs more or less cost/beneficial than institutional programs for severely and profoundly mentally retarded adults?

In order to arrive at sound program strategies, policy level analysts must be concerned not only with the prospective outcomes of proposed service alternatives, but also with the consequences of taking no action. Further, policy designers cannot look just to the existing system to define quality, but must imagine and explore the outcomes of innovative service technology that may yield more beneficial results (Weiss, 1973). For instance, it may well be that preventive or self-care approaches to human development would be more cost effective than existing direct service approaches.

Finally, it should be noted that quality assurance systems not only inform policy-making, but also serve as a means of purveying policy or programmatic vision to service providers. The content of quality assurance standards, for instance, sets the tone for the delivery of services and communicates programmatic expectations. The level and type of technical assistance and training delivered through quality enhancement mechanisms further solidify and expand the service aims developed at the policy level. Thus, quality assurance activities serve policy-making in two ways -- to provide information for strategic budget and programmatic choices, and to serve as a vehicle for diffusing programmatic policy through the system.

Operational Level

At the operational or service delivery level, the basic design of the service has been established, and the responsiblity is to assure that the provision of the service conforms to the established service design and

specifications. By definition, the prime concern here is with the control of service inputs, processes and outputs, and indirectly with client outcomes. Quality standards are established as a means to gauge the performance of individual service providers and the provider's performance is continually monitored and evaluated to assure that the standards are being met. If not, the quality assurance mechanisms act to coerce or persuade the provider to take corrective action.

Operational level quality assurance mechanisms, based on input process measures: ". . . assume that the objective of service is 'good,' that certain activities predictably lead to the achievement of these objectives, and that [one] can determine whether these activities have been adequately performed." (Lorisch, 1977) Given these assumptions, quality assurance decisions at the operational level are less complex and more limited than policy-level quality assurance decisions. They are, in fact, largely repetitive and routine in nature and governed by decision rules that are typically worked out in advance.

In keeping with the practical orientation of the project, the manual that follows describes operational level methods that focus on the quality of services delivered by individual providers. However, the study team also endeavored to include operational methods that facilitate the communication of programmatic policy and that provide information for the enrichment of policy development.

Strengths and Limitations of Current Approaches

Over the past decade, we have witnessed an extraordinary emphasis on human service provider accountability (Newman & Turem, 1974). Countless

quality assurance tools have been designed, developed, tested, and implemented. Yet, despite the flurry of formal quality assurance activities, some critics are still skeptical. Haselkorn (1978), for instance, writes:

> . . . there remain a number of thorny problems which will not be resolved simply with a deluge of forms, statistical tabulations, or postures of professional self-criticism. What we are witnessing, in the name of accountability, is often pseudo-accountability. This situation is especially evident in bureaucratic auditing and reporting, in the evaluation of records which may not reflect the quality of performance, in the empty compliance that may sacrifice service in order to give the appearance of accountability. (p. 330)

The predominant problems that constrain the effectiveness of quality assurance activities are: 1) a limited ability to obtain and communicate valid and reliable measures of service quality at a reasonable cost; and 2) the difficulty of constructing effective control mechanisms. In other words, formal bureaucracies are limited in their ability to oversee and control the individual behavior of practitioners and the organizational behavior of providers.

The section that follows focuses on the extent to which the objectives of quality assurance can be fulfilled given these limitations in the state-of-the-art. Specifically, the discussion centers on the three basic components of quality assurance (standards and measures, monitoring and evaluation, and control) and the ways in which they serve to advance each of the five quality assurance responsibilities reiterated below:

1. To assure that providers of human service have the capability to provide an acceptable level of service;

2. To assure that client services are provided consistent with accepted beliefs about what constitutes good practice;

3. To assure that a commitment of resources produces a reasonable level of service;

4. To assure that the services that are provided have the intended effect;

5. To assure that the limited supply of services is provided to clients

most in need.

Ability to Assure the Capacity of Providers of Human Services to Offer Acceptable Levels of Service

Standards and Measures. Standards and measures of the capacity of providers to offer minimal service are generally termed "input" standards and measures -- that is standards and measures of the resources entering into the service process. Inputs include:

Personnel -- personnel or staff are by far the most prominent inputs, generally accounting for 75% or more of a provider's operating costs. Typical standards and measures pertain to the qualifications of staff including their education and training, and to staffing levels expressed relative to client levels or workload.

Funding -- most financial standards and measures relate to the provider's financial condition. Does the provider represent a reasonable risk for the funding agency? Is the provider unlikely to be put in a position where financial constraints could seriously compromise the care provided to individual clients? These standards and measures are commonly expressed as ratios of assets to liabilities and revenues to expenditures. Most indicators gauge the trends in and stability of the provider's base revenues and expenditures.

Facility and Equipment -- facility and equipment standards and measures relate to the size of the facility, and to programmatic areas within the facility; condition of the facility with respect to health, and fire and life safety; and the presence and condition of essential equipment. Such standards are most relevant to residential and day care providers where the character of the facility -- both physically and aesthetically -- is a major concern.

The major drawback to using "inputs" as measures of quality is that they measure only the **capability** to perform and not **actual** performance. Such measures rest on the assumption that inputs predict performance; very few rest on empirical evidence. Focusing on inputs has the advantage of relying on concrete items that are easily counted and have face validity. However, demonstrating the construct or proven validity of these measures is a very

difficult proposition. While some researchers have been able to present empirical evidence linking particular human service inputs to service outcomes (Berkeley Planning Associates, 1977; Lally & Honig, 1977; Cooper 1974), as many, if not more, have not (Lamborn, 1960; United States DHEW Audit Agency, 1976).

Scores of researchers have also tested for significant relationships between various dimensions of the physical service environment (e.g., neatness, home-like furnishings, amount of available living and program space, etc.) and indices of service quality with mixed results. On the positive side, Eyman, DeMaine, and Lei (1979) described the relationship between environmental ratings of community homes and changes in adaptive behavior of retarded residents in those facilities. On the negative side, Conroy and Lemanowicz (1981) found no relationship between the standards of the Accreditation Council for Services to Mentally Retarded and Developmentally Disabled Persons (AC/MR-DD) and the development of mental retardation clients. Until recently, most "mileu" research has taken place in institutional settings (Gurel, 1964; Lawton, 1975), thus testing a somewhat limited range of environments.

One area where empirical research has been fairly conclusive on the relationship of inputs and outcomes is in fire safety. In an attempt to minimize excessive and costly facility and equipment requirements in small residential programs for disabled persons, the National Bureau of Standards (NBS) sponsored a study designed to establish the relationship between the demographic and developmental characteristics of developmentally disabled residents in group homes and their ability to evacuate the home and exercise due safety precautions. The results of the study have since been used by NBS in making recommendations on the fire safety requirements in homes for the

elderly and mentally ill as well as developmentally disabled persons (Center for Fire Research, 1982).

Monitoring. Inputs have the advantage of being relatively easy to observe directly or indirectly through existing documentation (e.g., number of staff, number of fire doors, educational credentials, capital improvements to facilities, etc.). Moreover, most inputs change little in the short run and thus need to be measured relatively infrequently. Revenues and expenditures seldom change significantly more than once a year. Staff credentials likewise change little in the short run. Staffing levels and training are about the only input that could conceivably change markedly within a given year.

The tangible and unchanging nature of most inputs means that they can be monitored fairly infrequently, and indirectly through reports rather than in person. This greatly reduces monitoring costs. Recognizing these facts, most quality assurance methods designed to measure inputs should and do obtain the data through periodic reports, tests, or record reviews, and do not trouble providers unnecessarily with personal interviews or on-site visits. For this reason, too, preliminary self-assessment reports or applications are increasingly common as part of licensing and accreditation procedures (Ashbaugh, Bradley & Stoddard, 1980; Commission on Accreditation of Rehabilitation Facilities [CARF], 1981; Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons [AC/MR-DD], 1978). A number of these techniques are described in Chapter III.

Control. The control mechanisms most commonly used to assure the quality of service inputs are licensing, regulation, and credentialing. These techniques are described below.

Licensing -- the process by which an agency of the government grants permission to individuals or organizations to practice or provide a service;

Regulation -- a statutory based process that relies on legal intervention by the government to punish infractions of the law by any individual or organization, but does not require any assurance of quality prior to practice;

Credentialing -- a process whereby individuals or organizations providing a service are formally recognized, accredited or certified as qualified to practice by a non-governmental agency.

Licensing is future oriented, requiring a would-be provider to take the time and make the effort to tool up, develop needed capabilities, and take safety precautions before securing permission to provide a service. The minimum standards for licensure usually pertain to the protection of the health, safety, and welfare of clients.

Like licensing, regulation is a statutorily-based process that allows legal intervention by public entities to punish infractions of the law. As noted, regulation operates only after a program is in operation. Unlike licensing, which is centrally concerned with assuring the **ability** to perform, regulation is more concerned with assuring the **adequacy** of ongoing operations. Licensing and regulation are both supported by the legal authority necessary to assure that providers are financially stable, meet minimum facility and equipment (fire and safety) requirements, minimum staffing levels, and personnel qualifications.

Given the extreme nature of these mechanisms -- especially licensing (regulating authority to practice) -- and the lack of a strong empirical link between positive outcomes and the qualifications and/or practice of staff (Ziarnik & Bernstein, 1982; Abt Associates, 1977), such approaches are too rigid to use to control the competence of human service workers. It is easy to see how uneducated medical practitioners present a danger to the public and why legal protection is necessary. It is also easy to see how violators of fire and safety regulations in human service facilities present a danger to public safety. However, it is more difficult to envision in what ways

untrained social workers pose a serious threat to the welfare of the consumer.

Moreover, locking human service provider qualifications into law would probably be a mistake. Giving legitimacy to unproven and ever-changing educational and training programs in this way may be premature. Over time, such qualifications, frozen in law, could well become outmoded, irrelevant and even deleterious to clients. For instance, Medicaid and Medicare regulatory provisions that disallow payments for paraprofessional services have done much to discourage the use of such resources. Many feel that this unnecessarily raises treatment costs with no measurable increase in service quality.

Various forms of credentialing and contracting, discussed in subsequent sections, represent less extreme and rigid means for assuring minimum staff qualifications.

Ability to Assure that Client Services Conform to Generally Accepted Standards of Good Practice

The process or practice dimension of service quality refers to the interaction between the client and the organization providing the service, and to the administrative and support activities integral to the delivery of the service.

Standards. Process standards and measures pertain to the program administration and support dimensions of service delivery such as facility maintenance, management style, programming, order and organization, record keeping, and the like. They also address face-to-face service delivery dimensions such as counseling methods, service staff attitudes, and behavior toward clients. Most process standards are ideologically based. Most are

also knowledge based -- that is based on empirical, theoretical, or scientific knowledge relating them to client outcomes.

Ideologically-Based Standards. Ideology stands above and to some extent governs the influence of theory, scientific knowledge, and empirical knowledge. In order to understand the overarching nature of ideology in conceptualizing quality, a definition is helpful. Mayer (1978), in discussing the position of ideology in social and institutional change, characterizes ideology as follows:

> Ideology is (1) a set of values that is (2) a property of an organization (3) designed to influence the acts of others regarding (4) the goals of the organization and (5) the appropriate means for pursuing these goals. . . We are assuming that an ideology deals primarily with output [outcome] goals, by which other types of goals must be justified. (p. 14)

As Mayer (1978) points out, ideology is not the only concept that directs action -- scientific, empirical, and theoretical knowledge are also bases for selecting among competing means. Ideology, however, dictates the general aims or goals of the enterprise as well as "the range of acceptable courses of actions to be taken" (p. 15). Therefore, it can be said that ideology governs the ends of an activity, such as service provision, and in turn the nature of the means to be used. The other knowledge bases provide guidance for carrying out ends and evaluating the relative effectiveness or efficiency of the intervention.

An example of this distinction can be seen in behavior modification programs for disturbed juveniles. If the end of such a program is to treat clients in a humanitarian fashion, then the use of cattle prods to control behavior -- even if it is an effective means of control -- would be ruled out as an intervention. Any standards governing such a program would constrain the use of aversive techniques such as the one described.

By and large, ideologically derived standards center on the **process** of

service delivery rather than on service inputs or outputs. Concentration on process dimensions can be explained by the fact that quality norms are more concerned with the ways in which clients are treated rather than the inputs or outcomes of the intervention. For example, if the end of a program for developmentally disabled persons is narrowly defined as reducing inappropriate behavior, ideological standards would constrain the use of aversive techniques to achieve that end. An ideological standard is not necessarily inattentive to the end but places more emphasis on the way in which the outcome is brought about.

In some instances, ideologically-based process standards may even take precedence over outcome standards. The designers of the Program Assessment of Social Services (PASS) (Wolfsenberger & Glenn, 1973) and the AC/MR-DD standards would maintain that some process standards -- such as those related to dignified treatment and normalized environment -- are important to assess even if they have no bearing on client outcomes. It is the adherence to these process concerns in and of themselves that forms the basis for defining service quality.

This is not to say the ideology cannot be translated into outcome standards. It is to say that those favoring ideologically based standards have not traditionally focused on service outcomes but on service processes. With respect to independence, for instance, one can clearly measure the extent to which a client's living situation and skill level make him or her a more independent and integrated member of the community. Other norms, such as dignity, are more difficult to describe in terms of outcomes and, therefore, will probably continue to be assessed as process indicators.

It is also possible that, over time, process indicators related to ideology will be correlated with successful outcomes. Work being conducted at

the University of California at Los Angeles with the PASS system has already shown direct connections between high process ratings and positive outcomes (Eyman, et al., 1979). It is probably safe to say, however, that even if some ideologically governed process standards are not ultimately correlated with client outcomes, they will still be maintained for purposes of program assessment. Because ideology asserts that adherence to such norms is an end in itself, such values will continue to govern the conduct of the program and the ways in which service providers treat vulnerable and needy clients.

Some of the most prominent ideals governing human service practice are individual dignity, protection from harm, normalization and equity. The norm of "**individual dignity**" dictates that each person in the society has a core of personal integrity and uniqueness that defines his or her individuality. Dignity is closely related to an individual's ability to choose, to select and maintain possessions, to be treated with respect, and to live in surroundings that foster individuality and allow for privacy.

"**Protection from harm**" is directed at potential abuse or exploitation of service recipients such as the elderly, handicapped, children, and others who may be particularly vulnerable because of mental impairment or physical frailty. The norm of protection from harm can be viewed along a continuum from prevention of physical abuse (as in the case of health threatening conditions in institutions) to the use of the least restrictive means of caring for the client. At all points on the spectrum, the normative orientation is toward client well-being and reinforcement of personal autonomy.

Wolfensberger (1972) defines "**normalization**" as follows: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally

normative as possible" (p. 28). Services with a normalization orientation are those that rely on an environment and process that are as culturally appropriate as possible to the person's age, sex, and other personal characteristics. Normalization analogues include the principles of mainstreaming and integration, and the utlilization of generic services to the maximum extent possible.

"Equity" is a norm that speaks to the allocation of resources to and accessibility of services by different individuals and groups in the society. The norm suggests that the allocation or distribution of resources for governmental or social ends should be carried out in a fair and just fashion so that no individual or group is deprived of its "fair share," just as no group should receive more than its just due.

Knowledge-based Standards. Knowledge-based process standards are based on theory, that is on more or less plausible or scientifically acceptable principles offered to explain how a service works. A human service theory explains the nature of the relationship between service inputs, processes and outcomes. Definitions of human service quality may be grounded in a variety of theories including social, behavioral, economic, cybernetic, biological, and physical. Social and behavioral theories, however, predominate in the field. Numerous theories in the social and behavioral sciences have influenced both the definition of quality and the standards selected to measure service quality.

Although the grand hope of social and behavioral science has been the discovery of immutable laws for human behavior comparable to those in the physical sciences, thus far the predictability of social behavior and its outcomes is still a relatively imprecise art. Social science has been useful in exploding myths and folklore about human behavior, but has not generally

succeeded in building strong generalizations that have held up, statistically, to replace the folklore.

The image social scientists have of what it means to derive "laws" for human behavior has shifted in the recent past. We have moved from deterministic to probabilistic expectations regarding human behavior. As a result, there is an increasing awareness of the dependency of behavioral theories on the cultural and linguistic context in which behavior takes place. There is a recognition that most social acts are affected by a highly complex range of stimulae, making "if x, then y" statements obvious simplifications. There is a recognition that most supposedly "neutral" or "objective" assertions about human needs or laws of behavior in fact embody major assertions about meaning, values, and context, and thus are social and even political statements and not merely theoretical in nature. All this is to say that the development and application of social, behavioral, and other theoretical propositions pertaining to the effective delivery of human services remain largely in a formative and highly conceptual stage. The following comments regarding social casework underscore this point:

- On behaviorally oriented casework, Thomas (in Roberts & Nee, 1970) observed:

  There is as yet no coherent set of principles and procedures for behaviorally oriented casework. The principles and procedures of such an approach must be informed at the very least by the knowledge and practice of behavioral modification and by the several functions beyond behavioral alteration itself that are served in the agency and program contexts of casework practice. (pp. 216-217)

- Conceptualizations about crises in casework are described by Lydia Rapoport (in Roberts & Nee, 1970) as follows:

  Crisis theory is not as yet a well formulated or holistic theory which has systematically validated propositions . . . it exists as a framework for viewing and treating individuals and families in situations of urgency and stress. (p. 267)

- The nature of family therapy casework was described by Frances H. Scherz (in Roberts & Nee, 1970):

> The forces that were tentative in the 1950's have steadily gained impetus until now it can be said that family therapy has, in many social work settings as well as in psychiatry, achieved the status of a therapeutic model. . . there is general agreement among those who accept family therapy as a therapeutic model that unless there are specific contradictions, the family should be the unit of attention for casework exploration and treatment. (p. 222)

As Haselkorn (1978) notes "[social workers] are still far from a homogeneous approach to practice, and will continue to practice with more rather than less conceptual and clinical diversity" (p. 333).

To recapitulate, then, there are a multiplicity of theoretical propositions explaining how human development services should and do work. Many of these theories are competing. Most of the significant theories relating to the delivery of human services (social, behavioral, economic, etc.) are broadly defined conceptual frameworks or models rather than well defined propositions. Consequently, these propositions are extremely difficult to prove. Even if these theories can be verified, the selection of a single theory that is universally applicable to the variety of complex client and service characteristics is practically impossible. Theoretical standards are generally too simplistic and rigid to be reasonably applied in the complex, esoteric human service delivery process.

In view of the inability to establish scientifically the superiority of particular service techniques as "the standard," some quality assurance organizations have substituted competency or "input" standards as described in the previous section. They define standards and measures of practice in terms of the theoretical knowledge (or competency) that a practitioner should have. Given a firm grounding in the range of theories in his or her field, the knowledgeable professional is expected to be able to select among competing theories in the course of providing service.

It is essential that the practitioner have sufficient technical expertise

based on systematic knowledge and doctrine acquired through formal training. The neophyte practitioner must have this training to gain the formal knowledge and skills and the implicit or tacit knowledge, values, and norms of the craft (Wilensky, 1970). It is the latter -- the tacit knowledge values, and norms -- that provide the basis for what is commonly referred to as the "art" of social work.

In the National Association of Social Workers (NASW) Standards for Social Work Services In Schools, Standards for Attainment of Competence (1978), Standard I states:

> Areas of required knowledge are . . . Human behavior and social environment including a variety of theoretical perspectives . . . psychodynamic approaches to understanding individual and group behavior, including cultural, racial and ethnic diversity; social learning theories; biological factors affecting growth and behavior; theories of social interaction, e.g., symbolic interaction, role theory, labeling, cognitive dissonance, referring group. . .

Such competency oriented approaches are clearly accepted and administered by many associations of human service professionals.

Other organizations have adopted standards prescribing a rational, problem solving or goal-related approach to casework. Wood (1978) maintains that such principles or standards (e.g., negotiation of a contract with the client) are related to more effective casework or group work based on her analysis of 22 studies of the effectiveness of human services. However, Fischer (1979), for one, fails to see the connection, and others doubt that casework can proceed on the basis of rational principles let alone be more effective because of them (Cross, 1979; Haselkorn, 1978). Cross questions whether the rational approach can work in human services because of the limited degree of control over the client. Similarly, Haselkorn and Cross find such principles narrow and naive because they fail to address the less quantifiable and more complex aspects of human services.

Process Measures. In addition to being technically adequate, the process of service delivery should also be sensitive to the needs of clients. Similarly, the art of program management and administration are important elements in service delivery. Capturing the essence of the service process, then, involves measuring not only technical skill, but also the qualitative manner in which services are conducted. Brook and Williams (1975) suggest that quality of care is best defined as the sum of the "technical care" provided, the "art of care" provided, and the interaction between the two. They state that "technical care" includes the adequacy of the diagnostic and therapeutic processes, while "art of care" relates to the "mileu, manner and behavior of the provider in delivering care to and communicating with the client" (p. 134). .e stresses that the two components are not just additive but interactive.

Most measures used to assess the technical aspects of the administrative support and service processes pertain to the existence of formalized program and client-specific case planning and management procedures (discussed in the previous subsection). On the other hand, measures addressing qualitative (art-of-service) concerns include the extent to which an agency displays concern, consideration, friendliness, patience, and sincerity toward clients. Qualitative measures can also gauge negative agency characteristics such as disrespect, condescension, and inattentiveness toward clients (Ward, Gutierrez, Most, Ostrander & Smith, 1976). They are generally concerned with the overall service or service "gestalt," rather than focusing on discrete aspects of the service process or the client's behavior or situation. These measures are heavily judgmental since they rely primarily on the conceptions and experience of the evaluator. Judgements are made regarding such things as client need, organizational setting, community attitudes, and the timing of

particular actions during the service delivery process. Miles (1979) points out both the virtues of art-of-service information as well as the drawbacks:

> . . . qualitative data are attractive for many reasons, they are rich, full, earthy, holistic, "real" and their face validity seems unimpeachable; . . . They tend to reduce a researcher's trained incapacity, bias, narrowness, and arrogance; . . . qualitative data can very usefully be played off against quantitative information from the same organizational setting (Sieber, 1973) to produce more powerful analyses . . .
>
> But the most serious and central difficulty in the use of qualitative data is that methods of analysis are not well formulated. For quantitative data, there are clear conventions the researcher can use. But the analyst faced with a bank of qualitative data has very few guidelines for protection against self-delusion, let alone the presentation of "unreliable" or "invalid" conclusions to scientific or policy-making audiences. How can we be sure that an "earthy," "undeniable," "serendipitous" finding is not, in fact, wrong? (p. 590)

Art-of-Service Monitoring. The manner in which a program is managed or the services are provided is not as easily measured or communicated to quality assurance agents as technical process measures. Yet qualitative indicators are no less important and perhaps are more important in human development services where the clients are more vulnerable and likely to be negatively affected by inconsiderate, uncaring and inhumane treatment. By definition, such dimensions represent interpersonal and informal processes which are difficult to observe and therefore difficult to document. At best, one can obtain indications of "good" service directly through observation, or indirectly by questioning parties to the delivery of the service. As a general rule, unless there is reason to believe that the judgment of the clients (or client advocates) or the service providers is likely to be biased, such judgments are probably the most telling insofar as the highly personalized, interactive and qualitative dimensions of service. Where these biases cannot be controlled, the judgment of informed observers may be called for.

Technical Measurement and Monitoring. Most measures of the technical aspects of administrative and service processes can be quantified. They are directed at formal procedures which are almost always documented as part of the provider's administrative records, case records and reports. Most measures are designed to verify administrative procedures and controls already in place. For instance, the review may establish whether individual client service plans and assessments are reasonably complete and up-to-date, whether adequate procedures have been established for citizen participation, whether staff education and training programs are sufficient, and whether reasonable precautions have been taken to ensure that clients are not subject to abuse. Such formal controls are relatively static and need not be checked very often. Moreover, they are easy to observe and verify directly through a review of standing operating procedures, and through random interviews with staff and clients.

As noted earlier, it is assumed that administrative procedures beget or are at least conducive to "good service." However, very few studies have been done to test such assumptions, and service providers complain that the requirement to document takes scarce time away from clients, is costly and does little to improve the quality of service. Haselkorn (1978) speaks of:

> . . . the mechanistic tools and rituals that trivialize the human experience, not to speak of the cost, the time, and the effort or the paper work involved. The morass of information being gathered and "data overload" bring to mind the query, "Where is the knowledge that gets lost in information? (p. 330)

Others point out that many formal, documented procedures are little more than window dressing, designed to satisfy outside reviewers. In reality, staff routinely employ less formal approaches which often bear little relation to formal procedures. Logic tells us that those providers accomplished in the art of documenting will fare better than those accomplished in the art-of-

service if technical measures alone are used to rate provider performance. The common disparity between formal organizational procedures and informal behavior has been well established in studies of organizational behavior for more than a decade (Azumi & Hage, 1972). Blau and Meyer (1971) say it well:

> From an abstract standpoint, the most rational method of effecting uniformity and coordination in a large organization would appear to be to devise efficient procedures for every task and to insist that they be strictly followed. In practice, however, such a system would not function effectively for several reasons. One is that it implicitly assumes that management is omniscient. No system of rules and supervision can be so finely spun that it anticipates all exigencies that may arise. Changes in external conditions create new adminstrative problems, and the very innovations introduced to solve them often have unanticipated consequences that produce further problems. (pp. 56-57)

Control. The choice of mechanisms for the control of provider practices is effectively limited to those that are personalized and less formal. As indicated earlier, studies of organizational behavior have long shown that the manner in which an individual carries out his or her job is influenced primarily by informal associations with peers and may bear little resemblance to formal work procedures (Freidson, 1970). A classic organizational study of an attempt to reform a penal institution clearly illustrates the gap between formally prescribed and actual procedures:

> The policy making group had gained status without gaining influence. It wrote new regulations and the guards continued to enforce the old. At this point -- one not uncommon in the administration of penal or other institutions -- reformulation of general policy has exerted little visible impact on actual procedures. (Azumi & Hage, 1972, p. 328)

While the organization can formally dictate the basic roles and responsibilties of each worker, dictating how s/he fulfills these responsibilities or how s/he plays a particular role is largely an exercise in futility. In the words of Ralph Nader (Institute of Medicine, 1975), "at best, regulation is a negative process occasionally enjoining bad behavior but

rarely compelling good." In fact bureaucratic control mechanisms manifest in regulatory and administrative procedures -- if overdone -- can alienate the human service worker (Argyris, 1971). The corollary is that the most effective means of control are those that are less formal and that rely more on interpersonal networks than on impersonal procedures (Organ & Greene, 1981).

As Maloof (1975) explains, the professionalization of practitioners generates an ethic, attitude, or frame of reference rather than a recipe for behavior. Accordingly, "management must rely on professional standards rather than hierarchical relationships to ensure the conformity of the staff" (p. 25). Service quality standards, then, that emanate from peer or professional circles are more likely to have currency with practitioners than those arising through government regulation.

Benveniste (1977, p. 46) emphasizes the influence of organized professions on the behavior of their members. He explains how sets of general rules about professional behavior, appropriate to various circumstances, evolve within the profession, and how they became gradually accepted as the norm. He contends that professions are a formal secondary network cutting across task-oriented organizations. As such, they represent an informal network which serves to mediate and protect the behavior of its members from demands of the hierarchical structure. Since professions emerge from a basic knowledge or skill, they have considerable ability to exercise influence on the processes taking place within organizations.

Finally, Beneveniste (1977) notes that professionally based forms of control tend to center on role performance. Formal standards and measures are rejected because they sharply narrow the practitioner's ability to exercise discretion based on his or her knowledge or experience. Professionals prefer

to be judged by their peers trusting that their peers are experienced and sensible enough to weigh all aspects of their performance.

Maloof (1975) and Walker (1972) both stress the superiority of positive incentives over negative sanctions as a means of influencing professional behavior in human service bureaucracies. Walker's (1972) rule is "reward good behavior and provide the bad with skillful neglect and bountiful supplies of technical assistance" (p. 53). He suggests social praise and recognition, attendance at conferences, time off, salary increases and other such incentives as preferred means of influencing professional practice. Hage (1974) puts it another way: "there is a difference between saying something is wrong, and pointing out how it might be done better" (p. 53). He argues in favor of reason and constructive rather than critical reviews as a means of influencing professional practice.

While the technical dimension of the service process may be monitored economically through reviews of agency and case records, the ability to monitor the qualitative aspects of service delivery in a reasonably efficient and reliable manner is severely constrained by the fact that such monitoring must be done directly through observation or indirectly through interviews with clients and/or staff. The fear is that in the press for accountability, the more easily measurable and mechanistic dimensions of service are emphasized and the human dimensions are slighted.

In controlling the practices of human service practitioners, the overwhelming evidence is that formal, bureaucratic mechanisms are less effective than less formal, less bureaucratic procedures. This strongly suggests the need to rely less on heavy-handed bureaucratic procedures in evidence today, and to look more to informal and constructive training and technical assistance approaches.

Ability to Assure a Commitment of Resources (Inputs) Produces a Reasonable Level of Service (Outputs)

Agencies of the government have the responsibility to assure that public funds are spent in a reasonably productive and efficient manner and for the purpose intended. Quality assurance systems developed to meet these ends variously take the form of fiscal management and program auditing procedures, program planning and budgeting procedures, and provider unit cost reporting and control systems.

Some would argue that cost is never a legitimate quality concern. They believe that service quality should not be compromised by efficiency considerations. What they are really saying is that "our first responsibility is to provide quality services to the individual client."

The human service worker is usually quite limited in terms of what he or she can do for an individual client. The amount of service that the provider can offer is constrained by the amount of funds made available by the government or charitable organization. Unlike medical services, most human development services are paid for from general program funds, or through fixed individual subsidies, and not through individual service cost reimbursement. And even when cost reimbursement arrangements exist there is usually an upward limit governed by the availability of funds (Gettings, 1981).

Thus, as a rule, the human service practitioner is not as free as the medical practitioner to provide additional services or more costly forms of service deemed to be in the individual client's best interest. Even more, the human service practitioner is often bound to serve all who seek service which

effectively dilutes the time available to each individual. Human service providers in many settings continually argue that public resource limits and pressures for service economies diminish the ability of the program to meet individual needs. This traditional conflict between the practitioner's judgment of what is right for an individual and society's interest in distributing scarce resources as widely as possible is increasingly the focus of public debate regarding the most effective allocation of resources available for human service programs. Though improvements in service quality do not always require increased resources or inputs, there can be little doubt that costs and quality are generally inter-dependent and as such must be approached together.

Measures. The keystone of any cost accountability system is the definition of reasonably accurate and representative units(s) of output to be costed (Greenberg, 1978). The unit cost index includes both a measure of cost and a measure of the output. The measures should be such that they can be applied consistently from provider to provider. The cost measure(s) should capture most, if not all, of the resources consumed in serving the client. The output measure(s) should capture, to the extent feasible, the bulk of the outputs (products or services) received by the clients. Three types of units may be employed for human development services: the cost per case or episode, the cost per time interval (day, month, year), and the cost per period of service.

Choosing the most appropriate unit to use to gauge program efficiency is difficult. In long term programs where the client is not expected to progress out of the program, and where the volume of services per client is not considered to be a prime indicator of the efficiency of the program, the cost per time interval may be the most appropriate measure.

In short-term programs, where the volume of service per client is not considered to be a prime indicator of program efficiency, the cost of service may be the most appropriate measure. In other programs where the volume of services per client and/or the time spent in the program are considered to be prime indicators of program efficiency, cost per case or episode may be the most apt measure. In most programs, some combination of these measures is probably appropriate.

Reliable measures can be exceedingly difficult to obtain for most human development services. This is because human development services are highly individualized and problem specific, and can vary widely in terms of the amount of resources, principally staff time, required to address them. For instance, in studies of the average per capita cost of providing residential and day activity services to mentally retarded persons, (Intagliata, Willer & Cooley, 1979; Baker, Seltzer & Seltzer, 1973; Jones, Conroy, Feinstein, & Lemanowicz, 1982) researchers have found that the costs are generally higher for more severely and profoundly retarded persons than for moderately and mildly retarded persons.

At the same time, similar services may be delivered by providers in a variety of ways. For example, Greenberg (1978) discovered in a cost study of in-home support services to the chronically ill elderly that the definition of what constituted in-home health aid services differed considerably across agencies. In some agencies, in-home health services consisted mainly of "quasi medical" and personal care, while in other agencies, these services also comprised light housekeeping and homemaker services.

The diversity of client types and service approaches frustrates attempts to establish standardized measures that can be applied uniformly to a universe of providers. Bowers and Associates (1978) and Coulton (1978) present

excellent discussions of the enormous problems involved in trying to establish a taxonomy of human services and unit of service measures.

The ideal set of output measures would be those that are sensitive to workload differences (resource requirements) associated with different types of cases or presenting problems and with different types of services. Realistically few such measures are obtainable.

Standards. Unit cost norms are necessarily based on experience since only experience can suggest what level of efficiency or productivity human service providers can achieve. While cost norms are typically set at the average "normal" level, they may also be set more liberally or conservatively. In practice, cost standards in the form of fee or rate schedules are often set at whatever level the funding will bear (Gettings, 1981).

Monitoring. In most reporting systems, the output measure categories (e.g., number of cases) are defined in a general way in order to keep the number of categories at a reasonable level and still embrace the wide spectrum of service approaches. Given these general unit definitions, such systems are not very sensitive to important differences in individual provider approaches. Thus they are of limited use for the purpose of individual provider accountability though they may be of some use for identifying exceptionally low output programs worth further investigation.

The routine monitoring of provider unit costs may be accomplished expeditiously through self reports with periodic audits to verify their accuracy. Such management information and reporting systems exist in many states. However, as indicated earlier, given the general unit definitions employed, they cannot be used in making final judgments as to the efficiency of one provider relative to others. At best such reports can be used to

identify seemingly inefficient providers warranting further investigation.

Evaluation. More conclusive judgments may be made on the relative efficiency of a given program if one controls or at least accounts for the cost effects of different service approaches and different client problems or demands. However, the imposition of such controls can be a relatively expensive proposition which can be afforded only on a periodic or *ad hoc* basis for selected sets of providers. The most common form of control is to partition or classify service providers into groups that provide like outputs to like clients and to compare those providers in like groups. Where a relatively large number of providers is involved, it may also be possible to use statistical measures of association or correlation to indicate the extent to which unit costs vary as a function of client and organizational variables (Wieck & Bruininks, 1980).

Control. Accountability mechanisms, whether regulatory or contractually based, invariably hold out funding incentives or sanctions intended to encourage efficient operations and discourage inefficient, wasteful, and fraudulent operations. The influence of prospective funding increases and especially decreases is particularly strong in the case of human development service providers, many of whom depend largely on a single source of funds.

The literature on organizational behavior warns of the problems involved in establishing objectives and rewarding performance without considering the possible "perverse" effects of such rewards. Examples of such organizational behavior can be seen in some social service programs. Researchers and administrators in several social service fields are familiar with the phenomenon of "creaming" or choosing easy, low cost cases in response to unit reporting and related control procedures that place a premium on processing a maximum number of units at a minimum cost. In the vocational rehabilitation

program, a legislative mandate to serve "individuals with the most severe handicaps" arose in part from the tendency of programs to reject severe or difficult clients in order to maximize success in terms of the sole criterion -- "number of cases successfully closed."

It is hardly surprising that individuals and organizations tend to do what they perceive as necessary to gain recognition, monetary advantage, or even to survive, taking their cues from the system's incentives and sanctions (Funkhauser, 1979).

Where the output is a tangible product, the quality of which varies little as a function of labor time and effort, the system that holds out rewards or punishments on the basis of volume may well serve to increase productivity. However, in the labor intensive human services arena where the worth of the service can depend heavily on the amount of effort expended by staff, the system may cut short the amount of time devoted to each client to the point where the service is no longer of value. Then again, a provider may simply choose to redefine the service or to overstate the outputs while continuing to perform the service as always -- an avenue quite easy to take since human service outputs are often loosely defined and difficult to observe or audit independently (Bowers and Associates, 1978; Coulton, 1978).

Donabedian (1976), in stressing the importance of being alert to such perverse behaviors, has stated: "It is safe to say that everything that human ingenuity can devise will be used to tame a regulatory mechanism . . ." (p. 25).

Ability to Ensure that the Services Provided Have the Intended Effect

Outcomes reflect what happens to the client as a result of the service. Outcomes correspond to the client service goals of the service and measure the extent to which the service has been effective in meeting its goals. Outcomes promise an answer to the question "what difference does it [the service] make?"

Standards. Because outcome measures relate to the actual results of service, they are generally regarded as being more objective than other approaches. However, like the input, process and output standards, many outcome standards are based on ideology and as such are no less subjective. The "normalization" principle discussed in Section 2.a.(1) of this Chapter suggests a myriad of outcome as well as process standards that gauge the degree to which a client's daily living approaches the cultural norm (e.g., engaging in social activities, shopping for one's self, etc.).

In addition, the "maximization of independence" principle which guides many human development programs is grounded in the value of individual self reliance. This principle underlies most outcome standards concerning programs designed to help develop or rehabilitate disabled and other disadvantged persons. The norm that dictates maximization of independence spawns outcome standards concerned with economic self-sufficiency as well as personal self-reliance (e.g., the ability to obtain and hold a job, the ability to feed oneself, etc.).

Unlike most input, process, and output standards, the standard levels of expected outcomes are not usually set in advance but are established as part of the performance measurement and evaluation process. This is because -- far more than the input, process, and output dimensions -- client outcomes are in

part a function of factors outside the provider's control, most significantly the interests and capabilities of clients and external situational factors. Setting outcome standards without controlling for or at least recognizing these mitigating factors is ill advised. Preferably, the actual performance of a provider or a group of providers is compared to the performance of similar providers during the same period or to the performance of the same provider(s) in earlier periods.

The development of outcome standards is also complicated by the tendency of evaluators to develop their own measures of client attitudes, behaviors and capabilities (level of functioning), rather than adopting those of other researchers. Weissman (1975) observes in her state-of-the-art review of 15 social adjustment scales:

> . . . there is . . . a strong need for standardization of methods between studies. . . . It might be best to include intact a standard and widely used scale and to supplement with innovations. In this way the art of assessments will not atrophy but information based on comparative data from a number of studies can accumulate. (p. 364)

Measures. As indicated earlier, human service outcomes are essentially concerned with changes in client attitudes, behaviors, capabilities, or situation. In the latter case, changes are relatively easy to measure (e.g., placement in a foster care home, placement in a residential home, etc.). However, problems in obtaining valid and reliable measures of attitudes, behaviors and capabilities are well documented in the psychological and sociological literature. The principal difficulties lie in capturing, in an effective and economical fashion, the many dimensions of client behavior and functioning that the provider may wish to affect. It is safe to say that no set of measures can begin to cover everything.

In a few human service areas, uni-dimensional outcome measures may be appropriate, for instance in vocational rehabilitation services. Typical

measures in this field are whether or not a client is working, percent of time employed, skill level, earnings, and so forth (Institute on Rehabilitation Issues, 1974).

The Utah Department of Social Services and the Welfare Research Institute have also had some success in the development of a battery of uni-dimensional outcome measures for state child protective services and foster care services (e.g., percent of children that return home and/or that stay home for a specific period of time). Indices of family stability and rates of placement and recidivism are central to these outcome measurement systems (Western Federation for Human Services, 1979; Bowers & Associates; 1978).

While relatively easy to obtain, such single-dimension client outcome variables are not well suited to the bulk of human development services concerned with sustaining or building the capacity of disadvantaged individuals to cope with the many exigencies of community living. The variety and complex inter-relationship of a client's problems and corresponding outcomes are simply too great to be represented adequately by a few one-dimension measures. The assessment of service quality using single-dimension outcome measures can be both incomplete and misleading. Even in the vocational rehabilitation field where single-dimension outcomes are perhaps most appropriate, evaluators are moving toward more multi-dimensional indices of client outcome incorporating measures in the physical, emotional and intellectual domains as they pertain to the work environment (Anthony, Cohen & Vitalo, 1978; Institute on Rehabilitation Issues, 1974).

Changes in attitudes, behaviors and functioning targeted by human service providers are commonly measured on scales and indexes. An index is constructed through a simple accumulation of scores assigned to individual attributes. A scale is constructed through the assignment of scores to

patterns of attributes (Babbie, 1975). These scales or indexes range from those comprised of explicit, discretely defined criteria or anchor points, which can be characterized as "anchored" measures, to those comprised of loosely defined anchor points, which can be characterized as "global" measures.

Well-anchored measures based on a number of specific criteria are, of course, much easier to interpret than are global measures. Though anchored measures are just as dependent on personal judgment as global measures of client outcome, the basis for that judgment is at least reasonably explicit. The quality assessor's attention is directed toward specific outcome dimensions, and the extent to which these dimensions have been realized is reasonably well delineated (e.g., the ability to walk with the aid of a cane).

Most of the progress in the development of indexes and scales of client outcome has been in assessing a person's level of functioning or more broadly his or her self-sufficiency or independence. These measures essentially address four inter-related areas of functioning:*

- **Social adaptation** -- covering interpersonal skills, activities of daily living, household work, etc.;
- **Vocational/educational performance** -- including work and education;
- **Self-care** -- activities such as bathing, dressing, and feeding oneself;
- **Mobility** -- the ability to travel from place to place.

There are many indexes and scales that have been developed, pre-tested, and are currently in use in the measurement of service outcomes (Weissman, 1975;

* Note: Westerheide, Lenhard and Miller (1974, p. 36) emphasize the need to address not only these outcome measures in developing an adequate measure of client outcome, but physical, psychological, and economic dimensions as well. These latter factors also influence a client's ability to cope with his or her particular situation.

Stewart, Ware, & Brook, 1977; Millar, Hatry, & Koss, 1977).

A related problem is that not all changes in client behaviors and functioning are manifest at least in the short run, and the short-run effects may or may not be lasting (Donabedian, 1978). For instance, the education and counseling of one-time child abusers may produce measurable changes in parent attitudes, but will these changes be lasting and will they be sufficient to prevent abuses in the distant future (Deutscher, 1979). Attitudes and behaviors are not necessarily related (Freeman & Sherwood, 1971).

Longitudinal measures might provide a clue to "true" outcomes but would certainly be of limited use for assuring the quality of a provider's current services. Moreover, the link between these longitudinal measures and the provider's interventions grows quite weak as the client is subjected to a wealth of subsequent life events (Vosburgh & Alexander, 1978; Williams & Evans, 1972). The rapid erosion of program effects is a familar phenomenon. One example is provided by the follow-up studies of Head Start, virtually all of which find that the initial differences between experimental and control groups are largely gone by the end of the first year of school (Deutscher, 1979).

Monitoring and Evaluation. Monitoring or evaluation of service outcomes may be carried out to inform policy level decisions or operational level decisions. At the policy level, evaluation may influence program funding decisions or add to the body of knowledge of the relative effects of alternate techniques. At the operating level, monitoring or evaluation of outcomes may inform provider funding decisions, identify exceptionally good or poor practices, or help to refine existing techniques.

At the policy level, unlike the operational level, the target of concern is not the individual provider or individual service or technique but

different types or groups of providers (e.g., institutional residential programs for developmentally disabled persons versus community residential programs, privately-owned and operated providers of service versus publicly-owned and operated services, behavior modification versus psychoanalytic approaches to changing behavior). Moreover, the hope is to generalize from the results by proving a cause and effect link between the program or technique and the outcome using the scientific method. By and large the most important and most troublesome outcome measures are those concerned with the behavior and level of development of clients.

The core problem in evaluating the outcomes of human service programs and techniques is the enormous complexity of human service organizational (provider) behavior and individual (client) behavior, and the causal effects of the former upon the latter. Its difficult enough to indicate that a relationship probably exists let alone proving it and generalizing from it. As Haselkorn (1978) puts it, "[one] must cope with a chaotic array of interlocking, client, worker, process, and social context variables which in spite of computer technology remain almost unmanageable" (p. 334).

To do so requires that these variables be simplified. And still it is costly. The high cost coupled with the limited availability of funds to support human service evaluation research makes it economically infeasible to conduct numerous evaluations, and demands that the objects of such evaluations must be prudently selected and the evaluation carefully conducted. Even then, the information lost in the course of simplification and the inability to control for the myriad of non-service factors that may account for client changes, conspire to make it difficult to achieve scientifically definitive or conclusive results.

The situation is made obvious by the fact that many findings and

conclusions of human service evaluation research are found to be in conflict (Lorisch, 1977; Fischer, 1971; Wood, 1978). As Cohen and Lindblom (1979) point out, "Standing in sharp contrast to the customary belief in the tendency of scientific investigation to converge on increasingly correct representations of reality is the phenomenon of divergence that marks much of social science professional social inquiry" (p. 553). As Veblen (1961) sees it, "the outcome of any serious research can only be to make two questions grow where one question grew before" (p. 33). Cohen and Lindblom (1979) suggest that the usual effect of professional social inquiry is to raise new issues, stimulate new debate, and multiply the complexities of the social problem at hand.

In order to generalize from the results, it is necessary to obtain reasonably uniform measures for a sufficient number of clients to permit statistically significant results, and to compare these measures in the presence or absence of the intervention. To do so, uniform outcome measures are typically employed, that is measures that can be applied generally to clients regardless of their individual potential for change as a result of the intervention. These measures are used under the simplifying assumption that clients are alike both in terms of their presenting problems or objectives and in terms of their potential for change. The potential for over simplification is typically overcome by controlling for client differences as part of the experimental test or control design. However, it is difficult to think of a human development service where the clients are truly homogeneous in terms of either problems or potentials. Consequently, the results may be misleading both in terms of the relative importance of the behavioral or situational objectives measured, and in terms of the degree to which client change is achieved.

In an attempt to isolate the effects of service intervention, these measures are compared in the presence (experimental) or absence (control) of the human service intervention using classical test or control group research methods. However, given the limited ability to recognize and control for external factors affecting client outcomes, the results are usually inconclusive.

The predominant problem, then, is the inability to isolate the effect of the service intervention on client outcome in view of the multiplicity of other variables influencing the client's state, the inability to control for bias through the differential selection of clients for the test or control groups, and the inability to generalize from one service situation to the next given the unique character of each situation. In other words, the evaluation researcher simply cannot fulfill the criterion for validity as required by the classical research model.

Essentially, the best research design employs more outcome measures built around individual client problems or goals and potential. It reflects a modification of classical research designs by accounting for differences in test or control group processes and client problems and potentials through better measurement rather than through the careful matching of test or control groups in order to reduce significant test/control group differences. A variety of quasi-experimental methods have been advanced (Campbell & Boruch, 1975) for the comparative analysis of group outcomes.

A second advance is the development and application of multivariate analytic techniques. It is difficult, and often times impossible, to isolate the relationship between specific input and process measures (independent variables), and indices of successful client outcomes (dependent variables). Many of the input and process elements are simply too inter-related or, taken

singly, are insignificant. Using techniques such as incremental multiple regression analysis and path analysis, researchers are able to isolate the relationship of input and process variables to outcomes with more regularity. The work of Moos and Schwartz (1972) in the development and testing of different environmental scales in mental hospitals is a case in point, as is the successful use of path analysis in relating vocational rehabilitation and developmental disabilities service variables to client outcomes employed by Flynn (1975) and Eyman, et al., (1979).

Another weakness common to evaluations of human service outcomes is the dearth of reasonable theories linking program inputs and processes to outcomes. As a result, the input and process variables selected are often poorly thought out and may be as responsible for poor evaluation findings in human service programs as actual program weaknesses. A prevalent fear is that the variables chosen are those that are easiest to measure thus artifically down-grading more difficult to measure variables such as warmth and empathy which have been shown to be significant variables in psychotherapy (Cross, 1979 p. 248). Warren (in Wolfensberger, 1972) underscores this fear by pointing to the dangers inherent in identifying irrelevant program variables:

> . . . the evaluator who limits his study to the effects of the experimental variables -- those few factors that the program manipulates -- conveys the message that other elements in the situation are either unimportant or that they are fixed and unchangeable. The intervention strategy is viewed as the key element, and all other conditions that may give rise to, sustain, or alter the problem are brushed aside. (p. 41)

There is little consolation in the fact that this weakness is common to program evaluations in general (Bernstein & Freeman, 1975). The key question is posed by Boruch et al. (1979): "Do we know enough about the program, target group and its operations to make estimates of program effects meaningful?" (p.39). Unfortunately, the answer is often, no!

A significant advance in this area has been the design of evaluability studies (Wholey, 1979) or formative evaluations of programs conducted for the purpose of deciding whether a more costly investment in a summative evaluation is warranted. The evaluability study involves "stepping through the theory and practice of the program to establish what we think we know and what characteristics of a program [if any] can be tested for effects" (Baruch *et al.*, 1979 p. 39).

Evaluations of client outcomes conducted for purposes of individual provider accountability and improvement in the techniques of individual providers are not saddled with the need to generalize beyond a given situation (i.e., to establish that a particular type of program intervention leads to a particular conclusion). On the other hand, they must establish that particular client outcomes associated with the intervention of a given provider are not isolated events. In other words the outcomes must be shown to be consistent and fair indicators of the performance of an individual provider. This creates the very same set of problems described for policy-level evaluation and demands costly measurement techniques and research protocols. In fact, the cost of such outcome evaluation techniques rarely justifies the benefits if they cannot be generalized beyond the individual situation.

The most prudent approach for quality assurance purposes seems to be outcome monitoring based on individual client-based techniques. Further, the objective in outcome monitoring systems should not be to prove but rather to suggest that a provider or practitioner is relatively effective or ineffective in terms of selected outcomes. Monitoring methods are designed only to point out possible areas for improvement subject to further investigation.

Control. The methods available to control those provider inputs or

processes associated with outcomes and their possible perverse effects were discussed in earlier sections. An added problem with outcome-based control techniques is not knowing for sure the extent to which an observed outcome is a function of a particular input or process. As Wood (1978) says:

> A lack of standardization among outcome measures makes cumulative evidence difficult to assess. The interventive variable is either different among the studies, inadequately defined, or inadequately controlled. The relationship of the definition and measures of outcome to the problem being intervened in varies, and the outcome measures also vary to the degree of validity and reliability achieved. . . . Such research can give little information about whether practice is effective or how to make it more effective. (pp. 450-451)

Consequently, information based heavily on the evaluation of human service provider outcomes can hardly be considered authoritative, and for this reason, contrary to public opinion, has been shown to carry no more weight with most practitioners and policy makers than ordinary knowledge (Cohen & Lindblom 1979). As many studies of policy analysis and evaluation show, scientific information has no compelling independent claim on the attention of decision makers. Clearly, the evidence argues in favor of treating human service outcome data as an increment to other knowledge and not as independently conclusive. Nonetheless, as Cohen and Lindblom (1979) lament, the likelihood that social scientists and workers in bureaucracies will resign themselves to these more modest claims for the authoritativeness of scientific knowledge and practice is not high.

Ability to Assure that the Limited Supply of Services is Provided to Those Clients Most in Need

At a minimum, the human development services authority should establish an **eligibility determination procedure** to be sure among those persons seeking

services, only those that meet a recognized level of need are provided services. If human development services were "entitlement" programs in which all persons meeting specified criteria (e.g., level of disability, income, etc.) would be automatically entitled to services under law, state or local agencies would have little or no leeway to make the determinations associated with this quality assurance aim. However, human development services are not open-ended programs and the funding agency therefore, does have some leeway and concommitant responsibility to establish criteria that ensure that those most in need receive services.

In many cases, however, this may not be enough. For instance, abused and neglected children and battered wives may not know about the availability of family counseling and protective services or may be reluctant to seek them out for fear of retribution. Persons who are mentally retarded may be unable to negotiate the many bureaucratic hurdles that must be faced in obtaining needed services. In such cases, **outreach efforts** are essential.

Outreach involves actively seeking persons in need of service but who are outside the service system. To do so effectively requires the establishment of formal and informal contacts with public and private organizations such as health, legal services, education, welfare agencies, clergy, and any other organizations or individuals who are likely to know of persons in need of human development services and who could refer these persons to the appropriate human development provider given some encouragement and guidance. Effective outreach must also include the active and creative use of the media and other means of informing the public on how to identify persons in need of service, why it is important for these persons to obtain particular human development services, and the actions the persons can and should take to obtain the necessary services.

Standards and Measures. In establishing **eligibility criteria**, public human development agencies must attempt to satisfy both the interests and needs of clients and the interests and needs of the public. One of the best illustrations of how the interests of clients of human development service agencies and the interests of the larger community might conflict is over deinstitutionalization. For years, local citizens have opposed attempts to locate small group living arrangements for mentally handicapped persons in their neighborhoods preferring instead that they be kept in remote facilities. This conflict in values can occur in many contexts. At worst, the assertion of community interest can be a reflection of narrow self-interest, bias, or ignorance. At best, it represents those utilitarian principles that underpin much of public policy and which can be summarized as the "the greatest good for the greatest number."

Another objective of the human development service agency is to make the limited supply of services available to those clients who stand to gain the most from the service or stand to lose the most from the absence of the service. These are obviously difficult and complex decisions and presume a level of knowledge that few if any agencies possess. The setting of eligibility criteria is best informed by systematic assessments of the supply of human development services and the current and potential users of services (Bloom, 1983; Ashbaugh, Hoff, Bradley & Reday, 1980; Bell, 1976). However, these methods are fraught with theoretical and practical limitations (Kimmel, 1977; Varenais, 1977). One of the biggest problems confounding attempts to strike an appropriate balance between service supply and demand through the setting of eligibility criteria is that the supply and demand situation differs from area to area and changes over time. The assessment of human development service needs (service demand/supply) remains a heavily subjective

undertaking as does the related setting of eligiblity criteria.

Standards for use in judging the relative ability of provider(s) to find and serve those most in need through outreach efforts may be derived empirically through formalized assessements of service need using community survey, client survey, provider survey, key informant survey, social and area analysis, and other techniques for profiling the types of services needed and the relative urgency of these needs. They might also be developed normatively in the form of profiles of the service needs of persons being served by like providers. These need-relative profiles may then be compared to the profiles of individuals served by the provider(s) of concern. An alternative albeit less compelling approach is to establish "process standards" defining minimum or model outreach efforts.

Monitoring and Evaluation. Eligibility determinations and redeterminations may be conducted by an administrative agency independent of the service provider and thus having no vested interest in which clients are deemed eligible for service. If so, any monitoring by a quality assurance agency need only be concerned with assuring that the eligibility standards and measures are being interpreted correctly, and not with the possible application of self-serving eligibility standards.

Independent mechanisms in the human development service field for making initial and continual program service need determinations include independent intake, information and referral agencies, or case managers or case workers. These agents or agencies screen clients according to established eligibility criteria. If eligible, the case managers or caseworkers at least coordinate the development of individual plans of service based on client needs that have been identified as part of the intake process. This may be done by the case manager or case worker alone, or as part of an interdisciplinary team. The

case manager then attempts to make service arrangements pursuant to the plan. The case manager continually reviews the progress of the client to assess continued or changing service needs. There are a variety of independent eligibility determination models (e.g., private, public, totally independent, partially independent, generic, categorical, etc.). However, none clearly stand out as the "model" to follow.

On the other hand, if eligibility determinations are made by the provider or any other agency known to have a vested interest in the process, monitoring is warranted to assure that clients are not being compromised by the self interest of the agency applying the eligibility standards and measures. One of the best known of these methods is the Professional Services Review Organization (PSRO) designed to review the admission of Medicaid and Medicare patients, and to validate their initial and continuing need for health care services. However, the cost of such oversight mechanisms can be quite high when considered relative to the cost of providing many human development services. Moreover, the ability of these review teams to assess client needs accurately is open to question. Almost all of these methods of admission and utilization review concentrate heavily on client records with minimal personal contact with, and observation of clients.

There are a great many difficulties associated with gleaning information from case records. The extraction of particular data from an entire case file can be cumbersome and time-consuming since a great deal of the information recorded in the file is irrelevant. There is also a great deal of uneveness in information available in the case records. In other words, there is no such thing as a standard case record. Records are often incomplete because of the inability of providers to use the required uniform formats, because of misunderstandings of the procedures for completing the forms, or because the

completion of such records conflicts with the direct provision of services. Relying on case records may also be constrained by restrictions on access for reasons of client privacy and confidentiality.

Audits of the extent to which agencies have complied with special case record requirements indicate significant problems. However, several large studies that relied on case records to identify service deficits have concluded that the deficiencies uncovered in large part reflected incomplete records rather than poor care (Brook, 1974).

Case record reviews may likewise be employed in developing need-related profiles of a provider's clients. However, the more common method is to have providers extract and compile such information routinely and to report this information periodically or on request to the quality assurance agency or to another administrative agency with the information available to the quality assurance agency on request. Most client information systems include some indicators of client problems and needs.

Control. Control over client admissions and service utilization in connection with the eligibility determination process may be exercised through regulatory mechanisms and/or contract mechanisms. By definition, regulations are designed to handle rules and not exceptions. Based in statute, they are also relatively difficult to adopt and change. Legislative as well as administrative reviews are required as are hearings before the public. Accordingly, regulation is best suited to the enforcement of nationwide or statewide eligibility criteria of a uniform nature -- criteria that are inviolable and that merit the use of legal sanctions.

The purchase of service contract on the other hand is a mechanism that can be used to enforce eligibility criteria that are tailor-made to particular situations. For instance, a state or local government recognizing the urgent

need for residential services for a specific sub-group of the population in need (eligible) of those services, may contract with a provider of these residential services with the stipulation that the provider serve one sub-group alone or in some proportion. Examples of the use of the contracting mechanism to exercise a degree of control beyond regulation are presented and discussed in Chapter III.

Local agencies and providers as well as clients affected by eligibility provisions should be allowed to request a variance to the eligibility criteria or procedures established under regulation. Like the appeal procedure, the variance request should be in writing and the time period allowed for action and resolution should be time limited. Such variances may be warranted in areas where the services available are not appropriate to client need and yet the client(s) have far more to gain from the service or to lose if they do not receive the service than do other persons in the area who meet the criteria.

The most prevalent and straightforward methods of encouraging providers to direct their services to clients deemed most in need are special funding provisions and incentives which may be part of either the regulatory or contract mechanisms. In a number of states, funds are allocated to providers according to formulas established by regulation or administrative directive that favor those providers serving individuals and providing services deemed most in need. Similarly contracts may be written that provide added funding for high priority client populations and services or for outreach efforts meeting specified standards. As indicated in the previous section, the contracting mechanism is inherently more flexible than allocation formulas since each contract can be to fit a particular situation.

Chapter III
Selected Techniques

Overview

The previous chapter provided an introduction to the concepts of quality assurance, the ways in which quality assurance information is used at each level of the human services system, and the strengths and weaknesses of aspects of quality assurance systems in facilitating the achievement of quality assurance objectives. In the following Chapter, specific quality assurance methods and approaches are delineated and analyzed according to their utility with specific services and target groups, the dimension of service quality measurement (i.e., input, process, outcome) for which the technique is best suited, and the practical and technical difficulties associated with implementation of the method.

The Chapter is organized into two parts -- locus of responsibility and specific techniques. In the first half, we discuss the various auspices under which quality assurance can be carried out and the specific methods that are likely to be consistent with the characteristics of each entity. The various groups include citizens, peers, private evaluation services, consumers and families, advocates, and accreditation organizations.

In the second section, we describe additional examples of quality assurance methods within selected categories of quality assurance techniques including prescreening and self-assessment, outcome monitoring and evaluation, case tracking and exception reporting, client surveys, observation,

performance contracting, training and technical assistance, complaint mechanisms, and consumer empowerment.

As noted in the introduction to the manual, HSRI canvassed the country to identify quality assurance approaches that appeared relatively cost effective, client responsive, quality enhancing, and relatively easy to apply. These methods are described in detail in the Appendix of this manual. The discussion of each approach also includes the name and address of a contact person on site from whom additional information can be obtained. The following sections include references to methods that were not selected for more intensive review (and are therefore not in Chapter V); methods that are summarized in Chapter V are highlighted in bold-face type.

Locus of Responsibility

Citizens and Volunteers

Introduction. Using citizens to gather information regarding program quality has become more common in recent years. Citizen interest in program oversight has evolved in response to several pressures and issues: (1) a growing skepticism regarding the ability of government or governmental proxies to provide responsive and efficient services; (2) a basic recognition of the value of citizen input; (3) an impetus to eliminate waste, increase efficiency, and to ensure accountability; (4) the use of citizens by public agencies to monitor publicly-funded programs that resist government oversight; and (6) involvement of citizens in order to develop support for difficult and controversial decisions (Dinkle, Windle & Zinober, 1982).

The antecedents of citizen involvement in quality assurance can be found in the citizen participation movement that began in the 1960's and included

such concepts as "maximum feasible participation of the poor" and "community control." It was through the Great Society programs and their concomitant requirements for citizen participation that citizen monitoring and evaluation of publicly-funded services -- including health planning, education, community development and urban renewal and others -- became widespread. Citizens also became involved in monitoring and evaluating nursing homes, public schools, biomedical developments and environmental issues.

State requirements for citizen review and oversight together with federal mandates and technical assistance activities have led to a significant level of citizen involvement to ensure the quality of human services at state and local levels. The specific roles and responsibilities that citizens can play in quality assurance are quite varied; to some extent, these roles are patterned after professional roles.

Citizens can participate in passive activities such as reviewing the results of an evaluation or quality assurance report as well as more active roles such as conducting independent reviews of a program or service system. Between these two extremes, citizens can become partners with professional staff to evaluate program quality. In some of these roles, citizens are involved in designing instruments to assess the quality of services (e.g., checklists), conducting site visits, interviewing staff and clients, assessing the way in which services are delivered, and preparing written reports.

Several citizen-related activities in quality assurance involve using parents, consumers and others to conduct visits of various programs. For example, boards of visitors -- citizen groups attached to public institutions in New York, Montana and Minnesota -- have unlimited access for purposes of investigating complaints. Further, some associations for retarded citizens in Canada and the U.S. coordinate the efforts of parents and other citizen

volunteers who drop in on providers for both informal and formal visits (Kentucky ARC, 1983; Levy, Levy, Liberman, Dern, Rae, & Ames 1981). The purpose of these visits is not solely to provide the quality assurance agency with additional "eyes and ears," but to promote the integration of programs into the community, and to increase citizen or parent involvement.

As highlighted in the statement above, in some ways using citizens to ensure the quality of services may be preferable to using professionals to conduct similar activities. At the very least citizen involvement promotes different values and outlooks. For example, citizens inherit the results of any quality assurance activity since they live in the community and may ultimately use the institutions with which they are involved. In addition, unlike professionals, citizens have greater access to the political arena and the media -- two vehicles that are often necessary to publicize deficiencies in program quality (Windle, 1982).

Service and Target Group Applications. Quality assurance activities directed by citizens have many applications; however, some examples of citizen involvement in quality assurance are more circumscribed than others. Many examples can be found where citizens have focused their activities on one target group, such as on developmentally disabled individuals, elderly persons or children. Within the target group, however, many services may be reviewed, assessed and evaluated.

In **Lancaster County**, Pennsylvania, citizens use PASS (Program Analysis of Service Systems, Wolfensberger & Glenn, 1973) -- a standardized evaluation technique based on the concept of normalization -- to assess the quality of a variety of human services, including residential programs, medical facilities, crisis intervention units and others. The PASS reviews by citizen teams are targeted to three groups -- mentally ill, and mentally retarded persons and

substance abusers, and services for both children and adults are covered.

Other citizen-directed activities are even more targeted, including the **Colorado System for Monitoring Residential Services** for developmentally disabled adults. Conversely, some quality assurance activities involving citizens cover the gamut of human service programs and clientele such as the **Rhode Island Evaluation of Community Services Task Force.** This Task Force, comprised of volunteers and paid staff, has conducted evaluations of family services, juvenile justice projects, and mental health programs.

It appears, therefore, that citizens can be used to assess program quality in a very targeted fashion (e.g., monitoring nursing homes that serve elderly persons), they can be included in somewhat broader activities such as evaluating a variety of services provided to certain target populations (mentally retarded, mentally ill and substance abusers), or they can focus on those programs that are providing generic human services to a variety of population groups.

The question this raises, however, is does the narrowness or the breadth of the service and target group application facilitate involvement of citizens in quality assurance? In other words, if citizens are used in a more limited and targeted fashion, are they more effective than if they are used across the continuum of services and population groups? The following discussion may provide some answers to this question.

Program Dimensions. For the most part, quality assurance activities involving citizens focus on reviewing and assessing the input and process dimensions of service quality. Few examples can be found where citizens are included in reviews of program ouputs and outcomes. Using citizens to apply input and process measures may prove to be the best use of their talents and insights since these measures involve less technical expertise than is

necessary to measure outputs or outcomes. As such, citizens can meet two of the five basic responsibilities of a quality assurance program: (1) to assure the ability to provide an acceptable level of service, and (2) to assure the ability to provide a service that is consistent with accepted beliefs regarding what is good practice.

Many examples of citizen-directed quality assurance activities encompass both input and process measures. For example, the **Nursing Home Information Project**, sponsored by the Urban Institute, trained citizen volunteers to monitor nursing homes focusing almost exclusively on inputs (e.g., staffing, condition of facilities, etc.), with a few process observation measures also included. In addition to monitoring the health, safety, and sanitary dimensions of care in nursing homes -- the areas that federal regulations address in detail -- the nursing home information project addressed other areas of vital interest to nursing home residents and their families, such as their views and preferences for care (Durman, Dunlop, Rogers, & Burt, 1979).

In addition to nursing homes, citizens have also been used across the country to monitor and review the quality of care provided in a variety of state institutional settings. For instance, the Greater Chicago Mental Health Association initiated a site visit review team in 1977 which monitors inpatient care in state institutions in Illinois (Bradley, Allard & Mulkern, 1984). The focus of the team's efforts is on inputs and certain process measures. For example, all aspects of physical plant, staffing, dietary services, client rights, and other inputs are reviewed. Intake, referral, and discharge procedures, as well as service strategies and other process concerns are also assessed. The site visit team uses observation forms adapted from material prepared by the National Mental Health Association (1976) for onsite visits. One of the more interesting aspects of this citizen monitoring effort

is its use of the media and the political system to secure implementation of its recommendations. Specifically, the site visit team stimulated a series in the Chicago Sun-Times which was responsible for the appointment by the Governor of a special task force to address problems in the mental health system. This sort of outside pressure may be difficult for professionals to secure.

The Montana Board of Visitors, a volunteer board attached to the Governor's office to investigate complaints at the state's facilities for mentally disabled persons, can also use the media to highlight some of its findings (Moorse, in Bradley, et al., 1984). In general, however, citizens attempt to use the power of persuasion and negotiation to convince facility administrators and others to implement program recommendations. Although some citizens pursue non-traditional avenues to ensure implementation, others are assisted in their attempts to make reforms by legislation that provides them with power to influence budgetary decisions.

For example, Massachusetts state law requires that a children's committee be established in each Department of Mental Health catchment area to review services for children funded by the Department, to assess needs for new programs, and to advise the Department regarding contract renewals (Bradley, et al., 1984). As part of its review of one facility, the children's committee in the western part of the state recommended that the program's vendor be changed because of the agency's continuing instability which threatened program quality. The agency in question -- an emergency shelter for adolescents -- had significant problems regarding staff turnover and financial management. In its review, the committee analyzed both input measures, (e.g., physical plant, administration, and staff), as well as process issues such as the methods in place for staff backup, the

administration of the program's funding sources and others.

Citizens are frequently involved in quality assurance efforts that focus on children's services. Another example is the Office for Children in Massachusetts which has a network of 43 local citizens councils -- one in each catchment area. In 1978, the Office received a grant from the National Center on Child Abuse and Neglect to review conditions in children's residential facilities across the state. Building on its statewide network of citizen participation, the Office recruited local council members to serve on seven regional Institutional Review Committees (IRCs). As noted in their guide to institutional review, "the purpose of these committees is to get citizens behind the walls of children's institutions" (Massachusetts Office for Children, 1980).

The institutional review committees use the same questionnaire for monitoring a variety of settings (e.g., state schools, pediatric nursing homes, correctional facilities, halfway houses, etc.). The questionnaire is directed at certain input and process concerns such as intake, discharge and aftercare; the existence of educational and therapeutic programs; and the status of children in particular wards, cottages or units.

Although many of the examples provided in this summary describe citizens performing active roles in quality assurance, other examples involve more passive roles. In **Fulton County, Georgia,** volunteers are recruited to review the abstracts of case histories and case plans involving permanancy planning in foster care. After their review of materials prepared by an agency caseworker, the volunteers identify weaknesses in the permanent plan, note obstacles to developing a stronger permanent plan, and propose ways to overcome those obstacles. These review teams, however, do not have the authority to enforce their recommendations. Implementation is left up to the

public agency child welfare worker.

Another form of passive citizen involvement in reviewing program quality is the citizen review group (CRG) concept initiated by the National Institute of Mental Health to implement the 1977 amendments to the Community Mental Health Centers Act. Members of a CRG in Florida reviewed evaluation reports of children's services funded by a mental health center. The *ad hoc* group of citizens -- including former patients and parents of children -- were particularly interested in the quality and appropriateness of services for children and adolescents. Based on their review of these reports, recommendations were made regarding improvements in quality of service (Burgner, in Bradley, *et al.*, 1984).

As is evident in the above descriptions, in general, citizens engaged in quality assurance efforts tend to monitor the input and process dimensions of service quality. There are, however, some examples where citizens have reviewed outputs or outcome measures -- especially when citizens have specialized expertise. One example where citizens have assessed output as well as process measures is the **Rhode Island Council for Community Services** model in which volunteers participate with staff and are selected according to their knowledge and skills relating to the program slated for evaluation. Usually, the teams conduct staff and client interviews, observe the service delivery process, and review administrative and case records. The evaluation process consists of a formative and summative stage. The analysis generally includes findings relative to project outputs, process, and client outcomes. The major limitation of this method, however, is that it is not designed to actively uncover service quality problems since it is an exception oriented method. Moreover, though the on-site review team is encouraged to provide technical assistance as appropriate during the on-site visits, there is no

formal control element.

Practical and Technical Considerations. Using citizens to perform a variety of quality assurance functions in human services presents a number of advantages and disadvantages. Some of these are directly related to the particular context in which a service or program is being reviewed or monitored, while others apply broadly to any citizen related activity. Some of the more common disadvantages of using volunteers include the following:

- Problems in scheduling site visits when many volunteers are either working full-time or occupied with other day time activities;
- Problems with retention of volunteers -- many of whom drop out of the activity, move on to paid work, move to other parts of the country and so forth;
- Volunteers' feelings of inadequacy, especially if they have not been properly trained or equipped with the tools and knowledge necessary to evaluate or review a program;
- Individual biases that may be difficult to overcome during the course of a review;
- Lack of financial support for expenses, especially if long distance traveling is involved.

There are many positive aspects to using citizen volunteers in addition to the amount of contributed time received by a particular agency or program. Citizen review brings a special focus and an "outside" perspective to a program that may not be present when professionals conduct comparable assessments. Moreover, citizens usually have more flexibility regarding the dissemination and communication of the results of their quality assurance activities. Finally, citizens themselves acquire new skills and knowledge by participating in such endeavors and thus expand the overall community's knowledge of special populations and their needs.

In order to increase the effectiveness of volunteers in public services, many publications have been prepared that address the management of volunteer resources. The principles in these training documents have been evolved by

citizens themselves or staff working with volunteers in human services programs. Some of the more pertinent guidelines that should be followed in developing a citizen-based quality assurance system are discussed below.

Legitimacy. Any citizen-initiated activity needs legitimacy (i.e., empowerment from the state legislature, the Governor, an administrative agency or other source of formal power). Approval and support from the program or service agency staff receiving the benefits of citizen review and evaluation must also be obtained. Many citizen review activities are mandated and tied either to licensing requirements or to budgetary review, thus providing citizens with the clout to implement their recommendations.

Framework. An agency planning to use citizens to review services should develop a framework for the volunteer program that includes the specific roles and responsibilities that citizens will assume. It is especially important to distinguish the differences in responsibilities between paid staff and volunteers. An agency plan should also highlight methods to retain volunteers such as formal recognition of their special input and worth to a project. Adequate supervision also appears to be helpful in terms of keeping volunteers. Finally, staff should support and monitor volunteer efforts.

Recruitment. Agencies must also develop a plan for recruiting, screening and training volunteers. Recruiting is an art in and of itself and must be tailored to the type of activity for which citizens are being solicited. For example, if programs serving developmentally disabled persons are the focus of a particular quality assurance project, then it might be appropriate to recruit parents or others with family members who are similarly disabled. Other persons in the community with an identified interest, either professional or personal, in this area should also be recruited.

Newspapers, radio announcements, and brochures may be used to attract

interested persons; however, as noted in one volunteer manual, the average response to such a recruitment appeal is roughly 2-5% of an identified audience. Using personal contacts is another important recruitment strategy (i.e., developing a network of persons who can act as referrals and links to others who may be interested in this type of activity). Some recruiters go as far as to place notices in such places as supermarkets, laundromats, bowling alleys, clubs, and ice cream or hamburger spots in order to involve a broad cross-section of community representatives. In the final analysis, a recruitment strategy should include all of the methods mentioned above in order to attract the maximum number of persons.

Further, guidelines should be established to help screen potential volunteers. If the agency has developed a description of the volunteer's responsibilities, it can be used to help determine if both the interests of the volunteer and the agency can be met. Screening also occurs during the training sessions when volunteers and trainers can assess and evaluate their potential abilities in a review/monitoring project.

Many of the examples cited earlier stress the necessity of preparing or training volunteers before they are used in a quality assurance activity. In some situations volunteers already have expertise in the particular area being assessed. In general, however, lay citizens need some tools, an understanding of the history of the program being assessed, and other pertinent skills in order to complete the proposed assessment. As noted in several volunteer publications, training should not become an overwhelming experience and should recognize the varied life experiences of the volunteers. Training must also be flexible enough to meet individual work or other related schedules. Some agencies have used creative and innovative techniques to train volunteers in quality assurance activities. The Massachusetts Institutional Review Project

staff developed a board game that enabled citizens who were unfamiliar with the state's residential treatment system to learn and discuss various aspects of the system. Some agencies, such as the Illinois Review Board and the **Lancaster** mental health and mental retardation program, involve volunteers in preliminary site visits so that they can observe how a review or evaluation is actually conducted.

Expenses. Finally, volunteers need some financial support for expenses such as mileage, meals and so forth that occur during the course of their reviews. Many staff and volunteers involved in citizen review efforts have underscored the importance of some minimal level of funding to help pay for monitoring or evaluation expenses. This becomes a critical consideration in states such as Utah, Nevada, and others where transportation costs are significant. This may necessitate that a state agency include a line item in their budget for such expenses.

Peers

Introduction. The use of peers to assess the quality of human services involves an assessment of the professional practices of individuals providing services within the agency by professionals external to the agency. The assessment is based on some comparison between actual service delivery and the accepted norms of "reasonable and customary" practice within the professional group (e.g., social work, psychology, early childhood education, etc.). Peer review ranges from informal consultations among professionals to more stringent and formal peer reviews such as those carried out within the context of accreditation.

The history of peer review is interesting and parallels both the growth in "professionalism" and the increase in the level of involvement of

government and third party insurers in the support of human development and health services. In the history of the development of professions, the first attempt to exercise quality control was the establishment of professional schools that provided training linked directly to those activities involved in practice. The second major device was credentialing; one first received a diploma and then received a "license" after a period of practice or apprenticeship. Later, the issuance of a license became contingent on passage of an examination.

By the early nineteenth century, education and credentialing requirements -- at least for physicians and lawyers -- were well established. Following a brief wave of anti-professional and anti-elitist sentiment during the Jacksonian era, the legitimization of the professions continued into the twentieth century with requirements for the accreditation of professional schools and with the development of state licensing boards for a variety of professional disciplines.

The use of professionals by government and third party payers to assess the judgement and conduct of their peers grew primarily out of concerns over the costs of medical care that began to escalate as early as the 1920s. The inflationary pressure intensified after World War II and came to a head with the passage of Medicare and Medicaid. At that point, both the government and private insurers began to assert their right to be assured that the services for which they were paying were necessary and appropriate. In order to head off an "invasion" by government and third party payers into the sanctity of the client/practitioner relationship, providers insisted that their work be reviewed by persons with equivalent experience and training (Young, 1982, p. 12). The role of peer review in quality assurance in the health field was legitimized in 1972 when Congress enacted legislation setting up Professional

Standards Review Organizations (PSROs). PSROs were to function in Medicare, Medicaid, and Maternal and Child Health programs. Their role was to assess the necessity and professional acceptability of the care provided.

As a quality assurance tool, peer review can be used for both quality regulation and quality enhancement. As a quality regulation tool, it is directed primarily toward the control of service utilization and the identification of abusive and inappropriate practices. Some have argued that the use of peer review to regulate has not been successful. Specifically, they point to PSROs and note that they have not proven highly effective, in part because neither cost savings nor increased service quality has been documented (Young, 1982, p. 12). It can also be argued, perhaps less convincingly, that using peer review to carry out policing functions is inconsistent with assumptions about professional practice. As Sechrest and Hoffman (1982) have noted:

> Part of the definition of a profession -- and part of the implicit compact with the public that the profession makes in return for monopoly on some service, privileges, or title -- is that the profession will train and support only qualified and trustworthy people. To base arguments for peer review on the proposition that there are incompetent and untrustworthy professionals who need to be controlled or eliminated is inconsistent with this premise. (p. 16)

As a quality enhancement tool, however, peer review has many virtues. It can serve an educational function by passing on to providers the most up-to-date service approaches. The mere publication of peer review standards can have a salutory educational impact. Further, the educational experience of the peer reviewer himself or herself cannot be underestimated. Finally, the peer review system that includes as much feedback as possible to the practitioner will provide the sort of information necessary to refine and improve treatment approaches. Consequently, as a forward-looking or quality enhancement mechanism, "a good peer review system should have the effect of

optimizing the treatment given in each instance" (Sechrest & Hoffman, 1982, p. 17).

Target Group and Service Application. The use of peers to assess quality is not necessarily limited to any one target group or service type. Three of methods identified in Chapter V that employ peer review techniques show the versatility and flexibility of peers as monitors. The first example is the **Colorado System for Monitoring Residential Services.** In that state, residential providers, consumer representatives and local citizen board members participated on peer review teams to review of residential services for developmentally disabled persons. The method, administered by the Colorado Division for Developmental Disabilities, involves annual site visits by the peer teams to 120 adult residential facilities in the state. Peers cannot review services within their own regions. The use of knowledgeable and concerned peers has reportedly enhanced provider acceptance of the procedure, and the sharing of information and service approaches was seen as valuable in the early phases of the process.

The second example, the **New York Home Care Quality Project,** was established to ascertain whether home care services funded by the City of New York were being delivered and whether the service was delivered at an acceptable level. Monitoring is conducted on-site by senior homemakers who have delivered home care services themselves for an average of 17 years. The application of the method has shown that their experience as homemakers enhances the monitors' ability to evaluate the efforts of home care vendors.

The third example is the **Commission on the Accreditation of Rehabilitation Facilities (CARF).** Like the methods described above, CARF uses providers of rehabilitation, day services and residential programs to survey their peers. Like the Colorado peer review method, CARF reviewers do not

assess programs in their own states. Attempts are made, however, to select surveyors in the same general geographic region. The peer review process is based on professional standards adopted by the CARF board and which presumably reflect the state-of-the-art in the field. The team spends about one and one half days on site applying the standards and making determinations regarding strengths and weaknesses of the facility's program. Once the CARF board acts on the recommendations of the surveyors, the facility is notified and a report with specific suggestions for program improvement is forwarded to the provider. According to those interviewed, the process is relatively inexpensive, is generally well-received and can be applied to a wide range of programs and settings.

As noted, peer review is applicable across human development services and target populations. The major variation from program to program is who should be considered a "peer" in the review process. In those areas where services are customarily delivered by one professional group (e.g., case management), the composition of the team and the design of standards is fairly straightforward. However, in residential programs, education and training programs, and other more complex services, judgements about practice should be made by a multi-disciplinary team reflecting the professional diversity within an agency.

A further question that emerges, depending on the nature of the service and the target group served, is the extent to which consumers or their representatives should be considered "peers" for the purpose of peer review. Since peer review may increasingly be used as a tool to ration scarce services (Simon & Rosenberg, 1982), involvement of consumers is one way of ensuring that standards are applied in ways that are acceptable to the clients of the service. Further, consumer participation in the peer review process can

ensure that the review is not merely an assessment of the technological aspects of care, but scrutinizes the less tangible and more qualitative aspects of service delivery as well.

Program Dimensions. Peer review tends to focus primarily on service inputs and service process, although such reviews can be used to assess service outcomes in certain types of programs. With respect to inputs, peer review teams review the training and experience of professionals within an agency, the ratio of such professionals to their clients, and other similar aspects of the service environment. It is the service process, however, that peer review teams are conceptually the most equipped to oversee since peer reviewers are ostensibly there to observe professional practice and compare it to some agreed upon norm of performance. Thus, most peer standards, such as those embodied in the CARF accreditation method and the Colorado residential review system, focus primarily on the way in which services are provided and administered.

Peer review can, however, be directed toward outcomes -- especially when it involves retrospective record review. This technique, used heavily in health and mental health oriented peer review, involves both a determination of the appropriateness of the service provided (given the diagnosis or presenting problem), and the nature of the outcome of the service intervention. Outcomes derived from client record review might include such measures as skills acquisition for developmentally disabled persons or improvement in reduction of abusive behavior among high risk parents.

The standards applied by peer reviewers presumably reflect the norms of customary practice within the particular profession. They are derived from analyses of the patterns of practice within a profession and also from expert opinion. In some instances, the criteria applied can be linked empirically to

beneficial outcomes. However, "Some of the criteria are necessarily arbitrary in nature and will probably never be supportable by empirical data" (Stricker & Sechrest, 1982, p. 19). Instead, they reflect what might be called "art of service" elements or professional norms rooted more in ethics and ideology than science.

Practical and Technical Considerations. As noted in the introduction to this section, the use of peer review to control service utilization and therefore costs is an application of the method which to date has not been shown to be effective. While it is true that the use of professional peers to judge the appropriateness and extent of care and services is by far more palatable to providers, there is still no real evidence that such utilization review has in fact resulted in significant cost savings.

On the other hand, peer review can serve as a valuable quality enhancement tool and can support the improvement of services and the dissemination of state-of-the-art service techniques. However, in order for the peer review process to serve a technical assistance function, the criteria applied during the peer assessment must be explicit to the extent possible. Those peer review procedures where the assessment merely involves the exercise of professional judgement using unstated or implicit criteria -- though valuable for quality regulation -- are inadequate for educational purposes. Only when the criteria are explicit can they be communicated to and subsequently applied by providers.

The process of peer review does have some inherent problems. For instance, it tends to reinforce the elitist character of professional guilds and is vulnerable to criticisms of cronyism. This criticism can to some extent be countered by the inclusion of consumers or their representatives on peer review teams. Further, unless the criteria applied during peer reviews

are updated and refined as the state-of-the-art changes, the applications of professional norms become static and no longer encourage progress and reform. Finally, the issue of confidentiality of records may constrain the use of non-professionals on peer review teams.

Private Evaluation Services

Introduction. Another option for program managers concerned about quality assurance issues is to rely on private evaluation services provided under contract. The evaluators serve as consultants, conducting the quality analysis and preparing reports on the findings. The use of consultants is a common method for conducting formal program evaluations that involve large-scale data collection. This type of evaluation is typically not part of a routine monitoring system but is conducted to the particular concerns of program funders or other policy-makers. The type of work under review here is somewhat different from this type of evaluation research, although formal evaluation research can provide useful data about service quality. Our interest is in the use of private evaluation services is as part of an on-going program of quality assurance.

There are several ways in which private evaluation services can be used to help assure the quality of human service programs. One is to use interviewers or trained observers from outside a provider organization in order to gather outcome data directly from clients. This is a particularly good use of outside consultants since clients may be reluctant to answer questions about service quality if the questioner is a representative of the agency providing the service.

Another way in which private consultants may be used is in designing a quality assurance system. Such tasks as the design and testing of data

collection instruments, creation of an automated client information system, and establishment of data analysis procedures may be beyond the technical competence of small providers or over-taxed public oversight agencies. Rather than hire staff to perform what is essentially a time-limited task, the agency may have private consultants perform the work. Finally, programs may use private consultants to provide the training and technical assistance in quality assurance systems to improve agency performance. Such expert program advice from private consultants and evaluators can serve a quality assurance function by encouraging compliance with "best practices" and standard procedures.

The **Evaluation and Technical Assistance Unit of the Rhode Island Council for Community Services, Inc.** provides a range of quality assurance services to administrative and provider agencies. Included in the services offered are formative or "evaluability" assessments as well as summative or full evaluations. In the process of conducting service assessments, the evaluation team is also encouraged to provide technical assistance when indicated. To carry out the evaluations, the Council for Community Services relies on knowledgeable volunteers thereby cutting down the fees they charge to a range of $5,000 to $10,000 for the average quality assurance report. The reports are based on the findings of the survey team and on the performance measures contained in the evaluation design.

Expert advice from an independent source need not come exclusively from private evaluation consultants hired to advise. The same type of help may come from volunteer experts, willing to share their knowledge on a pro bono basis. Although there is no financial incentive to motivate performance, volunteer consultants have assisted many human service organizations. Using volunteer experts or evaluation teams has worked well in the **Rhode Island**

example described above. In fact, many cities now have clearinghouses which match volunteer consultants with non-profit clients. The Community Renewal Society in Chicago and Community Training and Development in San Francisco are examples of organziations which porform this matching function.

Target Group and Service Application. There are no constraints to the use of private evaluators and consultants in any of the target group or service areas indentified in our taxonomy. There are organizations and individuals who are qualified to provide expert assistance to private and public agencies in each of the major human service areas.

Program Dimensions. Private evaluators can be used equally well to help assure quality in each of the four dimensions of human service provision -- input, process, output and outcome. The **Rhode Island Community Services** group conducts analyses that span all four. It is most likely however, that human service administrators and policy makers will use private consultants to assist with setting standards, monitoring and taking corrective action in the process and outcome aspects of service programs. It is these two aspects that present the most difficult conceptual and methodological problems. In dealing with these aspects, program managers may go outside their agencies for expert guidance.

Practical and Technical Considerations. There appear to be no technical considerations that are specific to the use of private evaluation services to assist in program quality assurance. However, there are a number of practical factors to be considered. The most obvious practical consideration is funding. Private consultants must be paid and funds must be obtained for this purpose. Given constraints on funding for human services, this presents a problem. However, in some agencies, it may be easier to obtain time-limited funds for the purchase of consulting services than to gain support for regular

staff positions that will require continued funding.

Using private evaluation services to <u>collect</u> data is a longer term commitment than involving consultants in the design of a quality assurance system, and may therefore be more expensive. In weighing the question of how private expertise should be used, an agency must consider how a consultant will complement existing staff capabilities and at what point in the quality assurance process a consultant can add the most value.

The longer term accountability of private evaluation consultants is another consideration. Unlike employees, consultants have no obligations to the agency beyond the terms of the consulting agreement. Using the financial mechanism of a contract, a provider organization can assure that the services purchased are actually delivered. Beyond that, the agency cannot hold the consultant responsible for the long-term utility of those services or for revising the products delivered to respond to changes in the agency's needs. Requesting additional work will generally involve the commitment of additional funds. A prudent purchaser of private consulting services will also work closely with the consultants so that they will be sufficiently familiar with the design and operations of the quality assurance system to make any needed changes.

Finally, it should be noted that the use of private evaluators cannot substitute for formal control mechanisms. While they may be useful in system design and data collection, outside evaluators lack the authority to enforce change in an organization. They may serve as change agents but cannot be expected to control programs or agencies. That is a major management responsiblity reserved for the senior staff within an organization. Private evaluators can help program managers and policy-makers institute quality assurance systems, they cannot create quality without a commitment from the

agency to use data on service quality to improve services.

Consumers and Families

Introduction. Earlier in this section of the manual, the role that citizens and volunteers can play in assuring the quality of human development services is discussed. The examples clearly show that lay persons and volunteers are prime resources for a wide range of quality assurance tasks. This section deals with the ways in which another volunteer resource -- clients and their families -- can serve the purposes of quality assurance. In addition to extending the capabilities of regulatory agencies and service providers to assess program quality, there are a variety of other reasons why clients and family members should be included in any service monitoring plan:

- Clients and their immediate families have a level of interest and a point of view not shared by either citizen/volunteers or service professionals;

- Involvement of clients and/or families in monitoring activities should temper a tendency on the part of professional peers to concentrate on the more technological aspects of service delivery;

- Using clients and/or their families as a source of information about a program can improve the likelihood that systematic client abuse or neglect will be uncovered;

- Inclusion of clients and/or their families in monitoring service quality underscores the role of consumers as partners in the provision of services;

- Clients and/or their family members may be more successful at eliciting quality-related information from other clients and their families;

- Participation in quality assurance may prove to be a strong motivational factor for the continued involvement of consumers and/or their families with the agency and its programs.

Involvement of clients and their families in quality monitoring is a fairly recent phenomenon. A variety of legal, social, and programmatic forces have stimulated an increasing recognition on the part of public officials and

service professionals of the importance of integrating consumers as active rather than passive participants in the service process. One factor is the growing assertion in the courts of the rights of a range of disadvantaged groups including developmentally disabled persons, children and the elderly. In some instances, legal intervention has resulted in court-ordered mechanisms through which clients or their advocates can air their grievances, preferences, or expectations (See: Halderman v. Pennhurst). Additionally, federal legislation (P.L 94-142) has elevated the role of parents in the provision of special education by mandating parental involvement in the preparation of the individual education plan and by giving parents due process rights so that they can appeal decisions made by the school district. Further, the self-help movement and the spread of consumerism has emboldened many clients and their families to be more assertive regarding their service needs and their level of satisfaction with services delivered. Finally there is growing agreement among many service professionals that inclusion of the client and/or family in service planning and service assessment enhances the service outcome.

An increasing acceptance among professionals of a less traditional and walled-off relationship with clients and their families makes consumer involvement in service monitoring not only theoretically valuable, but also possible. As a result, there are a variety of ways in which clients and family members can function as quality monitors. The following list ranks such roles from the most passive to the most proactive:

- **As sources of information** -- One portion of any systematic quality assurance system should be the measurement of consumer and/or family satisfaction with services rendered. The use of surveys of either current or former consumers of service is one of the most frequent ways that consumers are included in quality assurance activities.
- **As targets of consumer education** -- The more knowledge-able the consumer is regarding service options and indicators of service

quality, the more likely he or she is to select the most responsive provider and to demand a high level of service once the selection has been made.

- **As participants in structured grievance mechanisms** -- By providing clients, their families or advocates with a formalized avenue for airing grievances and complaints, administrators are provided with information about potentially abusive situations before they becomne full-fledged crises. One analyst goes as far as to state that "the public posting of all clients' comments received without exception would reduce the likelihood of unprofessional staff conduct and facilitate the rapid investigation of any serious problem. . ." (Quilitch & Szczepaniak, 1976, p. 9).

- **As parties to a performance contract** -- By assisting in the development of service objectives and the design of a service plan, clients and/or families can enter into a contract with an agency which can subsequently be assessed in terms of goal attainment.

- **As participants in structured monitoring activities** -- Consumers can be included as members of peer review teams comprised of service professionals or can function as independent monitors.

- **As advocates for other clients and/or family members** -- By acting as external advocates for individuals within a system, former consumers and/or their families can bring problems to the attention of the public in ways that are compelling and personal.

Service and Target Group Application. With the possible exception of very severely handicapped and infirm clients (e.g., fragile elderly persons, young children, or multiply handicapped non-verbal developmentally disabled persons), all clients covered under the rubric of consumers of human development services should be capable of participating in one or more of the quality assurance activities described above. Likewise, there is no apparent limitation on the types of family members that can be mobilized to assume quality monitoring functions. Methods outlined in the appendix and additional examples uncovered during the course of the development of the manual show the range of services that can be subjected to consumer monitoring, and the range of consumers that can augment quality assurance resources.

For example, family members and consumer representatives were included as participants on the teams that monitored residential programs in **Colorado.** As

discussed in the appendix, the Colorado Division of Developmental Disabilities established peer review teams that include consumer representatives from local associations for retarded citizens. The method, which has recently been refined, has proven widely acceptable and now includes an even stronger emphasis on consumer participation.

A monitoring committee comprised solely of parents has been established as a special unit of the **Association for Macomb-Oakland Regional Center** -- an advocacy group that acts on behalf of the clients receiving services either in Macomb-Oakland or in community programs. The role of the parent monitoring committee is to assess the agency's group homes to ensure that the persons living in those homes are receiving the best services possible in an enviroment that enhances and motivates individual growth. One of the primary reasons for establishing monitoring was to alleviate parental concerns regarding the stability of community homes once parents are no longer living. Further, the parent monitoring teams are seen as complements to ongoing quality assurance activities including quality of life monitoring and case manager visits.

The major areas that the parents review during their home visits include: general quality of life and environment, health, nutrition and client rights. Among the issues of greatest concern to the parents are the inside and outside appearance of the home, client-staff ratios and compatability, barrier-free accessibility for the multi-handicapped and the proper storage of medications. The site visit is governed by a checklist that was developed using input from the parents themselves and from checklists used by other agencies. Site visits are unannounced and usually include two monitors. Site visit reports are compiled by each team member and are shared with the Director of Macomb-Oakland who has 10 days to respond with a list of

any necessary corrective actions.

In another approach included in the Chapter V, consumers themselves served as sources of information regarding the quality of boarding homes in **Santa Clara County**, California. The project, sponsored by the **Mental Health Advocacy Project (MHAP)**, involved the use of social work students and board and care residents (many of whom were former state institutional residents), to collect information on a variety of aspects of care in boarding homes in the community. Initially, the social work students interviewed board and care residents regarding such issues as the "hominess" of the environment, the extent to which the home encouraged and supported independence, and fairness of the house rules. Subsequently, the residents themselves were trained to interview other residents. The product of the assessment was a guide to board and care homes in the county that ranked homes according to a variety of variables.

The approach to data collection and analysis included the design and field test of a questionnaire, training of students and consumers, conduct of interviews (in private whenever possible), and development of ratings. The latter tasks were carried out by three person teams that developed consensus statements for each facility (e.g., if eight out of ten residents said the food was very good, then the consensus statement read, "most of the residents say the food is very good").

The major problem encountered by the review teams was access to board and care facilities. Operators of the homes were, in some instances, extremely reluctant to let surveyors into the homes. They feared that the results of the survey might damage their reputations. Another source of opposition was a small group of parents that argued that mentally ill and developmentally disabled persons should not be permitted to make judgments regarding where

they should live without the supervision of mental health professionals or family members. This schism points to the fact that clients and family members do not always share the same point of view regarding service philosophy and approach. For purposes of quality assurance, this suggests that family members and actual clients should not necessarily be thought of as interchangable participants on monitoring teams or as similar sources of information.

There are also examples of programs in which consumers themselves designed and carried out evaluations. For instance, in Ohio, adult mental health service consumers representing Hill House (a psychosocial rehabilitation agency) have been conducting quality assurance reviews since 1977 (Smith, 1984). The consumers, who function as client advocates, have designed several instruments for assessing client needs and for evaluating client progress in the agency's multiple programs. Consumers submit the results of the surveys to the agency's staff and board of trustees with recommendations for improvement.

Consumers or potential consumers can also be used to monitor contracts for funding agencies. In Santa Clara County, California, the Area Agency on the Aging has appointed a board comprised of elderly individuals to evaluate the agency's contractors. The senior citizens on the board conduct site visits to programs for the elderly and interview the clients regarding their level of satisfaction with the quality of the service. Likewise, chronically mentally ill persons and their families were recruited by the Arizona Community Support Program to review the level of care being provided in residential programs under contract with the Arizona Department of Health (Fanning, 1984). Reviewers made site visits to each facility in the state using an open-ended questionnaire that focused on five areas -- physical

structure, residents' activities, staff and resident interaction, a comparison with the program a year ago, and the general character of the facility.

With minimal exceptions, each of the above techniques can be transferred to other target populations and services. For instance, family members of elderly persons could be recruited to conduct site visits at nursing homes, elderly clients of social service programs could design their own evaluation schemes, and parents of children in day care could be part of the development and publication of ratings of the level of day care services in a given community.

Program Dimensions. In the examples cited, consumers and family members tend to focus most frequently on the input and process aspects of services. In the three examples listed in Chapter V -- **Colorado residential monitoring, Santa Clara County board and care review, and Macomb-Oakland parent monitoring teams** -- the monitoring activities concentrated primarily on the physical aspects of the environment (e.g., accessibility, attractiveness, homelike character, cleanliness, etc.), and the way in which which the service was provided. In the latter instance, families and consumers are particularly good at investigating the extent to which the rights of clients are respected within a program, the level and type of interaction between staff and client (e.g., is the client treated with dignity), and the level of involvement of clients and their families in the service delivery process.

Though process and input dimensions of human service programs seem to occupy most consumer and family monitors, there are examples of outcome oriented consumer assessments. At Hill House for example, the clients designed a self-assessment instrument that reflected the clients' perspective on their treatment progress and on the program's effectiveness (Smith, 1984). In developing the questionnaire, the clients discovered that while the

clinicians' focus was primarily on behavior as an indicator of improvement or deterioration, clients responded much more readily and positively to questions aimed at feelings and needs. The questions included in the instruments were drawn from the client's own life experiences and on input from other Hill House clients.

Technical and Practical Considerations. The problems of recruitment, supervision, training, and retention outlined in the section on citizen monitors also pertain generally to the use of consumers and families in quality assurance activities. Because of their personal connection to the service system, however, the potential interest and commitment to the task of quality assurance should be greater among consumers and families than among individuals without such a direct association with the service system. Their level of familiarity with the service setting should also be greater in most instances.

Another problem, which is demonstrated by the **Santa Clara County** board and care review, is acceptance by providers of consumers and/or family members as legitimate quality monitors. The Macomb-Oakland example, however, shows that it is possible for parents and providers to reach accommodation. It would appear that the more difficult accommodation is between clients and providers in services where the relationship has traditionally been more paternalistic (e.g., services for developmentally disabled persons). Resistance, however, can be overcome with careful planning and consultation with all potential parties to the quality monitoring activity. The creation of a provider advisory committee in Santa Clara, for example, did much to alleviate the anxieties of the board and care operators.

In some instances, it may be necessary to alleviate the anxieties of consumers and families who are fearful that their participation in quality

assurance activities may result in repurcussions from the provider. A nursing home monitoring project involving familiy members of nursing home residents resolved this problem by sending family member monitors to facilities other than the ones where their relatives resided.

All in all, the technical constraints associated with the use of clients and family members as quality monitors are by far outweighed by the benefits of their input. Clients and their relatives bring a form of personal commitment and concern to the task of quality assurance that sets them apart from citizen monitors and professionals. This characteristic also gives them a special quality of empathy with the recipients of service and an insight into the consumers' experience.

Advocacy Groups

Introduction. In most instances, conventional quality assurance agents (state officials, accreditation agencies, etc.) can only assure that the conditions for carrying out quality programs exist within a system or in an individual agency. Typically, they cannot guarantee that the conduct of the program, on a day-to-day basis, will enhance the well-being of individual clients and protect their rights while they are receiving services. This is a role that advocacy organizations can and do play for many consumers of human development services. This section briefly discusses the ways that advocates can complement a larger quality assurance system and their particular strengths and weaknesses.

"Advocacy" is an amorphous term that has been used to characterize a wide range of activities as disparate as class action litigation and case management. Within the human services field, advocacy has taken a variety of different forms. In developmental disabilities, for instance, federal law

mandated the establishment of protection and advocacy (P and A) agencies in each state. With respect to the elderly, the Advocacy Assistance Program of the Administration on Aging combines a nursing home ombudsman program with legal services. In addition to these federally established entities, a multiplicity of other advocacy groups exists including internal advocacy systems established by state law, external advocacy mechanisms supported by public and private grants, organizationally-based advocacy systems (e.g., created by Associations for Retarded Citizens, etc.), county or regionally-based advocacy agencies, and volunteer or "citizen" advocates.

The type of advocacy practiced by these groups varies depending on the mission, auspices, resources, political context, and scope of the particular organization (Bradley, Hoff, and Reday, 1982). Strategies employed by advocacy organizations include the following (Fitzpatrick, 1981):

- **Legal advocacy** -- protection of the legal rights of disadvantaged persons by means of litigation and representation by legal counsel;
- **Service advocacy** -- enhancement of the effective delivery of programs and services appropriate to the needs of disadvantaged persons;
- **Citizen advocacy** -- representation of a disadvantaged person by a lay advocate who serves as the client's protector, counselor, and friend;
- **Systems advocacy**-- attempts to bring about system-wide reform in a particular service arena.

All of these functions are consistent with some quality assurance role.

Though advocates can be found in a variety of contexts carrying out a range of activities, there are some common characteristics. According to Fitzpatrick (1981), the common element among conceptions of mental disabilities advocacy is the "recognition that mentally handicapped citizens frequently are unable to understand their rights or how best to protect them and hence require the assistance of some concerned individual or agency" (p. 2). This characterization works equally well for vulnerable elderly

individuals and for children in jeopardy.

Given this understanding of advocacy groups and their functions, there are several reasons why advocates can play a special role in a larger quality assurance system:

- Because of their unique relationship to their clients, many advocates have a better chance of soliciting quality-related information from service recipients.
- External advocates have no direct connection with the service system and therefore have the freedom to be critical.
- Internal or state-supported advocates are usually insulated to some extent from the management of the service system and therefore have more freedom to be critical.
- Given their relative independence from service delivery, advocates are in a position to publicize weaknesses and inadequacies in the service system.
- Depending on the type of advocacy organization in question, findings of inappropriate or inadequate services can be backed up with litigation and legal enforcement.

There are a number of roles that advocates can play in assuring service quality. For instance, advocates -- especially legal advocates -- can seek enforcement of existing quality assurance regulations. Service advocates can provide a forum for complaints and allegations about service delivery problems. Citizen advocates can monitor residential services by visiting consumers and acting as spokespersons for individual needs and complaints. System advocates can pressure for the creation of formal complaint mechanisms that bring service problems and abuses to the attention of public officials. In the following sections, specific examples of advocates acting as quality assurance entities will be described and analyzed, and the strengths and weaknesses of such approaches will be discussed.

Service and Target Group Applications. There are no apparent limitations on the use of advocacy groups as quality monitors either with respect to target population or service. It is clear, however, that advocates are

especially effective when representing the interests of vulnerable and dependent individuals (e.g., developmentally disabled, frail elderly, etc.) in services where the risks of exploitation and abuse are the greatest (e.g., out-of-home placements, etc.). As such, advocates may be more associated with quality regulation approaches, (e.g., enforcement of constitutional, statutory, and procedural rights), but can also play a quality enhancement function as will be seen. The following examples display some of the approaches that can be applied.

The survey conducted under the auspices of the **Mental Health Advocacy Project** in Santa Clara County shows how an advocacy group can team up with its own clients to monitor service quality in residential arrangements. The clients in this method included both mentally ill and developmentally disabled individuals, and the targets of the monitoring were boarding homes. It is difficult to imagine how this inventive approach to assessing and publicizing service quality issues could have been carried out by an agency tied directly to the service system.

Complaint or grievance mechanisms, as noted above, can be used to achieve quality assurance ends. The **New York Commission on the Quality of Care for the Mentally Disabled** serves a range of quality assurance functions including the investigation of complaints of patients, residents and employees of mental hygiene facilities including allegations of patient abuse and mistreatment. As part of this function, the Commission conducts orientation and training programs for boards of visitors assigned to monitor the service process in the state's facilities for mentally ill and developmentally disabled persons.

One of the groups trained by the Commission is the Board of Visitors at the Manhattan Children's Psychiatric Center. According to Seide (in Bradley, et al., 1984) the Board is both an advocate and a watchdog. In the past it

has investigated both staff complaints and allegations of client abuse. Recently, the Board was asked to conduct an investigation by a concerned parent who alleged that child abuse was going on in one of the wards. In response, two members of the board with experience in the child care field spent several days at the facility reviewing records and talking to staff. They concluded that there had been abuse, but that staff had not been sufficiently trained in techniques for handling difficult clients. Based on these findings, the board recommended that a staff training program immediately be put into place and that accountability and authority on the ward be clarified. This example shows the virtues of complaint mechanisms, and also the ability of a board of visitors to serve both a quality regulation and quality enhancement function.

The use of citizen advocacy to assure service quality for frail elderly persons is exemplified by the Citizen Advocacy Project of the Nursing Home Residents' Advocacy program (Anderson, Bollenbeck, & Freeman; in Bradley, et al., 1984). The citizen advocacy concept was originally designed by Wolfensberger (1973) as a means of advocating for developmentally disabled citizens. In his framework, citizen advocacy is the pairing of a trained volunteer with a person in need of both companionship and protection. According to Anderson et al., the concept has proven effective in meeting the needs of nursing home residents.

In the Citizen Advocacy Project, citizen advocate volunteers serve in a variety of roles, both formal and informal. Formal roles include representation to obtain public benefits, and protective or professional services. Informally, the citizen advocates can provide friendship, guidance and affection. In some cases, the citizen advocate may be the resident's only friend. In describing the potential impact of this approach, Anderson et al.,

(1984) note the following:

> . . . the advocate may serve as service monitor for the community because his or her repeated presence delivers the message that outsiders are mindful of residents' safety and rights . . . The hope of the program is that expanded public experience can grow into public accountability. The potential for change, then rests not only in individual relationships and actions, but in the cumulative effect of involvement. (p.166-167)

The experience of a Nursing Home Ombudsman Program in Massachusetts shows how volunteer advocate/monitors can actually bring about changes in service delivery (Humphrey, in Bradley, et al., 1984). The Consumer Advocates for Better Care (CABC) has 12 visiting ombudsmen ranging in age from 22 to 77 years old. The majority of the advocates are low-income elderly who are paid for by federal Title V funds (Senior Aids and Green Thumb) or receive a small stipend through the Older Americans Act Program -- the Elder Service Corps. The visiting advocates monitor the care received by residents of nursing homes and rest homes in 22 communities. This includes 41 nursing and rest homes with a total population of 1,874 residents.

CABC advocates have uncovered many abuses in residents' rights ranging from complaints of cold or improper food to serious abuse and neglect. In one recent case involving a rest home, CABC advocates documented a range of abuses including lack of nutritious meals, physical abuse, withholding of medication for punishment, denial of leisure activities, and misuse of resident allowances. As a result of the latter investigation, the nursing home has now been closed. Based on these and other experiences, CABC advocates have also testified for improved regulation of nursing facilities at the state and national level.

Several internal or state operated advocacy programs around the country are also serving quality assurance ends. The Office of Recipient Rights in the Michigan Department of Mental Health, for instance, performs a range of functions including prevention of violations of rights by alerting facility

staff to conditions that may violate rights, investigation of rights complaints and other reports of apparent violations of rights, and monitoring incident reports and other assessments that may contain violations of rights (Office of Recipient Rights, 1983). Services are provided through "rights advisors" who serve residents of state facilities as well as those placed in community homes under contract with the Department of Mental Health. Target groups include both mentally ill and developmentally disabled persons.

In addition to ensuring that individual well-being is protected within institutional and community settings, the Office of Recipient Rights (ORR) monitors reports prepared by other quality assurance and regulatory agencies including licensing reports, studies by the auditor general, site reviews by the Joint Commission on the Accreditation of Hospitals, and certification surveys of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). The reports are reviewed in order to determine whether any potential rights violations are implied. (Coye, 1980).

Using information gained from the report review and investigation of complaints and allegations of rights violations, the ORR also performs a quality enhancement function by offering technical assistance to staff at the facilities. The purpose of the training is to educate staff regarding the state's resident rights statutes and to explain to them the ways in which they can comply. In explaining the purpose of the training, Coye (1980) makes the following point:

> . . . all mental health staff -- administrators, clinicians and direct care staff -- need assistance in understanding the changes they must make, especially in attitudes and practices. A right which may be limited is quite different from a privilege conferred. When the rights of recipients are in fact protected, the staff can be comfortable about compliance with the statutes and rules and know that recipients are receiving services which do not violate civil, environmental or treatment rights.

In sum, advocates -- either internal or external to the system -- can

carry out quality assurance responsibilities. Their services are particularly valuable for more vulnerable and disabled clients who are in situations likely to put them at risk of exploitation or abuse.

Program Dimensions. Because of their concerns for the procedural rights of service recipients, advocates are more likely to be concerned with monitoring the process of service delivery. Their focus is largely on ideologically-based standards that formalize such process concerns as placement in the least restrictive environment, equitable access to services, maximization of individual potential, and protection from harm. These are the sorts of elements that characterize the client's relationship to the staff, to other clients, and to his/her environment.

For instance, both of the nursing home advocacy projects discussed above are directed primarily at the conditions in which elderly persons live and the extent to which staff are attentive to their needs. Likewise, the Board of Visitors at Manhattan State Psychiatric Hospital focuses its resources on the investigation of complaints regarding the failures of staff to treat clients in a humane fashion. Further, the Office of Recipient Rights in Michigan is responsible for ensuring that the rights as spelled out in the state's regulations are respected and protected within the institution and in the community.

Technical and Practical Considerations The use of advocacy groups as quality assurance agents has some limitations that are endemic to this type of organization and that are the reverse side of advantages mentioned in the introduction. For instance, the independence of advocates from the service system may mean that they are seen as antagonists to the system and therefore encounter difficulties in gaining access to those programs or facilities that require monitoring. Reports from the board and care project in **Santa Clara**

County indicate that the biggest obstacle to the conduct of the assessment was access to the homes. Similarly, both reports on the nursing home advocacy projects note that access to nursing homes was perhaps the biggest problem encountered in attempting to protect the interests of frail elderly residents. This is one area where internal advocacy mechanisms such the Office of Recipient Rights have an advantage over external monitors in that they are usually based within the target facilities and their access rights are backed up by state statute.

Advocates are sometimes criticized for making judgements about service procedures without any programmatic knowledge. Advocates are best equipped to concentrate on issues that are fairly straight-forward (e.g., living conditions, physical abuse, etc.) -- issues that do not necessarily require the sort of expertise needed to make subtle professional judgments.

In their role as independent critics, advocates run the risk of alienating themselves from the service system and therefore diminishing their ability to influence change. In some cases, such as the abuses uncovered in a facility by the Consumer Advocates for Better Care discussed earlier, there was no room for accommodation, and closure appeared to be the only resolution. However, staff in the **Mental Health Advocacy Project**, through the creation of a provider advisory committee, did reach some accommodation with the board and care operators and moderated its monitoring statements. Clearly, polarization of advocates and service professionals can be counterproductive and cooperative links hould be forged where possible (Paschall & Eichler, 1982).

Accreditation Organizations

Introduction. State or local agencies may opt to require that service

providers be surveyed and accredited by recognized accreditation agencies in lieu of, or together with, their own quality assurance reviews. Accreditation is defined as follows:

> ...a process of evaluating and recognizing [the] performance and integrity of an institution that meets predetermined standards or criteria established by a competent agency or association, usually private. Accreditation entitles the institution to the confidence of the community and public and implies that a program of quality is being offered. The basic point behind accreditation is that the status of being accredited is assigned by some other party; it is not self assumed. (Ross, 1979, p. 1)

Accreditation schemes are obstensibly based on voluntary compliance. Some accreditation requirements, however, have been adopted by state and federal agencies as prerequisites for governmental recognition and the receipt of funding. This practice began in the health and education fields. For example, the standards of the Joint Commission on the Accreditation of Hospitals (JCAH), which were originally developed for voluntary accreditation, are now being used as a basis for funding decisions by federal payment agencies. The JCAH standards are said to have "deemed status" which means that they are considered the equivalent of state certification for Medicaid funding.

In the education field, instead of granting "deemed status" to a particular accreditation system, such as that sponsored by the Joint Commission on the Accreditation of Hospitals, the Commissioner of Education recognizes an institution as accredited and eligible for federal funds if the accrediting was done by any of a number of agencies deemed qualified to accredit educational programs.

Since 1968, the Accreditation and Institutional Eligibility Staff (AIES) and advisory committee in the Office of Education have set conditions for the recognition of agencies that accredit higher education, proprietary, and vocational education. AIES is variously seen as an ally or policeman of

educational accrediting agencies. Agencies apply for recognition every four years. AIES goals are to eliminate discrimination by educational bodies, to reduce the proliferation of accrediting agencies, to promote due process, to develop and enforce ethical standards, and to increase the number of "public" members on accrediting bodies.

Like precedents exist in human development services, but at the state rather than the national level. For instance, the Federal Rehabilitation Act of 1973 mandates that states establish standards for all rehabilitation facilities as a condition for accepting federal funds. Rather than develop its own standards and assurance system, the State of Ohio, for one, chose to mandate "that all rehabilitation facilities which provide services to clients of the State Vocational Rehabilitation agency must be accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF), the National Accreditation Council for Agencies Serving the Blind or Visually Handicapped (NAC), or the American Speech and Hearing Association (ASHA)" (Etling, 1978, p. 23). The **Commission on Accreditation of Rehabilitation Facilities (CARF)** has been successful in securing "mandates" or "deemed status" for its standards in some 50 states.

Similarly, in the state of Maine, homemaker home-health service providers must be accredited by the National Council for Homemaker Home-Health Aid Services in order to qualify for state funding. In North Carolina, providers accredited by the National Council for Homemaker Home-Health Aid Services may waive some state licensing requirements. At least a half dozen states require public and private schools for the blind and visually handicapped to be accredited by the National Accreditation Council for Agencies Serving Blind or Visually Handicapped.

Service and Target Group Applications. Obviously, this method can be

applied only in those human development service areas where private accreditation mechanisms exist. Some of those functioning in the field are:

- American Speech-Language-Hearing Association (ASHA);
- National Council for Homemaker Home-Health Aide Services, Inc.;
- Accreditation Council for Services for Mentally Retarded and other Developmentally Disabled Persons (AC-MR/DD);
- National Accreditation Council for Agencies Serving Blind or Visually Handicapped (NAC);
- Council on Accreditation of Services for Families and Children;
- **Commission on Accreditation of Rehabilitation Facilities (CARF).**

Accreditation mechanisms, by their very nature, concentrate on input and process dimensions of program quality as verified through periodic on site reviews. These accreditation mechanisms cover standard categories of human development services and target populations as shown in the table on the next page.

Program Dimensions. Accreditation schemes focus almost exclusively on service inputs and the process of service delivery. Specifically, accreditation standards concentrate on such input characteristics as staff/client ratios, staff capabilities and education, physical plant and environmental amenities. Process concerns tend to include such areas as the content of service plans, the nature of the service approach, and the appropriateness of services provided. Though accreditation standards may require that an outcome monitoring system be in place in the agency, with the exception of CARF, accreditation surveys do not as a rule address service outcomes.

Practical and Technical Considerations. Advocates of such public/private quality assurance hybrids see them as having the advantages of both the public and private control schemes. Antagonists wonder whether such advantages are

APPLICABILITY OF ACCREDITATION METHOD BY
HUMAN DEVELOPMENT SERVICE CATEGORY
AND TARGET POPULATION

	HUMAN DEVELOPMENT SERVICES										
TARGET POPULATIONS	Residential Long Term	Residential Interim	Counseling	Information and Referral	Education and Training	Day Programs/ Activities/ Nutrition	Homemaker/ Chore Services	Emergency Services	Case Management	Speech and Hearing Pathology	Other
Developmentally and Other Disabled	3,6,4	3,6,4	3,6,4	3,6,4	3,6,4	3,6,4	2	3,6,4	3,6	1	3,6,4
Aged							2				
Native Americans							2				
Dependent and Neglected Children	5	5	5	5	5			5	5		
Runaway Youth											
Others Needing Protection and Support											

NOTE: 1 = American Speech-Language-Hearing Association (ASHA); 2 = National Council for Homemaker Home-Health Aide Services, Inc.; 3 = Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (AC-MR/DD); 4 = National Accreditation Council for Agencies Serving Blind or Visually Handicapped (NAC); 5 = Council on Accreditation of Services for Families and Children; and 6 = Commission on Accreditation of Rehabilitation Facilities (CARF).

more apparent than real. The purported advantages are that the scheme retains the professional acceptability associated with professionally-dominated accreditation associations. At the same time, the government is able to take economic advantage of the work of private accreditation bodies in making funding eligibility or licensing determinations, and is able to make its influence felt through these groups.

The major disadvantages of accreditation schemes are that: (1) the professional domination of most accrediting agencies and their minor consumer/public representation raises questions concerning the professional versus public interest, and (2) stand-in quality assurance agents can reduce the interaction between providers and the state and thereby reduce responsiveness on both sides.

Less clear is whether such a scheme provides a degree of insulation of quality concerns from the political and economic pressures associated with potentially compromising program funding and licensing decisions. Conversely, the accreditation body may lower its standards from a more ideal level to a level which most, if not all, providers can attain in order not to jeopardize a providers' right to operate. If the latter is true, state deeming of privately-developed standards may effectively pre-empt such quality assurance agencies and result in a diminished level of expectation.

Provider Acceptability and Ability to Influence Provider Practice. Professionally-dominated accreditation and certification bodies are thought to have more influence over professional practice than do government agencies. As Maloof (1975) and other organizational theorists explain, the professionalization of practitioners engenders an ethic, attitude, or frame of reference rather than a recipe for behavior. Accordingly, Maloof (1975) notes, "management must rely on professional standards rather than

hierarchical relationships to ensure the conformity of the staff" (p. 25). As it pertains to adherence to service quality standards, then, standards emanating from professional circles seem to have a greater likelihood of acceptance than those developed by government. This is particularly true in view of the prohibitive problems of monitoring and controlling service delivery processes from outside of service delivery organizations. Professional persuasion rather than administrative coercion is widely accepted as the most effective means of controlling human service practice.

Economy. A final determination of the relative costs of public versus private quality review teams can only be made on a case-by-case basis. However, two factors make it probable that the cost per surveyer day of the private alternative would be less than the public alternative in most cases. First, most accreditation groups use a cadre of independent surveyers on an as-needed basis, paying them $150 or less per day. It would be hard to schedule the time of full-time staff as efficiently. Second, the number of providers participating in multi-state accreditation schemes is considerably larger than the number of providers participating in any one state. The cost of central office operations required to administer an ongoing quality assurance process, to keep the standards up to date, and to train surveyers can thus be spread over a larger number of providers thereby reducing the administrative and support costs per surveyer day.

Responsiveness to Concerns of Consumers. Given the fact that the managing boards of many accrediting organizations are entirely or predominantly members of a human service profession, there is some reason to assume that perpetuation of the particular professional group rather than more general consumer interests is the primary concern of such organizations. Even more, it is unlikely that the accrediting and certifying organizations will

reduce this professional domination of their own volition. Among the basic attributes of a "profession" is the proviso that "professional behavior can only be evaluated by a professional's peers." Thus while professional groups ardently seek community sanction to exercise such authority, they do not admit that the community -- clients or other outsiders -- are able to make judgments about competence and appropriate professional conduct (Hardcastle, 1977, p. 14).

There may well be some exceptions to this general practice. For instance, the National Association of Homes for Children has developed and field tested a citizen-peer review accreditation process. A layperson recruited from a local chapter of a national service organization such as the Junior League is invited to participate in the on site review of a children's home seeking accreditation. The lay individual is also encouraged to submit independent reports and recommendations directly to the Chairman of the Commission on Accreditation (Relihan, 1979).

Moreover, a number of accrediting organizations include a procedure for interviewing consumer advocates in connection with their on site reviews in order to obtain consumer evaluation of the services provided.

Responsiveness to State and Local Concerns. A principal concern of state administrators is that the use of an accreditation mechanism can lead to diminished state and provider communication and a loss of responsiveness to state and local concerns. In order to respond to this concern -- one shared by many state administrators considering the use accreditation organizations -- accrediting bodies have recently taken a number of steps to keep state officials informed and involved. Some of the steps that can be taken include asking state officials in advance of the surveys if there are any particular problems the surveyor should look for, inviting state representatives to the

survey orientation sessions and exit conferences, and checking with state officials following the survey to make sure they are satisfied with the survey's procedures and results. They also make a practice of briefing and training interested state officials on the accreditation standards and on site review procedures in order to promote state understanding and hopefully support.

States may also elect to conduct limited program reviews addressing particular concerns not covered in the accreditation reviews. This procedure is currently followed in the State of Iowa as a complement to the reviews of day program providers conducted by the **Commission on Accreditation of Rehabilitation Facilities (CARF).**

Compromising Accreditation Standards. Many feel that privately established quality standards are less likely to be skewed to federal or state priorities or to be distorted by political expediency. Yet, in view of the growing litigousness in many areas of American life, privately developed standards -- especially when they are used to determine eligibility for public funding -- are vulnerable to legal attack.

Anderson (1975) identifies three areas of vulnerability (1): possible liability under the federal and state anti-trust laws; (2) liability to consumers or individuals who rely upon the accreditation; and (3) possible liability for injury to business (p. 86). The growing tendency to challenge or threaten to challenge accrediting agencies in the courts has been an unwelcome consequence of the linkage of accreditation to eligibility for federal funds. It is easy to understand how accrediting agencies might think twice before denying accreditation to recalcitrant service providers for fear of incurring the expenses associated with lengthy court actions, and the possible exposition of untidy aspects of the accrediting agency's operations.

The concern that the rigor of the standards of these accreditation bodies will decrease over time in response to political pressures is probably justified. Eventually, these organizations are bound to come under the same political pressures faced by public quality assurance agents. Many accreditation agencies derive their prominence because their stamp of approval is linked to federal or state funding or other major benefits:

> It isn't entirely cynical to conjecture that the nongovernmental accrediting commissions, with no largesse of their own to bestow, might soon be standing at a lonely altar or perhaps lying in a pine box. And with their demise, the government agencies which were ostensibly interested only in determining eligibility would have to become accrediting agencies as well (Kirkland, 1975, p. 196).

It is important to note that this is only a problem to the extent that it causes an accreditation organization to lose sight of its "raison d'etre" -- to stimulate higher performance. There is no reason why an accreditation group should become totally absorbed in assuring minimum standards compliance as a surrogate quality assurance agent of the state. It can and should continue to apply higher standards on a voluntary basis to those select providers interested in the challenge of working toward higher levels of performance and in the recognition gained from meeting them. The concepts of multi-tiered standards or the graded achievement of model standards is hardly new (e.g., Standards for Foster Family Systems, American Public Welfare Association), and seems especially fitting in the case of accreditation bodies taking on the responsibility for assuring compliance with minimum standards along with their longstanding responsibility to promote the achievement of higher level standards. Certainly, setting the standards required for state licensing or funding apart from the standards for provider recognition could dim their appeal to the state, and thus must be approached with some caution. Nonetheless, one would hope that accreditation organizations will move in this direction, lest the human services field lose what has long been an influencial source of support for higher quality services -- the private accreditation body.

Techniques

Pre-Screening and Self-Assessment

Overview. Pre-screening coupled with self-assessment is a quality-enhancement method by which an organization voluntarily monitors its own operation using a pre-designed set of standards. These methods are usually spelled out in manuals and are composed of checklists that organizations can use to monitor their own operations. This technique enables an organization to assemble and organize information about itself including both strengths and weaknesses. Knowledge gained from this process can be used to improve service quality and effectiveness. Self-assessment can assist a human service organization in assuring operational quality in a cost efficient, non-threatening manner since the data is immediately at hand and the results stay within the organization. In short, the agency is not held accountable by any monitoring organization for the findings. It is a convenient quality assurance approach that can increase staff involvement and enthusiasm, improve service quality, and hasten beneficial changes in practice. Self-assessment can also be used as an adjunct to third party review methods to screen and to identify service providers that might benefit from more formal quality enhancement efforts. This allows quality assurance resources to be used more efficiently.

The concept of organizational self-assessment gained recognition through Aaron Wildavsky's work on self-evaluation (Wildavsky, 1972). It is an approach used extensively in the mental health field, and has been recognized there as a worthwhile approach (Neigher, Ciarol, Hoven, Kirkhart, Landsberg

Light, Newman, Struening, Williams, Windle & Woy, 1982). Voluntary self-assessment efforts, however, are thought to be more useful tools than mandatory self-assessment (Woy, 1982). Research has shown that self-assessment has improved mental health programs (Wildavsky, 1972; Kirkhart, 1982; Woy, 1982; Attkisson, Brown, & Hargreaves, 1978). The National Council of Community Mental Health in a recent study declared that self-assessment has had a "major influence on policies and programs" (Kirkhart, 1982).

Its success as a quality assurance mechanism has thrust self-assessment beyond the confines of mental health. Many human services agencies have designed and implemented self-assessment mechanisms, with encouraging results. For instance, the Urban Institute's multi-state study (in Georgia, South Dakota and West Virginia, as well the Child Welfare Agency of the Minnesota Chippewa Tribe) on self-assessment for child welfare programs reported positive results in the use of their self-assessment manual. Specific results indicated that 70% of the staff from the 65 local agencies reported that self-assessment workshops were useful in their work, and 55% found that self-assessment helped them to identify problems of which they were unaware. Not only was self-assessment found useful in the area of problem identification, but also in the areas of staff morale, effective service delivery, improvement of policies and procedures, as well as improved communication within the local offices and between state and local offices (Schenet & Sonenstein, 1981).

Other agencies we have identified using self-assessment techniques include the United Way of Texas, **United Way of New York** and the substance abuse program of New York's Phoenix House Foundation. Phoenix House has declared self-assessment "necessary to improve the quality of care," finding it a useful tool for clarifying treatment philosophy and program goals. Self-

assessment was a dynamic tool in program staff education, stimulating staff to "communiciate, conceptualize and self-examine" as well as function better as a team (De Leon, 1979). So too, the United Way organization Greater New York Fund felt that the benefits of self-evaluation were numerous, both internally and externally (Newman & Van Wijk, 1980). Internally, they found that self-assessment provided:

- A better and shared understanding of what an agency is expected to achieve;
- A clearer understanding of specific roles to be performed by individual staff members;
- A more specific definition of progress or success for individual cases;
- A more precise delineation of the limits of the objective an agency is expected to achieve;
- A more pronounced focus on outcomes and results; and
- Better information for planning and decision making.

External benefits were:

- Increased ability to communicate and account to the public and funding agencies for financial contributions received;
- Improved ability to demonstrate to consumers and the public a real concern about program effectiveness.

Self assessment is a mechanism that lends itself to rapid feedback and therefore allows programs to implement necessary changes without the bureaucratic and time-consuming delays that usually accompany organizational change. Wildavsky (1972) views the ideal organization as self-evaluating (self-assessing). He feels that self-assessment can lead to improved performance through the refinement and alteration of existing policies.

Despite the apparent positive qualities of self-assessment, there are also some instrinsic problems. Because self-evaluation is voluntary, agencies may choose not to employ such a method. Agency staff may perceive that self-

assessment has no practical value, or is potentially disruptive and/or time consuming. Even if agency staff do participate in self-assessment, they may neither wish to inspect the troubled areas uncovered, nor give themselves unfavorable ratings.

Self-Assessment Designs. Although most self-assessment instruments use a basic format of questions and checklists, there are several different designs. Externally developed systems are multi-program data systems developed by persons or organizations external to the specific program. In many cases, externally developed self-assesment systems are not oriented to a specific program or target group. For example, a Quality Assurance Manual was developed by the United Way of Texas to obtain information specific to management areas of finance, personnel and administration. It does not address the individual services provided by specific agencies. Its focus is procedural rather than programmatic. Its informational objectives are limited to input and process dimensions only.

Another example of an externally developed process which is flexible and intended for use by a number of agencies is the technique designed by the **United Way of Greater New York.** This method includes questions on outcome and results. It provides the framework for a step-by-step assessment including suggested forms and procedures. The advantage of this generalized mechanism is that while it can be adapted for different human services programs, it also provides a common format that allows for cross-agency comparison.

Internal self-assessment instruments are those that have been developed exclusively by a single organization for its own use. The obvious advantage of this form of self-assessment is that it is designed for the specific needs of an individual program and can accommodate changes within that program. Its primary disadvantage is its limited usefulness for cross or interagency

comparison. Furthermore, it can be time-consuming and costly. Phoenix House, a substance abuse rehabilitation center, recently developed such an internal self-assessment process. Although they found it to be a useful internal device for obtaining self-knowledge, its development involved many hours of staff training and costly consultation (De Leon, 1979).

The Urban Institute developed a program-specific process for use by child welfare agencies. Although this technique was externally developed, it has some of the advantages of an internally developed instrument because of its comprehensive format covering seven major areas of child welfare services. Further, the process can be used for intra-agency comparison as well as cross-agency comparisons.

An intensely participatory form of self-assessment is the quality circles process. Quality circles, used heavily in Japanese industrial settings, are now seen as a way of addressing quality problems in American organizations. Quality circles involve voluntary employee participation in decision-making and problem-solving. Although quality circles have not been used widely as human service quality assurance mechanisms, they have been used in some agencies (e.g., by a local community and human services department in Minnesota). The Minnesota group used quality circles to improve the operations of five separate agencies (Mercer, 1982).

Quality circles have strong potential uses in the human services field. Quality circles may be used to improve communication between human services clinicians, management and supportive clerical personnel. Its potential is also seen as a vehicle for problem-solving and a stimulus for program coordination (Mercer, 1982).

Service and Target Group Applications. There is nothing inherent in self-assessment that prevents its use with any service or target group. Self-

assessment may be adapted or designed for any type of service. However, certain self-assessment designs are structured for specific programs and target groups, making it impossible for cross-service comparisons. Nonetheless, those self-assessment techniques designed for specific services are good mechanisms for comparisons within the same service area. Self-assessment can be used in all human services. Below are descriptions of four self-assessment approaches along with a discussion of their application, advantages and disadvantages.

The Local Child Welfare Services Self-Assessment Manual is an instrument designed by the Urban Institute for the use by child welfare agencies (Sundel, Homan, Lucas, Burt & Clarren, 1978). It is a systematic and practical method for program administrators, supervisors and line social services staff to assess agency performance in an objective fashion. The objective is to facilitate internal agency improvement by providing a standardized framework for self-assessment of child welfare services. Its major benefits are:

1. It alerts staff to problem areas of which they were previously unaware.
2. It provides a systematic method for documenting problems and reasons for change.
3. It facilitates discussion of service delivery issues among staff.
4. It provides base-line data as measures for evaluating changes and documenting progress in services and programs. (p. III - 16)

The self-assessment manual contains seven sections dealing with different facets of the child welfare process. The seven sections are organized to reflect the sequence of decisions or activities that occur in an agency offering child welfare services. Following each checklist is a resources section that highlights related research findings and provides a bibliography. Each checklist includes goals, performance indicator questions, objectives and criteria questions. The scope of the child welfare services

manual is limited to process and outcome. For instance, the intake/service section includes questions regarding adequate preparation for court hearings. The following, taken from the manual, reflects the process orientation: "Are case records maintained in such a way that data for drawing up a petition for removal or terminating of parent rights are immediately retrievable" (p. III-9)? A typical outcome question may take this form: "Within the past year, did more than 5% of the cases received at intake later return as referrals" (p. III-9)? Though this instrument is restricted to process and outcomes and can only be used by child welfare agencies, it is a good vehicle for comparisons among programs in the child welfare delivery system.

The United Way of Texas Guide for Agency Self Assessment (1981) is a procedural manual concerned exclusively with administrative issues. It addresses the elements of input and management process only. Because of its generalized design, it can be used for all human services personnel wishing to learn more about management. Use of this manual does not require any specialized training. A typical question from the manual demonstrates its input focus: "Does the agency evaluate its physical facility requirements on a periodic basis" (p. 24)? Other questions deal with process dimensions, for example: "Are job descriptions and accounting procedures specific enough to facilitate a smooth transaction from one employee to another" (p. 32)?

The Self-Assessment Manual for Human Services Organizations of the **United Way of Greater New York Fund** is another example of limited information objectives having a major emphasis in determining outcomes. This manual is general and can be adapted to the needs of different human service providers. It supplies the framework for an agency to define goals and objectives clearly and to assess its performance. Because it only provides a

framework, each individual agency has the task of identifying its own issues; clarifying its own mission, program description, and program goals; and determining measurable objectives for the agency as well as for individual cases. On the negative side, the process can be time-consuming, and is probably not suited for inter-agency comparisons unless agencies collaborate on the finished design.

The Phoenix House Substance Abuse Foundation method is an example of a program-specific approach developed internally by staff who have been specifically trained in self-evaluation (De Leon, 1979). The obvious advantage to this type of instrument is that its design takes into account the specific needs of the program and can be easily revised to accommodate program and external changes. The advantage of program specificity, however, may also be a disadvantage since the method lacks the adaptability for use by other agencies or programs. Another major disadvantage to this type of internal agency method is the costs involved. Phoenix House hired consultants and spent considerable time and funds to train staff in self-evaluation. This commitment of time and funds is not feasible for many agencies.

Program Dimensions. This section describes the uses and limitations of self-evaluation with respect to the four program dimensions of input, process, output, and outcome. The preceeding section has shown that the self-assessment mechanism can be designed to generate information and knowledge in all four areas. Input, process and output are fairly easy dimensions for which to design measurement checklists. Outcomes, however, present certain difficulties for self-assesssment. The research literature suggests that self-assessment is most effective when the instruments used are simple.

Outcomes are not, however, easy to discern. Outcomes gauge the results of a program or service on individuals served. In order to ascertain results,

program goals and objectives must be clearly defined, and standards and indicators must be designed. This is one of the most difficult tasks in the area of human services (Neigher et al., 1982). Because these areas are difficult to define, self-assessment instruments geared to outcome are equally complex to design. It is also necessary for each agency and program within an agency to design individual instruments tailored to individual goals and objectives.

Outcome monitoring may involve more analysis of data than the three other dimensions. Such analysis can require a substantial amount of work on the part of the agency. Not only is the analysis complex but agency record systems may not have all the necessary data to produce to precise outcome measurements. Alternatively, some agencies may not have the capabilities (e.g., clear ideas of goals, a sufficient data bank, funds, or expertise) to design self-assessment methods that measure outcomes. Though these difficulties may deter some agencies from using self-assessments to measure outcomes, there is evidence that self-assessment outcome methods can be a valuable tool for quality assurance (Kirkhart, 1982).

Technical and Practical Considerations. Self-assessment has made important contributions in the quality assurance of human services (Kirkhart, 1982; Woy, 1982; Frankel & Sinclair; 1982 De Leon, 1979; Attkisson et al., 1978). Nonetheless, it is constrained -- as are other quality assurance methods -- by problems of goal definition and measurement design. Likewise, self-assessments are also subject to problems of reliability and validity.

Design Problems. Self-assessment measures must be sensitive to the problems of establishing uniform goals. There are often contradictions between program goals as perceived by federal officials and interpreted in regulation, and goals perceived by local agency staff (Neigher et al., 1982;

Downs, 1967). Thus goal definition and agreement can be problematic at the onset. Once goals have been established and integrated into the self-assessment instrument, they become fixed. However, as the technical, political, and economic environment change, so do goals. Instruments, therefore, must be flexible enough to accommodate these changes. Problems of goal definition are frequently accompanied by problems of translating goals and standards of quality into meaningful and operational criteria (Frankel & Sinclair, 1982).

Reliability and Validity. Self-assessment is not a statistically reliable method of documenting program quality. Because it is not scientifically controlled, it cannot yield scientifically valid results. Instead, self-assessment measures are guides to determining program performance and problems that can be useful aids to agencies, especially when used in conjunction with other quality assurance mechanisms such as formal program evaluation and peer review. One reason for the questionable reliability -- which is shared by other methods -- is the dependence of self-assessment methods on information provided by agency staff. Although self-assessment is voluntary and does not involve formal sanctions, some staff may still fear reprisals. Thus, staff and personnel may be motivated to suppress valuable information or bias the data out of fear of retribution. This suppresion or altering of information distorts results and creates inaccurate conclusions (Wildavsky, 1972).

Conditions for Success. There are certain preconditions that enhance the potential for success of self-assessment as a quality assurance mechanism. One element is the participation and enthusiasm of agency staff. Staff must be prepared to examine their assumptions and performance with objectivity. In order to implement remedial change, staff should be open to change by altering

objectives and routine behavior. Communication must be honest and flow freely in order to make best use of the self-assessment instrument (De Leon, 1979). Finally, staff should realize that use of the self-assessment instrument is a means toward better services for the organization's clients.

Outcome Monitoring and Evaluation

Introduction. Outcome monitoring systems are quality assurance mechanisms that describe the impact of service on individual clients. Such systems describe the end result of the human services delivery process on individuals. Outcome monitoring uses a "pre/post" design to measure changes in clients that may have taken place as a result of receiving a service. The pre-intervention assessment serves as a base-line against which to compare client changes as a result of service. Assessing the need for services after the receipt of services is the post-intervention indicator. Formal program evaluation seeks to compare changes in the condition of individuals using services with similar individuals who are not users of services (control group). Evaluation tends to take the form of a scientifically controlled study that seeks to test the causal relationship between the service activities (intervention) and the outcomes. Outcome monitoring, however, does not attempt to prove the changes observed in an individual were due to the intervention, it merely measures the changes that have taken place since the onset of service.

Outcomes of care may well be attributed to factors other than delivery of a specific service. Studies relying on outcomes may be subject to distortion unless "extrinsic circumstances impinging upon outcome are clearly understood and controlled in the study design" (Brook, Davis-Avery, Greenfield, Harris, Lelah, Solomon & Ware, 1977 p. 136).

Outcome monitoring generates information on the effect a program is having on its participants. This information can be expressed as the percent of clients who have reached a pre-determined service goal or goals, a reduction in particular problems, or a change in circumstances as a consequence of service. By definition, data on the outcomes of human development services are always related to a change in client status.

Because outcome monitoring, unlike outcome evaluation, is not designed to prove that a service intervention caused change(s) in client status, outcome monitoring is most appropriately used as a quality-enhancement tool rather than as a quality-regulating or accountability tool. To hold a provider accountable for changes in client status that may or may not be attributed to that provider's actions, is hardly justified.

Service and Target Group Applications. Outcome measures may be devised for every type of human development service and target population. However, outcome monitoring engenders a host of technical problems with regard to the validity and reliability of the information secured (Neigher & Schulberg, 1982). Outcome measures are difficult to obtain for some types of services -- especially those that require monitoring of progress over time in order to assess service success. Such follow-up can be very expensive. In some services, clients may be anonymous and outcome impossible to track (e.g., "hotlines"). In other areas, there is a stigma attached to the client's problem (e.g., child abuse, drug use) and, therefore, the client may be reluctant to provide accurate information.

Another more technical problem exists in the construction and validation of scales or indices used to measure changes in client behavior, knowledge or functioning -- outcomes commonly associated with many human development services including residential care, counseling, education and training, and

day programs. It has been shown that change in client behavior, functioning and knowledge can be as much, if not more, a function of a client's capacity and propensity to change as it is a function of the provider's intervention. Thus the use of general criteria that reflect an expectation of common results for all clients is likely to be restrictive and insensitive to individualized situations. Further, outcome information can be expensive to collect; difficult to aggregate, interpret and assess; and cumbersome to use. These seemingly unresolvable problems have led some to view outcome measures as "the 'holy grail' of quality control, devoutly wished for but rarely seen" (Peele & Palmer, 1976, p. 151).

Outcome measures may not be as useful in gauging the effectiveness of long term maintenance programs (e.g., residential programs) as they are in human development services where the central purpose is to bring about rapid and observable change in client behavior or functioning.

Finally, outcome measures have no utility for quality regulating or accountability purposes in services such as case management and counseling where the number of intervening client variables (e.g., client motivation) and situational variables (e.g., supply of services in which to place a client) may outweigh any service effects, or mask the service effects. Thus, it may be impossible to establish a link between service and outcome.

These measurement problems notwithstanding, Ciarlo (1982), for one, believes that outcome evaluation and monitoring is worth pursuing:

> We need not wait until all . . . (problems) . . . are removed and the measures are perfect. A better strategy would be to choose carefully among available measurement techniques, recognize their specific limitations, compensate as well with study designs or measure modification, and begin the process of implementing outcome evaluation . . . in many of our programs. (p. 36).

Various approaches to using outcome monitoring for quality assurance purposes are now being tested around the country and are on a trial basis in a number

of places. The approaches chosen for inclusion in this manual are illustrative of these efforts.

In the State of Oregon, the Office of Mental Retardation/Developmental Disabilities administers a system whereby teachers of children with developmental disabilities periodically report on student growth using a standardized instrument called the Student Progress Record (SPR). The Office of Mental Retardation/Developmental Disabilities feeds back the comparative results to the teachers allowing them to gauge for themselves the progress of their students relative to like students in other programs, and to indicate whether any alternative service techniques may be needed. The teachers reportedly have come to value this information, and over the past six years the SPR ratings have been an integral part of the Individual Education Planning (IEP) process in Oregon.

Temple University, under contract to the Commonwealth of Pennsylvania, uses a short form of the Behavior Development Survey (BDS) to monitor the level of functioning and behavior of persons with developmental disabilities who are placed out of an institution into community residential arrangements. The forms are completed through interviews with the residential staff person most familiar with the client. The interviews are conducted by trained interviewers.

Clinical staff follow up on every client who appears to have lost more than 12% of his/her adaptive skills. Temple staff report that over 90% of the clients identified as regressing have subsequently been determined to be having genuine difficulties which can be ameliorated. They also report that over half of these individuals would probably not have been detected.

Temple University has also used the BDS data to perform special analyses of the probable efficacy of alternative service patterns. For instance, they

recently conducted an analysis of client growth at the Pennhurst Center as a function of client levels of medication while controlling for key client characteristics. The results identified marked variations among Center physicians in their use of medicaitons. Follow-up visits were conducted to be sure that physicians were using medications appropriately. Technical assistance was provided as necessary.

The Community Human Service Department in Ramsey County (St. Paul), Minnesota, recently implemented a program monitoring system covering a broad spectrum of human services that centers on the measurement of the achievement of client outcome objectives. This method is applied to purchased services as well as those provided directly by the agency. The Ramsey County system identifies major objectives for each service area and then presents the outcome measures used to assess accomplishment of those objectives. In a chemical dependency treatment program, for example, the primary objective is to "maximize freedom from use of alcohol and drugs." The outcome measures related to the objective are "percent of clients who do not use alcohol and drugs during the reporting period" and "percent of clients who maintain abstinence six months following termination." For each measure, the system has performance standards which represent the agency's judgment of what level of performance is expected. For the two measures listed, the standards are 80% and 50%, respectively. In addition to expected performance levels, the agency has identified minimal and optimal levels that bracket the expected level. Data is collected through a combination of client surveys and case record reviews which use data collection forms designed by the agency. Ramsey County officials are currently testing the validity and reliability of their measures.

The Milwaukee County Department of Social Services uses a similar

approach in monitoring the quality of purchased services. Like Ramsey County, the Milwaukee system covers a wide range of human service programs including homemaker/chore, child day care, information and referral, adolescent counseling, and vocational counseling. Unlike Ramsey County, however, Milwaukee has not attempted to define formal performance standards for service providers.

The applicability of outcome monitoring systems to the major target groups and service areas is great and is expanding. A method is being tested by the Child Welfare League of America for monitoring outcomes in child welfare services (Magura & Moses, 1980). In their guide to outcome monitoring in social services, The Urban Institute presents ten outcome measurement procedures that have been or are being used to measure outcomes in a wide variety of service settings, including public social service agencies, private family service agencies and public employment programs (Millar, Millar, Hatry, Koss, Jennings, Pixley & Schainblatt, 1981).

Program Dimensions. Most of the outcome monitoring systems found to be in operation in state and local human development service agencies are serving quality enhancement purposes as opposed to quality regulation purposes. Though some may have been established for purposes of quality regulation, the pursuit of such aims has been frustrated by the administrative and technical problems cited above and by related political problems.

Some outcome monitoring systems are used to accompany training and technical assistance for providers. By monitoring outcomes, program officals can identify providers possibly worth emulating or possibly in need of training and technical assistance by virtue of exceptionally good or poor client outcomes. A related use is to identify clients whose exceptionally good or poor outcomes suggest the need for alternative or special service

arrangements.

Practical and Technical Considerations. The cost of establishing and operating a client outcome monitoring system varies according to the data collection method used. The Urban Institute (Millar et al., 1981, pp. 92-93) analyzed the costs of social services outcome monitoring systems, and produced a set of cost estimates for outcome monitoring systems covering 100 clients per month, which is presented here by data collection approaches*:

- **Agency records** -- for indicators requiring only aggregate data both start-up and operating costs would be high. Indicators which track individual clients would have very high start-up costs and moderate operating expenses.

- **Client feedback** -- a full-scale system for monitoring client functioning and satisfaction would entail high start-up costs. Operating costs for such a system would fall between $41,000 and $52,000 annually. A scaled-down version, collecting much less detailed information, could be implemented at low start-up costs and an annual budget of approximately $10,000.

- **Trained observer** -- using caseworkers, the start-up cost would be high as would the operating expenses of $63,000 to $71,000 annually. With independent caseworkers, the start-up cost is likely to be moderate with operating cost remaining at the same level. In using an outside observer, such as a consultant, the cost for start-up would be high and the annual operating cost would drop to the $51,000 to $57,000 range.

Obviously, the cost of establishing a client outcome monitoring system is a practical consideration for human service managers grappling with service quality issues. As with other decisions, the benefits to be derived must be weighed against the costs to be incurred.

Case Tracking and Exception Reporting

Introduction. Case tracking and exception reporting is a mode of quality

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* Costs shown are full operating costs. Where agencies use existing staff for some or all of the work, actual additional costs incurred will be less.

assurance which relies on computerized data processing and analysis. Case tracking in particular relies on regularly reported data on individuals receiving service which in turn permits agencies to follow clients through various programs. The purpose of the tracking is to assess client progress and to identify problems. Exception reporting uses case tracking to identify deviations in individual cases based on pre-determined norms. For instance, given that the appropriate number of client visits associated with a specific problem can be determined, this system can automatically identify any irregularity in service utilization. Exception reporting relies on a large volume of data which is best managed by computers and can be a component of a general management information system.

This section of the manual discusses the particulars of computerized quality assurance systems that use case tracking and exception reporting. In the past, computerized management information systems were primarily management tools used in industry. Within the past two decades many human services agencies have adopted management information systems for their own use. This trend is especially significant in the assistance payments and mental health fields. The 1972 Social Security Amendments authorized Professional Standards Review Organizations (PSROs) to review the quality of federally-supported health services. PSROs provided an impetus for other human and health services programs to implement computerized data processing systems to assist them in complying with the new federal regulation mandating documentation of medically necessary treatment, quality of service and effective and economic care. Mental health centers were specifically encouraged to make use of information systems to aid them in compliance with the 1975 amendments to the Community Mental Health Centers Act which required centers to spend two percent of their previous year's operating budget on

local program evaluation. Computerized data systems were found to be the most effective means of handling the large volume of data necessary to process and report compliance with the new regulations.

Other factors encouraged the expanded use of computers in human service programs. Computers have been useful in aiding the development of standards of service as well as providing valuable links between two or more service providers for the treatment of an individual client's needs (Schoech & Arangio, 1979). Without the aid of computers, the volume of data necessary to perform the above functions could not be secured at a reasonable cost.

Computers have proven to be a particular assest in human service quality assurance systems. In addition to case tracking and exception reporting, computers process data that is indicative of service quality such as length of stay for inpatients, use of medications, client pre and post service status, and level of functioning. Computer processing of client assessment and progress reports may produce and quantify information on client changes that are associated with service intervention. Problem-oriented records within automated systems have been found to be particularly useful for quality review (Gifford & Maberry, 1979). Likewise, the integration of client problems, treatment objectives and goals, and client progress "allow for continuous monitoring and review of treatment effects" (Hedlund, Vieweg, Wood, Cho, Evenson, Hickman, & Holland, 1982). Quality assurance through case tracking and exception reporting can be more easily managed for multi-treatment and multiple program plans by means of a computer rather than manual information systems.

Despite their usefulness in quality assurance activities there are also problems associated with computerized human service information systems. One of the most frequently reported is the difficulty in obtaining adequate

funding for the initial implementation of such systems (Schoech & Arangio, 1979). Much has been written documenting the resistance and distrust of administrators and clinicians toward automated data systems. Computers are perceived by some as detached machines lacking values and ideology -- key ingredients in human service delivery. Furthermore, automated quality control systems, like all quality control systems, have the ability to document management and clinical deficiencies. These fault-finding abilities can be regarded as threats to job security. In some cases, such anxieties have created staff resistance toward computerization. This resistance can inhibit effective results (Schoech & Arangio, 1979; Pearson, 1969; Elias, Dalton, Cobb, Lavois, & Ziatiow, 1979; Siegel, 1980). Further, Elias et al., (1979) and others have noted the potential for violations of client confidentiality in an automated system. Programs that have not devised adequate coding systems for tracking clients through multiple interventions and agencies are not always able to ensure confidentiality.

Throughout the last 15 years, the use of automated information systems has increased substantially. The future will bring greater advances in computer technology along with reductions in the costs of that technology. As government and consumers continue to demand greater accountability from social and human services agencies, such agencies will make greater use of computers in decision-making, quality assurance, clinical treatment and financial and program monitoring (Schoech & Arangio, 1979).

Service and Target Group Applications. Case tracking and exception reporting can be useful for all types of human services programs and can be used for all client types without restriction. The basic principles of collecting and processing data are similar across human services areas. All programs need to keep and collect data on client census, client services,

demographics, and so forth. All agencies must perform roughly the same basic administrative functions. Although there are no technical restrictions with regard to the use of computers, there are restrictions that grow out of the complexity of client data. Computers are best suited for case tracking functions that monitor simple rather than complex data elements.

In some human service programs, clinical treatment issues are difficult to summarize in a form that can be manipulated by an automated data system. To develop the standards or norms against which performance is measured in a case tracking and exception reporting approach to quality assurance, case data should be relatively unambiguous. In a family service agency, for example, it is not difficult to record the number and length of client visits but it is a different matter to summarize the content of those visits for inclusion in an automated data system. This same point is valid with regard to outcome monitoring. A computer-based case tracking system can report on the achievement (or lack of achievement) of outcomes, but only if they are well defined and measureable. In sum, to benefit from case tracking and exception reporting, the work of the agency must be described in standardized data elements.

Individual programs have encountered difficulties in attempting to describe and implement systems dealing with complex problems. For instance, the Department of Psychiatry at Tufts University attempted to design a management information system to fill the complex needs of the Bay Cove Mental Health Community as well as the requirements of federal and state regulations (Adler & Edwards, 1981). The task became extraordinarily complex. Inconsistency arose between government and local agency requirements. Agreement among agency staff, program managers and federal and state administrators was nearly impossible to secure and thus threatened the

uniformity needed to generate a successful, useful system. Changing federal and state requirements exacerbated the complexity of problems, and the Tufts project was subsequently abandoned.

Another factor that limits the use of computers is the size and purpose of an agency. Several small private, non-profit agencies have chosen not to use computer systems for quality assurance and/or management since such systems are neither economical given the small amount of data generated, nor are they necessary to generate the types of data (e.g., federal and state regulatory compliance information, or third party insurance data) that larger agencies must amass. Efficient use of a case tracking system requires a data base large enough to justify the cost of automated data processing.

Program Dimensions. This section describes the uses and limitations of case tracking and exception reporting with respect to the four program dimensions of input, process, output and outcome. Also discussed are examples of programs and data elements used in particular computerized information systems.

Inputs. The inputs to human services are easily stored in computer systems. Generally, data such as client numbers, client demographics, staff numbers, staff complement, staff qualifications, and units of service per client are typically collected system-wide by public agencies to monitor quality. These public agencies, such as state and local departments of social services, collect data that enables them to administer, evaluate and manage health and human services systems. The purpose of the data collection is to monitor compliance with licensing requirements, to assess the completeness of administrative systems, and to evaluate bookkeeping systems. While staff/client ratios and other input components indicative of quality are of concern to individual agencies, the volume of data generated for this category

is generally not large enough to warrant computer storage.

<u>Process</u>. Process describes the interaction between the client and the individual organization in addition to administrative and support activities. Case management, which inherently involves case tracking, is in part concerned with monitoring the process of service delivery, and is facilitated by automated systems. Computers have the ability to track individual clients through different services and a succession of programs. They have the capacity for monitoring simultaneous and multiple service interventions -- a task that would be extremely cumbersome using manual tabulations.

Performance standards, an essential component of quality assurance, are important to the assessement of process. Performance standards are key indicators of program functioning and establish a pre-determined acceptable level of performance which in turn can be used for exception reporting. The following example of a performance standard for service process is taken from the State of Florida Department of Health and Rehabilitative Services <u>Performance Review Report</u> (1974). This example tracks the response time of a family services agency:

> Counselors will make their first contact with families referred for Protective Supervision within established time frames. This contact will be documented:
>
> a. 24 hours for families which are in crisis situations
>
> b. 5 days for abuse/neglect cases where no present danger exists
>
> c. 10 days for cases involving status offenders.

The CHARTS, <u>Community Health Automated Record and Treatment System</u> used by The Heart of Texas Region Mental Health and Mental Retardation Center in Waco, Texas, has a specialized patient tracking system which is keyed to a specially developed "master" problem and has been used for quality review,

program planning and clinical research (Gifford & Maberry, 1979). This system has special process features which monitor direct client service with clarity and efficiency, giving clinicians prompt descriptions of treatment plans, and succinct descriptions of patient progress with each problem to date. In both the Texas and Florida examples, monitoring is continuous thus facilitating rapid and appropriate corrections.

Outputs. Outputs are the products of a service system. Output data encompass such measures as the number of clients at a certain functioning level who have completed a particular activity. These counts need not be simple. They may be designed in such a way as to describe or monitor the quality of a particular aspect of a service on a specific population. For instance, computerized output measures may quantify the number of drug abusers between the ages of 18 and 35, having high school diplomas, who returned for a follow-up visit six months after completion of a rehabilitation program. Outputs are compared to pre-determined standards to monitor quality and are therefore useful for exception reporting.

Outcomes. Computerized outcome measures can be either agency-based or system-wide. Once established, standards for outcome measures can be quantified by computer systems, thus making computerized outcome measures a valuable tool for quality enhancement (Gifford & Maberry, 1979). Outcome measures are not, however, always reliable from agency to agency, and such computerized techniques should not be used as a tool for quality regulation.

One example of the use of computerized outcome measurement is the **Temple University** developmental disabilities monitoring approach. In that scheme, individualized level of functioning data is collected at periodic intervals on developmentally disabled residents of community living arrangements in the Southeast Region of Pennsylvania. The data is analyzed according to pre-

determined norms and if a client's functioning has slipped below an acceptable level, the system sends up a red or pink flag depending on the extent of the decline. Red and pink flags alert developmental disabilities officials of the need to investigate the situation and to provide technical assistance when indicated. Likewise, the system recognizes progress above the norm so that providers can be rewarded for positive results.

Practical and Technical Considerations. Examined here are the practical and technical problems encountered in using computerized information systems for case tracking and exception reporting in human services. Such problems are not limited to this application alone, but can be generalized to computerized information systems generally.

Design Problems. The most salient considerations in computerized systems are those addressed in discussions of other quality assurance approaches including the establishment of uniform goals, performance standards and norms. The objectives of federal officials, state policy makers, local public administrators, and the service provider undoubtedly diverge (Adler & Edwards, 1981). Thus, establishing goals that conform to the needs and regulations of each separate public entity can be an arduous task. For many of the same reasons, standards and norms are difficult to set because of problems in choosing the indicator by which the standard or norm is measured. For instance, the standard or norm may be generated from statistically valid findings based on empirical research or from the experience and judgment of human service professionals. They may also be based on the historical performance of the program. Deciding which standard or norm is the best indicator of an ideal for quality assurance may also present problems. Once standards, norms and goals are established, there is a risk that they will become inflexible and unresponsive to environmental changes. Technical,

political, social and economic trends can make it necessary for standards and goals to change. Computerized quality assurance mechanisms must be flexible in order to accommodate change.

One problem faced by automated quality assurance mechanisms using exception reporting is that the analysis is performed on a routine basis producing a regular flow of data. Because of the volume and routine nature of the output, there may be a tendency for staff and personnel to overlook these problem indicators and not to treat them as a serious call to action. It is necessary for staff to be alert to the problem indicators and act upon them in a timely fashion to assure success of the exception reporting system as a quality assurance mechanism.

Computer-based information systems sometimes produce data and analysis in unusable forms (Siegel, 1980). A quality indicator may show variations in quality but may not provide enough information in order to make corrections. For example, a system-wide quality indicator may show that a percentage of home care providers arrive fifteen minutes late but may not identify the specific providers where this tardiness is occurring. Systems must be designed in such a way that the information reported is in a form that avoids the need for further processing and that minimizes distortions in interpretation. So too, language used by computers can be confusing and lead to misinterpretations. The literature reveals many examples of computer language systems that have led to misinterpretation and confusion by agency personnel (Pearson, 1969; Siegel, 1980; Schoech & Arangio, 1979).

Decentralized computer systems involving time sharing and multi-agency computers, although cost efficient, present some problems. Often the data collected and analyzed are not under the agency's control, thus creating an accessibility problem. Data and computer time may not be available when

needed. Feedback time also can be slow, resulting in delays in use of quality control mechanisms. Decentralized data processing necessitates transportation which runs the risk of misplacement or loss of valuable data.

Human Element. Generally, externally imposed monitoring can generate an atmosphere of mistrust and fear on the part of service providers. This fear and mistrust may also occur with automated information systems. Dehumanization has been attributed to computer use ever since computers were first used in the social services field (Pearson, 1969; Siegel, 1980; Hedlund et al., 1982). This accusation is indicative of an unfamiliarity with computer use. Even when effective computerized quality assurance programs are implemented, this resistance can result in non-use of the data and analyses generated. General management and clinical staff may resist externally imposed monitoring systems if they perceive monitoring as a threat to job security. This is also the case with computerized monitoring systems. This fear can influence personnel to undermine such systems and render them ineffective (Schoech & Arangio, 1979).

Keys to Success Although there have been formal studies on the impact and problems of automated information systems in human services, the literature reveals that some lessons has been learned about the successful use of automated systems as quality assurance mechanisms. Summarized below are those factors that can contribute to the successful design, implementation and use of computer systems:

- Adequate resources, design and implementation time is necessary for the success of computerized systems. The complexity of human services warrants the initial use of consultants during development time.
- Simplicity of system design encourages success. System design must produce information useful for management functions. In many cases this requires the translation of complex concepts into simple measurable instruments.
- Input from clinical staff and management personnel during development

and implementation can counteract much of the fear associated with computerization. In can also generate enthusiasm and positive valuable participation on the part of the staff (Siegel, 1980).

- Gradual implementation of the system helps to identify problems while at the same time acclimating staff to its use.

- The design and use of a good, understandable operational manual further enhances the utilization and acceptance of computers for quality assurance.

- Prompt feedback of computer data maintains staff cooperation while strengthening the computer's effectiveness. Overall, staff knowledge of the benefits and uses of computerized systems will further the utility and success of such systems as a method to monitor and improve the quality of services.

Client Surveys

Introduction. Client surveys have been used to solicit the opinions of service consumers on a variety of issues related to program quality. Client surveys may be used alone or in conjunction with other monitoring or evaluation techniques as one part of an evaluation plan. Data may be collected through personal interviews, telephone surveys, or self-administered questionnaires. The instruments used range from highly structured and standardized questionnaires to formats utilizing global and open-ended questions.

Until recently, quality assurance and program evaluation activities focused on the professional and technical aspects of service. Studies were conducted by professionals and only rarely was consumer input considered (Giordano, 1977; Ware, Davies-Avery & Stewart, 1978). This situation has changed considerably during the past decade and client surveys are gaining increased credibility. In part, this new interest in consumer attitudes reflects a larger societal trend toward consumerism (Justice & McBee, 1978). It is also a reaction to increased consumer activism and demands that those who provide service should be accountable to those who receive it (Ware *et al.*, 1978). While client surveys are being used with greater frequency, many

organizations are still reluctant to use the results of such surveys for decision-making because there is still some reservation among professional providers concerning the degree to which clients can give unbiased and reliable feedback on service programs.

Client surveys can be useful for the organization, as well as the client, in a number of ways. One is that client surveys provide an additional index for program evaluation (Giordano, 1977). Human service programs are notoriously difficult to evaluate. They are characterized by vague goals, ambiguous technologies, and clients who present an almost infinite variety of problems, expectations, and predispositions. Given the complexities of program evaluation in such settings, researchers are becoming increasingly aware of the importance of evaluating programs from a variety of vantage points. Consumer feedback is one way of augmenting the more traditional monitoring and evaluation strategies such as record review, staff interviews, and personal observation.

An incidental benefit is that the very act of soliciting client perceptions can give clients a sense of empowerment. Requesting client feedback allows clients to make their concerns known and gives them the sense that the organization is sensitive to their needs.

Service Target Group Applications. Theoretically, client surveys could be used for almost any type of program. The **Family Service Association of America (FSAA)**, and **Milwaukee County** cases are examples of the areas in which client surveys have been useful. Such areas include family service agencies, work assistance programs, adult and child day care, Title XX services, transportation services, victim/witness services, homemaker and home meals programs, advocacy programs and general social services.

Some types of programs pose more problems than others. For example, the

problems of "acquiescent response set" (the tendency to agree with questionnaire items regardless of content), are more pronounced with some types of clients. Certainly agencies serving mentally retarded clients must use caution in extrapolating from client data alone. One strategy that has been used successfully in evaluating developmental disabilities programs has been to obtain data from someone close to the client such as a parent, guardian or advocate either instead of or in addition to data from the clients themselves.

Programs in which clients are held against their wishes may also be less than ideal settings for client surveys. Prisons and juvenile justice programs are examples of coercive settings in which clients may not be able to separate their negative feelings about being in the program from their assessments of how the organization actually operates (Giordano, 1977).

On the other hand, there are some types of programs where client surveys may be <u>more</u> useful than other evaluation strategies. Programs such as information and referral or case management that involve the client in the services of multiple agencies are a case in point. In those instances where no single agency is providing all of the services to a client (e.g., some community support programs in the mental health area and certain social services agencies dealing with multi-problem families), client surveys may be the most economical means for getting data on the client's experiences with the complex service system. Secondly, in programs where service outcomes are only apparent in the long-run, client surveys can provide an interim assessment of how the process is going. Examples of such programs include services for the chronically mentally ill and the severely physically handicapped.

Finally, in those instances where treatment is highly individualized, it

is difficult to construct standardized measures that yield useful data. In these instances client feedback may be especially useful.

Program Dimensions. This section describes the uses and limitations of client surveys with respect to the four dimensions of quality assurance. It also describes the different types of programs to which client surveys might be applied.

Input. Input has been defined as the resources that are invested in the organization. Client surveys are of limited use in evaluating program inputs. Because clients typically have a rather limited exposure to the overall operation of the organization, they are not really in a position to judge the quality or adequacy of inputs for the organization as a whole.

Process. Client surveys are most often used in evaluating the process of service; more specifically, the "art-of-care." Areas that are typically included in client evaluations of the art-of-care include the responsiveness of staff to client needs, staff courtesy, convenience of the agency's hours, and the organization's accessiblity. Since all of these involve subjective assessments, they are areas in which the client is the single best judge.

The **Family Service Association of America's** system for evaluating member agencies is a good example of the use of client surveys to monitor the "art-of-care." The FSAA format includes items on client satisfaction, relationships with counsellors, and the convenience of services.

The technical side of the service process is somwehat less amenable to study by client surveys. The claim is often made, and with some justification, that clients are frequently unqualified to make judgments concerning the technical aspects of care. Usually, more scientifically rigorous outcome studies and peer review systems are used for this purpose.

This is not to say, however, that client surveys have no place is

assessing this aspect of the treatment process. Some agencies evaluate the technical aspect primarily through record review by assessing the adequacy of documentation in client files. In such instances client surveys can be useful as a means of verifying record entries. The **Milwaukee Purchased Services Monitoring Program** includes this type of validating procedure. Information on services provided by agency staff is extracted from client records. These data are then compared with information provided by clients on the types and amounts of services they have received. When significant discrepancies emerge, the agency is investigated.

Outputs. Client surveys are not typically used to measure or evaluate output. Output measures such as the number of clients served and the types and amounts of service provided are usually captured by the agency's information system. These data can be extracted from an MIS far more economically than from a client survey.

Outcomes. Professional opinion is split as to whether client surveys should be used to measure outcome. On the one hand, there are those who suggest that clients receiving services are too personally involved and therefore lack the objectivity required to assess outcome. Further, they would argue that clients' expectations of services are too often unrealistic and that they, therefore, use inappropriate yardsticks against which to assess service outcomes.

Others would argue that since the problems that motivate clients to seek services are so individualized, the client is the best judge of how well or poorly the services have met his/her needs.

The one factor that all researchers would agree on is that the problem of measuring service outcomes has proven to be a particularly intractable one. This being the case, we would suggest that it is frequently useful to obtain

evaluations of outcome from a number of different sources. Usually, outcome assessments are conducted by evaluation professionals who assess the client's status after he/she has received a prescribed service regimen. In addition to this, data can also be obtained from clients. Significant discrepancies between the provider's view and the client's could mean a number of different things. One is that providers and clients have different expectations about what constitutes a successful outcome. Identifying either client or provider misconceptions could be a very important by-product of the research and could point to the need for client orientation sessions and/or in-service training for staff to sensitize them to the clients' cultural milieu and expectations. Discrepancies might also mean that the service program is failing to identify and treat additional problems that the client might be experiencing.

There is also a subset of programs for which client assessments may be the only outcome measure available at least in the short-term. These are programs in which it is extremely difficult to see the immediate effects of service. Child abuse programs and programs for individuals convicted of driving under the influence of alcohol are examples. In these programs the intervention is intended to change attitudes and subsequently the way the client reacts to stress. Since the effects of the treatment are not necessarily visible at the time of serivce, the client's evaluation of change is an important piece of information. In those programs where objective measures based on a record of actual behaviors are not possible because of the length of the follow-up period, an assessment based on the client's feelings about the treatment process and changes resulting from the treatment may be the only source of outcome data that is practical.

For a number reasons we do not recommend the use of client surveys by

themselves to measure service outcomes. In the first place, outcome is far too complex and ambiguous a concept to rely on any single perspective. Secondly, clients experience the treatment process in a very personal way. In many instances it may be difficult for them to separate the process of treatment from their assessments of treatment outcome. In those cases one cannot obtain an uncontaminated assessment of outcome per se. It seems to us that client surveys measuring outcome are best used as a supplement to other, more objective outcome technniques.

Practical and Technical Considerations. The design of any client survey should conform to the general principles of sound research design. In addition to these general principles, there are a number of specific technical considerations that complicate the design of client surveys. These include: maximizing the reliability and validity of data obtained from clients enrolled in service programs; establishing norms that make the data from client surveys more easily interpreted; and controlling for factors that tend to be associated with variations in client attitudes. Each of these technical considerations is described below.

Reliability and Validity. All research attempts to measure accurately (or reliably) the phenomena under study. Most measurements, however, typically contain some amount of error. The literature suggests that data from client surveys may be especially vulnerable to problems of reliability and validity. Reliability is defined as the consistency of a measure over repeated applications. Validity is the degree to which an item actually measures the concept it is intended to measure. In client surveys there are a number of sources of error that can reduce considerably the reliability and validity of the measurement process.

A large proportion of published studies reporting the results of client

surveys fail to include data on scale (or item) reliablity (Ware et al., 1977; LeBow, 1975; 1982). This makes the survey data somewhat difficult to interpret since it is unclear how much information is actually contained in the scales.

The difficulties in obtaining reliable data from clients are not insignificant. However, there are strategies that appear to improve the reliability of data. Ware and his colleagues have conducted intensive studies of client satisfaction with medical care (Ware, Wright, Snyder, & Chu, 1975). Their work has included reviewing the literature on client satisfaction, testing and validating scales, and designing instruments. Their conclusions are encouraging; they suggest that well-constructed scales can in fact yield reliable data. Given the complexity of phenomena typically studied with client surveys (such as client satisfaction) and given the problems related to data reliability, Ware strongly recommends the use of multi-item scales rather than single item measures. Their research suggests that composite measures provide a better indicator of client or consumer attitudes than do single-item global measures.

Tests of reliability include checking for internal consistency (the level of homogeneity or intercorrelation among items of a scale that theoretically measure the same constant), test-retest reliability (the stability of a respondent's responses over time), and inter-rater reliability (the degree to which two or more raters agree in their ratings).

A second technical consideration is the issue of validity, or the degree to which measures actually reflect the phenomena they are intended measure. One threat to the validity of measures used in client surveys is the tendency for respondents to try to give socially acceptable responses to questions. In their efforts to appear to conform to widely accepted beliefs or attitudes,

respondents sometimes distort their true sentiments. While this is a problem in survey research generally, it is especially troublesome in client surveys. Since clients are frequently dependent on the service provider in a variety of ways, they may be reluctant to express sentiments that reflect badly on the service provider. On occasion, clients may feel that negative comments could result in the withholding of service or a reduction of effort on their behalf. Clearly, if clients feel constrained in their ability to express concerns about a service program or their progress in the program, the validity of resulting data is suspect.

Fortunately, there are a number of strategies that may make clients less reluctant to provide valid feedback. Perhaps the most obvious is assuring respondents of the confidentiality and anonymity of their responses (Warfel, 1981). If clients know that all data are to be aggregated and that no personally identifying information will be released, they may feel more comfortable in expressing their true sentiments. These assurances are typically provided in an introductory statement at the beginning of a questionnaire or in the introductory comments made by an interviewer.

In the case of client interviews, measurement validity can also be improved by having a person other than the client's primary service provider conduct the interview. It is almost always bad practice to have an individual closely associated with the treatment or service process asking clients for feedback concerning the program. If the program has a research staff, these individuals might be appropriate interviewers. If not, clerical staff can be recruited for the task. Many programs recruit and train volunteers to conduct interviews.

As noted earlier, a closely related threat to measurement validity is "acquiescent response set" (ARS), or the tendency of respondents to agree with

statements on a questionnaire or interview form regardless of content. Once again, this is a problem for survey research generally, but it is probably more pronounced in client surveys. Researchers who have examined the tendency to acquiesce have found that it is not distributed randomly throughout the population. It appears that individuals with lower incomes and fewer years of education have a greater tendency to acquiesce than do others (Lenski & Legget, 1960). Children and young people also tend to agree more frequently (Shuman & Presser, 1977; Sudman & Bradburn, 1974). Since clients of social service agencies tend to come disproportionately from these subpopulations, researchers designing instruments for client surveys have to take additional steps to counteract the potentially biasing effects of ARS.

Strategies to minimize the effects of ARS center on the instrument design phase of the research process. A study of the phenomenon (Sigelman, Schoenrock, Winer, Spanhel, Hromas, Martin, Budd & Bensburg, 1981) among developmentally disabled clients sheds some light on the problem. While this population may not be representative of the typical social service agency, the results illustrate the issues well and the authors suggest ways of dealing with the problem. Sigelman _et al._ (1981) conducted interviews with institutionalized mentally retarded children and adults and with retarded children living in the community. Their interviews included an item-reversal technique, which involves placing oppositely worded pairs of questions throughout the interview. For example, respondents were asked to answer the question, "are you usually happy?" and later to the opposite of this question, "are you usually sad?" Respondents who answered yes to both questions were defined as acquiescing. The results indicate a discouragingly high incidence of acquiescence with as many as 51% of some subsamples agreeing to both questions in the pair.

Clearly, the results of this study cannot be generalized to other populations without some caution since other researchers have found ARS to be more prevalent among mentally retarded individuals than in the general population (Rosen, Floor & Zisfein, 1974). However, the authors do make suggestions that are useful for client surveys in general. One is that questions eliciting a yes/no response should be avoided where possible. Where this is not possible, they suggest that check items should be inserted into the questionnaire or interview schedules. Such check items could take the form of the item reversal technique or adding questions that clearly demand a "no" answer. While these techniques may not improve the quality of the data obtained, they will at the very least provide an indication of the data's validity.

Factors Associated with Variations in Client Attitudes. One of the most common uses of the client survey is to measure client satisfaction. Research that has been done in the area of attitudes toward services suggests that satisfaction tends to vary somewhat systematically. Wilson and Banfield (1964) found that ethnic background influences attitudes toward government services. Jacob (1972) suggested that the extent of service use is related to satisfaction. Rigorous sampling methods and the use of statistical controls in analyzing the data from client surveys will minimize the possiblity of results that are biased because of faulty sampling methods that focused on only certain segments of the program's clientele.

Establishing Norms Data interpretation is made considerably easier if it is possible to compare the results with other studies on similar populations. It is often hard to know how to evaluate survey results without such normative comparisons. For example, if a survey of client satisfaction indicates that 70% of clients are satisfied with referral services, should one

conclude that the agency is adequately meeting the needs of its clientele? Without knowing how other agencies perform on similar measures, one is at a loss to know just what 70% means.

Two sorts of standards can be used. One is the use of criteria that are based on expert judgment or knowledge of "best practices." In these instances, program scores are compared with these criteria and judgments are made concerning the adequacy of the program's performance. Where such criteria are not available or appropriate, an alternative is the use of data-based norms. This involves pooling the data from multiple programs and arriving at norms for acceptable performance. This is a practical approach to a technically difficult problem. One drawback, however, is that such norms reflect general practice rather than some specified ideal level of performance.

One of the methods described in Chapter V to this report suffers from the inability to anchor survey results through either a normative or criterion-based analysis (**Purchased Services Monitoring Program of Milwaukee County**). The Department of Social Services of Milwaukee County monitors a variety of purchased services through its Quality Assurance Office. The annual monitoring process includes four components: a consumer satisfaction survey, agency site visits, Title XX compliance review, and a service verification and documentation review. The client satisfaction survey is currently being conducted with a 2% sample of cases. The county has conducted this survey for several years. However, they are unable to compare the results of one year's survey with those of the next year since they have changed the sampling procedures and questionnaires used each year. This inability to compare the agency with itself over time clearly limits the utility of the surveys. Further, since the survey is conducted with a wide range of service types

(e.g., transportation service, victim/witness services, adult day care, etc.) and since questionnaires are slightly different for each type of agency, it is difficult to compare the survey results for the organizations evaluated with each other.

Three other methods provide better models of studies that include normative comparisons. One is the Quarterly Evaluation of Programs for the Elderly in the State of Nevada, Nevada Division for Aging Services (1978; 1979). The State of Nevada monitors all service providers funded under the Older Americans Act of 1965. The complete monitoring process includes a review of budget information, assessment of the achievement of grant application objectives, a staff questionnaire, and a participant questionnaire. In the participant survey, a standardized questionnaire is sent to 10% of each provider's clients. The Nevada Division for Aging Services developed straightforward coding procedures for the client satisfaction questionnaire and has established criteria for acceptable scores. Agencies that fall below this standard are notified of the need for remedial action. The major strength of this method is that the state has established norms for what constitutes acceptable standards of performance. The process can be applied objectively and the norms set a standard against which agencies can be evaluated.

A slightly different approach is being used by the Region X Administration on Aging (Human Resources Planning Institute, 1978). The DHEW Region X office commissioned Human Resources Planning Institute, Inc. to develop a method for measuring the quality of services to consumers of federally assisted programs for the aged. The method includes a consumer satisfaction component. The interview schedule is a brief one-page document and has been tested and validated for six services: nutrition,

transportation, health screening, outreach, information and referral, and home services. It focuses on both the technical and process aspects of care. The instrument was designed for repeated use and is scored according to standardized instructions. Since the same standardized instrument is used over repreated trials, agencies can, in effect, act as their own controls, and changes in levels of client satisfaction can be monitored over time.

The most well-developed example of a normative analysis is provided by the case of the **Family Service Association of America.** The Family Service Association of America (FSAA) has developed a standardized consumer satisfaction instrument for use by its member agencies. The instrument focuses on the the client's perceptions of the problem(s) that brought him/her to the agency, client satisfaction, global evaluations of the service program, and suggestions for improving services. An instruction manual provides agencies with information on sampling, administering questionnaires and interviews, and standardized coding procedures. Agencies have the option of sending their survey results back to the FSAA for a comparative analysis. The FSAA maintains a national data base and can provide a comparison of the agency's survey scores with the scores of similar agencies from the national data base. In addition, the use of a standardized instrument and coding procedures allows agencies to monitor their own performance over time.

The ability to compare scores for the same organization over time or to compare scores from similar agencies enhances most evaluation studies. This is especially true of evaluation studies using client surveys to obtain feedback on satisfaction with services. Typically, client satisfaction surveys tend to show fairly high rates of satisfaction. These scores by themselves, then, do not always provide a lot of information. Comparing these scores with available norms, however, makes it somewhat easier to interpret

variations within the rather small range that such surveys tend to exhibit.

Observation

__Introduction.__ Observation as a research method is the process of looking at relevant aspects of and recording information about behaviors or settings. Some of the most well known work using observation techniques has been conducted by anthropologists such as Margaret Mead. In Coming of Age in Samoa, Mead records her time spent among a group of Samoans observing and recording behaviors, assigning meaning to these behaviors, and using these data to explain an unfamiliar culture. Another well-known example is a book entitled Asylums: Essays on the Social Situation of Mental Patients and Other Inmates by Erving Goffman (1961), a sociologist. This book is based on Goffman's observations of life in a mental hospital collected while he was posing as a hospital employee. Goffman used insights gained during this experience to generalize to other populations residing in similar "total institutions."

Observation is a versatile method that can be applied in a variety of settings. Most of the work that has been done using observation has been of a basic, as opposed to evaluative, nature. However, there is no reason why the method should not be used for evaluation and monitoring purposes. There are, in fact, several examples of innovative studies in which the use of observation strengthens the study considerably. These will be described at several points during this discussion of the method.

The technique can be used in a variety of ways. It can be used to examine characteristics of behaviors or environments. The study conducted by Mead that was cited earlier is a good example of the use of observation to examine behaviors. In the area of environmental assessment, PASS (Program

Analysis of Service Systems) (Wolfensberger & Glenn, 1973) may be the most well known. PASS is a monitoring method that has been used extensively to assess the degree to which residential facilities for mentally retarded persons are normalized.

At times the method is used in a highly structured fashion as when Robert F. Bales, a sociologist interested in small groups, had observers record observations of group dynamics using highly structured check-off forms. At other times, the method is used in a very unstructured fashion. The example of Goffman (1961) illustrates this very exploratory use of the method. Goffman went into his setting without extensive lists of formal hypotheses or elaborate forms on which to record his observations. Instead, he used his observations to generate hypotheses and understandings.

Applications of the technique also vary in the degree to which is visible as an outisde. Clearly, in Margaret Mead's study in the Samoan Islands, the Samoans were aware that she was an outsider and that she was observing them. In Goffman's study, however, the observer posed as a hosptial employee and all staff, with the exception of the highest administrators, were unaware that they were being observed.

Service and Target Populations. As with any method, observation may be more appropriate for some settings than for others. The approach is ideally suited for programs in which behaviors take place in a relatively small, publicly accessible area and in which the number of relevant actors can be kept to a minimum. Residential programs are frequently ideal settings for observational studies. Gubrium (1975) conducted an observational study of one long-term residential program -- a nursing home -- and wrote up his findings in a book entitled Living and Dying at Murray Manor. Gubruim used an unstructured observation format to examine, among other things, interactions

between staff and their elderly clients at this nursing home.

A similar application of the method is found in Julius Roth's study of a tuberculosis sanitorium -- an interim residential facility. In this study Roth (1963), who contracted TB while a graduate student and therefore was forced to spend time in a sanitorium, used observation to understand how patients cope with the unstructured time and indefinite duration of sanitorium life.

Since observation allows the researcher to examine **actual** behaviors, as opposed to **reported** behaviors, the method is well suited for studies whose intent is to look at subjects' unintentional behaviors and at the consequences of these behaviors. In a classic study entitled Pygmalion in the Classroom: Teachers Expectations and Pupils' Intellectual Development, Rosenthal and Jacobson (1968) used the technique to examine the degree to which teacher expectations concerning students' abilities influenced the way the teachers treated different children.

Observation is less useful for those programs with restricted accessibility. For example, it would be difficult to monitor the interaction between therapist and client or between doctor and patient, since these sessions are typically considered private and confidential. On occasion, an observer may obtain permission to sit in on such sessions. However, the observer's presence may significantly effect the interaction. The bias that results because the therapist and client are aware that they are being observed may reduce the utility of the whole exercise. In settings where there are more actors and more activity, the observer's presence may be less obtrusive and, as a result, less biasing.

It was noted previously that observation is especially appropriate for those programs that involve a finite number of actors interacting in an

accessible space. If the number of actors becomes too large or if the pace of activity becomes too fast, the reliability and validity of observational data may suffer since the scope and pace of relevant data may exceed the observer's ability to record information accurately. This may be the case in settings such as large emergency wards.

In terms of specific target groups, observation may be a particularly useful approach to use when there is any reason to doubt the reliability of data collected with other methods such as self-reports. For example, in an earlier section on the use of client surveys, problems with the reliability of self-report data from children and individuals with certain types of developmental disabilities, such as mental retardation, were noted. Self-report data from these groups may be biased by a tendency to acquiesce or simply by the limited knowledge and experience of the respondents. In such instances, direct observation by itself, or in conjunction with interviews, may be a highly useful approach.

There may be other groups, such as runaway youth or individuals involved in corrections where the reliability of the data may be suspect for a different set of reasons. In these instances respondents may have a motive for deliberately trying to mislead interviewers or record false information on questionnaires. Direct observation of behavior is one way of bypassing respondent resistance.

Program Dimensions. Input. If input is conceptualized as the flow of resources -- such as staff, money, ideas, and supplies -- into an organization, then observation is not likely to be the most effective method for monitoring this program dimension. Since there are typically records that desecribe the transactions, methods such as record review will usually be a far more economical and reliable approach.

Process. Observation is probably most useful in monitoring the process of service or treatment delivery. In fact, it may be more useful than many other methods when the intent is to monitor the more intangible, hard to quantify aspects of process. Since observation allows the researcher to tap into actual as opposed to reported behaviors, it allows one to obtain data that are relatively unbiased by the actors' desire to present a socially acceptable front. This is a particularly useful attribute if one is interested in monitoring such value-laden issues as whether staff treat clients with courtesy and dignity or whether a treatment approach fosters normalization.

Output. As with the process dimension, output is usually best captured by methods other than observation. It is usually far more economical and reliable to get this type of count from existing records.

Outcome. Observation may be a useful approach to monitoring outcome in certain situations where other methods have weaknesses. The **Temple University** monitoring method, is is a case in point. In this example, the monitors were interested in obtaining evaluations in residential programs. Residence supervisors provided assessments of client functioning on a variety of dimensions, based on their observations of client behavior over an extended period of time. The strength of this method is that observations are made within the client's natural setting and the client's behavior is, therefore, unbiased by the presence of an outside observer or the continued nature of the typical experimental setting.

Practical and Technical Considerations. A number of technical concerns surrounding the observational method have already been alluded to in this section. At least three sources of bias threaten observational data. The first relates largely to the issue of reliability and concerns the degree to

which the observer is able to record accurately all of the relevant behaviors or environmental factors in the observational setting. Clearly, in large settings that involve numerous actors engaged in complex interactions the threat to reliabilty reaches its height. To the extent that the method is restricted to small settings in which manageable numbers of actors are involved, the reliability of the data can be more easily controlled.

The second source of bias is the potential for misinterpreting the behaviors under observation. Whenever one uses the observational technique to study behavior, there is a need to assign meaning to or to evaluate the concrete behaviors observed. When the distance between the behaviors observed and the meanings assigned can be minimized, the threat to validity is decreased. In a fine study designed by Jelinek, Dieter-Haussman, Hegyvary, and Newman (1975), observation was used to monitor the quality of nursing care. Observers recorded information concerning very concrete aspects of nursing care. The researchers did not focus on global assessments of adequacy but focused instead on task specific behaviors that had a generally agreed upon relationship to quality of care. This is the major strength of the study. The concrete nature of the tasks included on the researchers' various checklists left little room for ambiguity and required little in the way of interpretation.

The third potential source of bias is the observer himself. This problem was described earlier in this section. Clearly, potential bias is reduced if the observer's presence is undetected or if the setting is such that the actors would tend to forget about the observer. However, despite its methodological advantages, the practic of inserting observers surreptitiously into settings raises some ethical as well as political concerns.

A final concern that should be raised with respect to observation is

whether or not the observer should become involved in the situation being observed. Some studies are designed in such a way that the observer is supposed to be an active participant. In others, the observer is instructed to remain neutral and refrain from influencing the behaviors under observation. On some occasions, this non-involvement may raise some ethical concerns. Jelinek et. al., in the nusring care evaluation cited above, found this issue to be particularly troublesome. The nurse observers who were supposed to be neutral data collectors found it very difficult to stand by and merely watch observed instances of poor nursing care.

Performance Contracting

Introduction. Private agencies now design, deliver and evaluate virtually every type of social service being offered by national, state, and local authorities. By some estimates, private purchase of service agencies have overtaken the public sector in the conduct of such activities (Sharkansky, 1980). This "privitization of the service system led inevitably to the use of the contracting mechanisms as a means of control (Bradley, 1981). Service contracts represent agreements between the state or local funding agency and the service provider that call for the provider to deliver services to clients for which the governmental agency will provide a specified amount of fiscal and other support. To the extent that these contracts include performance requirements, they are termed "performance contracts." As one might expect, some contracts are rife with performance provisos, while others contain relatively few. Contracts have a number of general advantages and disadvantages as quality control or performance control mechanisms relative to regulation.

Conceivably, the range of quality criteria that can be included in a service contract may be even greater than in regulations because the requirements need not be strictly based in statute but may include any number of additional requirements. One advantage of contracting arrangements is that they are far more flexible and versatile than regulations. The sanctions agreed upon in a contract may be more or less severe. They may provide for non-payment, partial payment, or full payment for services, or they may provide for no further funding until some corrective action is taken, and satisfactory service provider performance is demonstrated. Regulations generally provide for full payment or no payment; discretionary partial payments and other such arrangements are not usual.

Contractual provisions are also more amenable to change than regulatory provisions. Reasonable contract amendments may be granted at almost any time and at the very least, at the time of contract renewal -- usually on an annual basis. Thus, service quality requirements and/or associated sanctions are much more amenable to change than are regulatory requirements and sanctions.

The associated drawback is that the relatively changeable nature of contract provisions may diminish their weight in the eyes of service providers and the discriminating public. Practitioners may spend more effort seeking changes to contractual provisions than seeking ways to comply. Though such resistance certainly takes place with respect to objectionable regulatory provisions as well, the difficulty in obtaining waivers of regulatory requirements is generally understood and avoided where possible.

Service and Target Group Applications. Service contracts are also more flexible than regulations in the sense that they can be more easily tailored to suit particular service provider situations. A day care program serving Hispanic clients may receive, through a contract modification, additional

funds to provide language instruction. A provider serving a rural population may be required (and funds authorized) to include private client transportation arrangements. Such exceptions or special provisions are purposely excluded from many regulations for reasons of simplicity and equity. The added administrative burden and cost of devising and administering a myriad of exceptions contradicts one of the main purposes of regulations: to reduce the time that must be spent by public administrators to personally direct and oversee service providers on an individualized basis. Of course, the administrative burden of developing and administering individual contractual arrangements is equally costly. Clearly, it is more difficult to tailor rules to each individual service provider than to require that providers conform to some uniform set of requirements.

Another consideration is that the contracting mechanism allows government agencies to sidestep the legal problems involved in promulgating regulations to meet a variety of special service arrangements and/or clients. If such variations are legitimized in law, legal challenges on discriminatory grounds by out-of-favor providers or consumers are almost inevitable on the grounds of selective or discriminatory enforcement, and arbitrary or capricious use of discretion. For example, Morgan (1974), in discussing the legal aspects of the federal day care regulations (FIDCR) claims that an argument might be made successfully before the court on behalf of the children not in day care that "the high cost of meeting the FIDCR (which includes more than that deemed necessary for the child's protection) uses up the appropriation and leaves them without any services" (p. 70), thus generating a greater evil than the good it seeks. Individual contractual agreements seldom prompt such legal challenge.

Program Dimensions. As indicated earlier, performance contracting is a

control mechanism which can be and has been applied to all human development services and target groups. Performance contracts also have been written that are responsive to each of the basic quality assurance objectives and corresponding dimensions of service quality, specifically:

Objective	Quality Dimension
To assure service access to those in need	accessibility
To assure the capability of providers to peform	inputs
To assure good practice	process
To assure efficiency	inputs divided by outputs
To assure desired outcomes	outcomes

The advantages of performance contracting relative to other control mechanisms have been demonstrated only insofar as assuring access to services. The mechanism is being used in a number of states to assure the accessibility of services to those clients deemed to be most in need. The Contracts specify: (1) those services for which the government agency is willing to pay, and (2) the criteria that must be met for persons to be eligible to receive these services. These provisions are in addition to and serve to qualify those regulatory provisions that govern the funding of human development services generally. Through the use of the contract mechanism, the government agency is able to delimit the regulatory funding allowances in order to target priority services and persons in the face of limited resources.

One of the most dramatic illustrations of this use has been by agencies funding programs for mentally ill and mentally retarded persons. In furtherance of policies favoring community over institutional placements, some

state mental health officials have agreed to pay for community-based residential and day programs and other community support services only if all or a substantial number of persons receiving such services have been previously institutionalized or are at risk of institutionalization (Pennsylvania, New York).

The effectiveness of the contract as a lever for controlling access to human development services may be: (1) constrained by the limited supply of providers -- in other words by the limited ability to secure other providers should existing providers refuse to accede to the priorities of the contracting agency; and (2) limited to the extent that the contracting agency doesn't control the client intake process.

Limited Supply of Services. Low rates of reimbursement, the lack of start-up funding, public payment delays and uncertainties (Massachusetts Taxpayers Foundation, 1980), and the trials and tribulations of providing social services serve to discourage private initiatives in many areas. Moreover, in some areas the delivery of particular types of services may be controlled by a single provider or a single chain of providers. As Gurin and Friedman (1980) conclude in their study of purchase-of-service mechanisms for the elderly, children and disabled persons in Massachusetts, "access is primarily a function of the availability of services . . .," which is restricted by the limited availability of funds (p. 19).

One technique used by states in an attempt to increase the number of providers willing and able to accommodate more difficult clients has been to set higher rates of reimbursement for such clients. This practice is particularly prevalent in programs for developmentally disabled persons. However, in doing so, a number of states have reportedly encountered a tendency by providers to retain more difficult cases by decreasing efforts to

maximize functioning. This is particularly troubling in the field of developmental disabilities where the aim is to stimulate growth. Based on interviews with key informants in California and New York for instance, there is a suspicion that some providers are understating the levels of functioning of their clients in order to maximize revenues, and state officials are trying to think of ways to correct this problem.

Not long ago, the Medicaid offices in several states including Illinois abandoned their differential reimbursement schemes for developmental disabilities services being piloted under Title XIX. They concluded that the added cost of administering their increasingly complex reimbursement procedure, outweighed any possible program savings that might have ensued.

Considering the Illinois and California experiences, it is clear that any system that differentiates rates must be kept simple (Gurin & Friedman, 1980), and must somehow control for perverse behaviors (Donabedian, 1976, p. 28). In most cases, a strong case management and/or advocacy system where the case manager continues to assure the appropriateness of services might serve as an effective control of fiscal disincentives to client progress.

Limited Control Over Eligibility Determination Process. The effectiveness of the contract mechanism as a control over service access may be constrained to the extent that the provider contracts to provide services privately or with other governmental agencies and thus is not solely dependent on public funds for survival. As Gurin and Friedman (1980) note in their study of contracting for protective services for children in Massachusetts:

> Excessive demand is a constant and pervasive problem . . . , to the point where the [overriding] criterion [for placement] often becomes whether a provider has an open slot and is willing to take the case. . . . the providers are in a position to choose the cases they can handle. (p. 13)

The effectiveness of the contract in this area is also constrained by the fact that the contracting agency has less than complete control over the client

selection process. Some purchase-of-service arrangements are based on the "open-referral" system whereby a provider is authorized to use contracted slots for clients applying directly to that agency without any screening by the contractor agency. The state contracting entity may have even less control to the extent that it is denied access to client records. Even where contract provisions specify that the public agency may have access to client records, this right may be overridden by the right of individual clients to withhold permission from the contracting agency to review their records. If the funding body is to exercise a reasonable degree of control over client access to services, the agency should have some control over the intake process or at least have the ability to verify that the clients admitted for service in fact meet contract specifications.

The Use of the Contract Mechanism to Assure Provider Efficiency and Outcomes. Attempts are being made in a number of states to implement performance contracts whereby providers are rewarded for increases in efficiency. One of the more ambitious is the "quantitative performance measurement model" in New York (Lund, 1979). For several years, the Department of Mental Health in Pennsylvania has employed a number of provider performance standards as part of its formula for the allocation of state funds to county mental health programs. This is done in an attempt to influence indirectly the performance of community mental health providers (Hadley, *et al.*, 1982; Hadley *et al.*, 1983).

Failed attempts to establish or maintain performance contracting schemes that attempt to influence provider efficiency and effectiveness far out number attempts that have been successful (Ashbaugh, Bradley, Conroy, Feinstein & Moore, 1983). The difficulty of measuring provider efficiency and effectiveness validly and reliably generally confounds attempts to enhance

these qualities through the contract mechanism. Most measures are simply too loosely defined and ambiguous and are thus subject to easy misinterpretation and/or manipulation by providers. The administratively adept providers, perhaps more paper-oriented than client-oriented, might shine under such schemes.

On the other hand, well-defined measures are by definition narrow and, as mentioned earlier, can lead to perverse and undesirable behavior. One of the best known examples of such behavior in the human development service area, is the phenomenon of "creaming" or choosing easy, low-cost cases in response to performance appraisal schemes that place a premium on serving a maximum number of clients at a minimum cost. In the federal vocational rehabilitation program, a Congressional mandate to serve "individuals with the most severe handicaps" arose in part from the tendency of programs to reject severely handicapped or difficult clients in order to maximize success in terms of the sole criterion -- "number of cases successfully closed." It is hardly surprising that service providers do what they perceive as necessary to gain recognition, monetary advantage, or even survival (Funkhauser, 1979).

In private industry where the outputs are tangible products and where quality may vary little as a function of labor time and effort, a system that holds out rewards or punishments on the basis of volume may serve to increase productivity. However, in the case of labor-intensive social services where the worth of the service can depend heavily on the amount of effort expended by staff, such a system may cut short the amount of time devoted to each client to the point where it is no longer of value.

Two outcome monitoring approaches which are not tied to specific incentives or sanctions are those pursued by the Division of Mental Health in Colorado (Miller & Wilson, 1981), and by the Program for Mental

Retardation/Developmental Disabilities in Oregon. In Colorado, information that can be used to formulate indicators of provider efficiency and effectiveness is required to be reported as part of the contract. There are, however, no contract provisions or decision rules linking program funding incentives or sanctions to these measures. The measures are used later as part of an independent evaluation of the provider -- an evaluation designed to control for, or at least to account for, many of the variables affecting client outcomes. Colorado delays the consideration of sanctions and incentives pending the completion of a more thorough-going evaluation, and decreases the likelihood that providers will attempt to manipulate the information, client mix, or service patterns in consideration of such funding incentives or sanctions. In the state of Oregon, the client outcome data is fed back to providers of services to developmentally disabled persons as a way to inform them about their clients' progress relative to clients in other programs around the state.

As Peters and Waterman (1982) argue so convincingly, the measurement and feedback of the growth of the clients cared for by service providers should be enough to motivate most direct care staff to improve their programs. If not, there is little else that can be done short of "bountiful supplies of technical assistance" (Walker, 1972, p. 53). As Hage (1974) says, "there is a difference between saying something is wrong, and pointing out how it can be done better" (p. 83).

Practical and Technical Considerations. As discussed in the previous sections, the efficacy of the performance contracting mechanism has been demonstrated only insofar as assuring the access to services by those deemed most in need. In spite of repeated tests, it has yet to be shown to be a practical tool for assuring the quality of program efficiency, outcomes, and

practice. It is limited as an efficiency and effectiveness control mechanism primarily by: (1) the inability to measure these program dimensions accurately; (2) the inability to predict and thereby avoid undesired provider behavior induced by these measurement limitations, namely "creaming" and false reporting; and (3) the emphasis on short term inputs as opposed to long term outcomes. It is limited in its ability to affect the way providers practice because it is practically impossible to force human service practitioners to practice in a particular way. Human service practitioners tend to practice in accord with professionally established or peer-established standards of good practice, and not in response to bureaucratically-imposed requirements be they based in contract or regulation.

Even in the case of performance contracts designed to assure access to services, the effectiveness of the performance contract mechanism is constrained by: (1) a limited supply of providers (or a "sellers' market") which makes leverage difficult, and (2) the extent to which the contracting agency has control or oversight over the eligibility determination process (i.e., limited ability to monitor the process whereby clients gain access to services).

Training

Introduction. It is fair to say that most quality control schemes are characterized by the exercise or threat of exercising formal sanctions, many of which are relatively severe, and negative. They are coercive not persuasive. Such formalized quality assurance schemes are well suited to the control of measurable and reasonably stable service inputs (e.g., staff, facilities or equipment), and even some measurable outputs (e.g., number employed, number served, or number completing training). However, they are

less suited to assuring that service provider processes conform to "quality" protocols. Put simply, this is because individuals providing services tend to respond negatively to negative sanctions and positively to positive sanctions.

In terms of controlling the practices of human services practitioners, the overwhelming evidence is that formal, bureaucractic mechanisms are less effective than less formal, less bureaucratic procedures (Blau & Meyer, 1971; Carzo & Yanouzas, 1967; Azumi & Hage, 1972; Weissman, 1973). The literature on organizational development strongly suggests the need to rely less on heavy-handed bureaucratic procedures, and to concentrate more on informal and constructive training activities. As Maloof (1975) explains, the professionalization of practitioners, which can largely be accomplished through training, generates an ethic, attitude, or frame of reference rather than a recipe for behavior (p. 25). The gentle persuasion of peers rather than administrative coercion is generally thought to be the most effective means of controlling human services practice. Practitioners are more likely to respond to peer-based forms of control such as training than to administrative-based forms of control when it comes to questions of methods or practice. Sarason believes that the growth and development of the staff members of an agency should be as important a goal as the provision of service to clients. He argues that service agencies that treat the provider as a co-equal object are more likely to respond to service failure by seeking new ways of providing that service. As an analogy, Sarason (1972) aruges that the reason that schools are no longer places where children learn is because they are no longer places where teachers learn (p. 123ff).

While organizational standards can formally dictate the basic roles and responsibilities of each worker, attempting to dicate how s/he fulfills these responsibilities or how s/he plays a particular role is largely an exercise in

futility. In fact, bureaucratic control mechanisms, if overdone, can alienate the human service worker (Miller, 1978; Argyris, 1971). The corollary is that the most effective means of control are those that are less formal and that rely more on interpersonal networks than on impersonal procedures (Organ & Greene, 1981; Azumi & Hage, 1972).

Before entering into the mechanics and examples of this approach, it is important to appreciate the preeminent importance of training and technical assistance as a quality assurance tool. The strongest argument for training may not be the most obvious. The one most often cited is that it helps to assure good practice by increasing staff competence. Though this has certainly been shown to be true (Schinke & Wong, 1977; Bernstein, 1981; Maloof, 1975; Benveniste, 1977), the most compelling rationale for training is that it serves to build and maintain a cadre of direct care staff positive in their approach to their work and committed to good practice.

It goes without saying that, more than in most fields, people are central to the provision of human development services. The programs are designed to provide services to people with developmental disabilities and the services are provided by people, caring people, very few of whom might be accused of entering the field for monetary gain. The overwhelming majority come to the job already motivated to perform well. They have entered the field for humanistic reasons and ask little more than to be recognized and supported in their efforts. The somewhat contrived efforts of commercial enterprises to motivate their employees are hardly necessary; yet, many offices have failed to give service staff even the barest amount of recognition and support. Instead, by their actions, they display little regard or concern for these individuals and are more ready to sanction and coerce than to train and persuade. Aside from the inverted logic of this approach -- sanction first,

train second -- the negative message is clear and breeds a system of care governed by distrust between direct care providers and the state. Training helps workers cope with the stress that comes with trying to help disadvantaged persons and that, if unchecked can lead to burn-out (Daley, 1979; Krell, Richardson, LaManna & Kairys, 1983). Participative training can enable workers to recognize those strengths and skills that they do possess. Workers can experience a degree of satisfaction by sharing in the successes of other training participants or even by sharing in their failures (Zimmerman, 1978; Kagan, 1983). "If nothing else, training can provide a welcome relief by removing the worker, at least for a short time, from the ringing telephones and constant crises associated with day-to-day client work. A successful training experience can help instill a new determination or enthusiasm in workers simply by offering them a brief respite and some new ideas for working" (Broadhurst & MacDicken, 1979, p. 4).

Service and Target Group Applications. The need for training spans all human development service providers. The literature is filled with descriptions of model training programs designed to fill these needs (Freeman, 1981; Jones & McNeely, 1981; Fortune & Rathbone-McCuan, 1981; Benavides, Lynch & Velasquez, 1980; Leitner, 1980; Elmer, Bennett, Horway, Meyerson, Sankey & Weithorn, 1978; Clement, 1983; Gill, Berger & Cogar, 1983). There is a wealth of training materials including video tapes, audio cassettes, books and other instructional packages. Rarely should one have to develop training packages anew.

The difficulty comes in the identification and dissemination of these training materials. In 1980, the Catalogue of Human Service Information Resource Organizations, compiled by the Educational Research Information Center (ERIC), listed 157 clearinghouses at the national, state and local

levels holding training materials relating to human development services. Though many of these resource centers have sinced vanished in the face of budget cutbacks, a number continue on. Federally sponsored information centers and clearinghouses known to contain training materials relevant to the provision of human development services are:

- Project SHARE, Rebecca Elson, Project Director, 1530 East Jefferson Street, Rockville, Maryland 20852;
- Educational Research Information Center (ERIC) (elementary and early childhood education), Judy Conrad, National Institute for Education (ERIC), 1200 19th Street NW, Washington, D.C.:
- Educational Research Information Center (ERIC) (handicapped and gifted children), Don Erickson, Assistant Executive Director, Council for Exceptional Children, 1920 Association Drive, Reston Virginia, 22091;
- National Technical Information Service, Judith Hunt, 5285 Port Royal Road, Springfield Virginia, 22161;
- Clearinghouse on Child Abuse and Neglect Information, National Center on Child Abuse and Neglect, Joe Wechsler, Office of Human Development Services, Department of Health and Human Services, P.O. Box 1182, Washington, DC 20013;
- Resource Center on Aging, American Association of Retired Persons, Paula Lovas, 1909 K Street NW, Washington DC 20049.

In addition, reviews and listings of training materials are often found in the newsletters of associations of public administrators and providers in the human development services field. A number of these associations, (e.g., the National Association of Social Workers, the International City Management Association) also have holdings of and references to human development services training materials.

In recent years, more and more states with and without federal assistance, are establishing their own information centers and clearinghouses to complement and supplement other sources at the national level. Colleges and universities that have studies in human service fields, particularly those conducting programs of continuing education in these fields, are also good

sources of training materials as well as trainers. The West Virginia Training Resources Center, for example, maintains an inventory of training materials and references to other such materials relating to the delivery of mental health services in addition to conducting programs of continuing education and training. The Western Washington University serves as a clearinghouse for child protective service training materials and trains child protective service workers (Doueck, 1981). This is done under contract to the state Department of Social and Health Services. The Rhode Island Head Start Training Center serves as a clearinghouse for Head-Start related training materials in Rhode Island.

In the area of developmental disabilities, there are federally-funded University Affiliated Facilities, and Research and Training Centers. These organizations themselves develop training programs and materials, and should also serve as knowledgeable sources of information on training materials available in the field.

In 1983, the New York State Director of Staff Training and Development in the Office of Mental Retardation and Developmental Disabilities, formally proposed to mental retardation/developmental disabilities offices in other states that they arrange to inventory and share training materials. This sharing arrangement has since begun.

In some metropolitan areas, technical assistance centers have been established to provide management assistance, training and consultation to non-profit organizations including providers of human development services. These non-profit technical assistance centers are funded by corporations and foundations. Services are provided primarily by knowledgeable and experienced volunteers who are recruited and whose efforts are coordinated by the technical assistance centers. Services are provided at nominal rates to help

cover staff costs. In San Francisco, community training and development has more than 200 skilled volunteers providing services to hundreds of non-profit organizations. In Denver, the Technical Assistance Center provides like services to non-profit agencies throughout the State of Colorado. The Non Profit Management Association is a national organization of firms and individuals providing assistance to non-profits primarily in human services.

Program Dimensions. The provision of training as a way of enhancing service quality will primarily affect the process of service delivery in that it influences professional practice. As such, training -- once delivered -- also becomes an input to the program. Insofar as the content of the training is correlated with client progress and change the training should also enhance program outcomes.

Technical and Practical Limitations. Several factors are repeatedly cited as constraining the impact of these training programs on staff practice: (1) limited staff participation, (2) training programs and materials not relevant to the demands of the job, and (3) a working environment not supportive of, or conducive to the practice of what has been learned. What is interesting is that all of these factors relate less to the training techniques themselves and more to training program preparation and follow-up.

Limited Staff Participation. Staff are variously motivated toward training. While some ardently seek training others may be less than enthusiastic. To assure that all staff receive that training deemed essential to performing their jobs adequately, some programs mandate that staff participate in in-service training or that persons participate in pre-service training in order to qualify for hiring. Others attach rewards to the completion of staff training. New York requires that entry-level staff in

publicly-administered programs for persons with developmental disabilities complete a program of in-service training during the first year at the conclusion of which they are raised two pay grades. They are working on instituting a comparable scheme for private providers. California certifies staff serving persons with developmental disabilities who have completed specified programs of training.

The staffing of human development service programs is notoriously thin. Budgetary and hiring restrictions, high staff turnover, low wage levels and the limited opportunity for advancement conspire to make it so. At the same time, these factors heighten the need for training. Indications are that training can reduce staff stress and turnover, and can accelerate the rate at which staff become proficient in their jobs (Kirigin, Ayala, Braukmann, Brown, Minitlin, Phillips, Fixsen & Wolf, 1975; Schinke & Wong, 1977; Schinke, Smith, Gilchrist, & Wong 1978; Lackey & Burke, 1980). The difficulty comes in arranging time off for staff to take the training without seriously depleting the staff on-site. Many programs hire temporary replacement staff to cover for individuals being trained. However, the cost of these temporary staff can be quite high (Ziarnik & Bernstein, 1982).

One practical and quite common approach is for supervisors or more experienced staff members to train newer, less experienced staff on-the-job (Jorgensen & Klepinger, 1979; Feldman, 1977). However, the value of such training is a function of the knowledge and experience of those providing the training. Logic tells us that the knowledge that might be obtained from a single individual or small group of individuals in-house, is no match for the body of knowledge accumulating outside a given program. In fact, it is the search for broader knowledge that has been shown to be the prime motivator for case workers to seek outside training and continuing education (Zimmerman,

1978).

Self-instructional techniques cannot provide some of the benefits that derive from participating in team training -- most notably the stimulation that comes from the sharing of one's experiences and learning from the experiences of others (Broadhurst & MacDicken, 1979). This limitation notwithstanding, self instructional techniques can derive from the larger body of knowledge and thus infuse training programs with new ideas and approaches. Moreover, practically speaking in many human development service programs, self-instructional methods may be the only reasonable way for new staff to learn enough to perform essential job skills within a reasonable period of time, without short-staffing the program, and without critical disruptions in service to clients. Staff shortages and budget limitations simply make it impossible in many cases to release staff for enough participatory training to enable them to reach an acceptable level of performance within a reasonable period of time following hiring.

The **Newton-Wellesley-Weston-Needham Area Mental Health/Mental Retardation Board in Massachusetts** has developed such a self-training technique for use by residential and other providers of services to persons with developmental disabilities. The self-orientation/training program is designed to be completed by new staff within their first three months on the job. It covers their roles and responsibilities, the program philosophy, administrative procedures, and dozens of service techniques regularly used by staff members serving persons with developmental disabilities.

Training Irrelevance. The presentation of material irrelvant to the trainee for the improvement of his or her performance is an important issue. Information on the needs of those staff to be trained can be obtained simply through surveys of the prospective trainees asking them "in order for the

training to be successful for me, I will need to learn . . ." (Broadhurst & MacDicken, 1978).

Of course, this approach assumes that the prospective trainees know what knowledge and skills they most need to improve skills. Many staff development authorities believe that training needs are better defined in terms of the worker's inability to perform certain tasks. This approach is enhanced when surveys of allied professionals, and possibly consumers are used to add an external perspective. Utilizing these procedures, Pecora, Dodson, Teather and Whittaker (1983) applied the Worker Ability/Characterstic Method to assess the knowledge and skills of staff working in a voluntary foster care agency in the State of Washington.

Still another approach is to tailor the training program to address problem areas uncovered in reviews of service providers that are conducted by the state licensing or regulatory agencies, by private accreditation agencies, or by other quality review organizations. An obvious advantage of this approach is that the training need is defined in terms of the inability to meet specific performance standards, standards that might not be considered by the workers, or key informants who would be surveyed as part of the "training needs survey" described above. The Vocational Rehabilitation Training Program in the State of Georgia employs just such systematic follow-up to the surveys of day programs conducted by the **Commission for the Accreditation of Rehabilitation Facilities.** This follow-up is used to design more relevant training programs for the vocational rehabilitation providers in the state.

Working Environment Not Conducive to the Implementation of What is Learned. This last problem is widely recognized as stunting the effects of much human service training (Gronvold, 1978; Tucker, Hart & Liddle, 1976; Feldman, 1977; Kagan, 1983; and Ziarnik & Bernstein, 1982). Ziarnik and

Bernstein (1982) contend that the effects of staff training on staff performance is blunted by environmental factors such as the lack of monetary incentives, lack of recognition for work well done and the absence of clear cut management emphasis on the application of what has been learned. They argue that if environmental conditions work against staff implementation practices learned in training, no amount of training will have much effect. The work environment must support the exhibition of learned skills if such skills are to be implemented satifactorily.

Training to improve staff skills, then, is only part of the answer; providing a work environment conducive to the use of these skills is the other part. In other words, training and good management go hand in hand and should be considered together and not separately in the design and implementation of training programs.

Consumer Empowerment

Introduction. In many service settings, it may be appropriate to transfer Some or all of the responsibility for monitoring and evaluation (feedback) to the consumer or client. As Etzioni (1965) has observed, the organization can be classified by the extent to which control is delegated. In many of the "helping" services, transfer of responsibility and control (empowerment) may actually be part of the clinical process. In their report on consumer needs assessment in board and care homes, Schott and Tempby (1979) state: "Many consumers and clincians have found that a major aspect of recovering is the gaining of more control over and responsibility for his or her own life . . ." This control includes the ability of the client to influence the quality of services received.

While such transfers of control may be ideologically attractive, there

are several policy questions to address including:

- when does control work best at the client level?
- how much power should be vested in the client?

Answers to these questions will vary from organization to organization; there is no formula that can determine the optimal shift of control for classes of clients or services. But we can examine in some detail the opportunities for transfer of responsibility, together with examples from selected projects that illustrate application of consumer empowerment principles.

Three vehicles are commonly proposed as consumer empowerment tools:

(1) Creating an "informed consumer" by providing consumer information on service planning and selection;

(2) Creating consumer complaint or feedback systems as part of service monitoring and evaluation;

(3) Creating a service market by providing consumers with vouchers rather than direct services, to use in selection of providers.

One, two, or even three such consumer empowerment approaches may be used simultaneously -- by providing information, for instance, in voucher systems, or by using information as part of a credentialing review process. And there is nothing in any of these approaches that automatically transfers control or facilitates client empowerment. Any of these may be introduced without shifting the locus of control to the consumer or client. But, if control is in fact shifted, so that consumers assume some responsibility for the quality of services provided -- either through actions prompted by more information, by working through markets to optimize their service package, or by exerting control through the licensing or certification process -- then the system may be able to reduce costs for quality assurance and gain more direct quality control for the services themselves.

Consumer Information. Better consumer information about available

services is recommended as an empowerment approach. Information may aid the client/patient/consumer at all steps in the service program -- from entry to exit. Providers and referral agencies vary greatly in the degree to which information is made available. Some organizations have made consumer information a central part of quality assurance. One example is the **Family Day Care Training Program (FDCTP) in Fairfax County, Virginia.** To appreciate the creativity of the FDCTP approach, it is important to consider the pattern of family day care administration and information which is more typical at the county level. In most states, counties are responsible for family day care licensing and administration. Information to users is available through provider lists in some counties, or through referrals to a small number of homes in others. In addition to provider identification, some counties provide information on "how to select" care, through brochures. The program in Fairfax County has been aggressive and ambitious in the area of quality of family day care homes. Rather than pursuing a regulatory approach (licensing) the county developed a program of provider education combined with consumer assistance and edcuation (Fairfax County, 1979). Consumer assistance and education in this program is accomplished through:

- Referral list of trained providers;
- "How to Choose a Family Day Care Provider" brochure;
- Speakers bureau.

The referral list provides a more qualitative indicator of homes, by listing only those providers who have completed a 40-hour, 10 week course in child development, parent provider relations, and Red Cross health and safety.

In addition to the 40-hour course, there are a number of other resources for providers included in this county program:

- A provider network;

- Provider-day care center cooperation, satellite programs;
- Ongoing provider education (i.e., workshops, consultations and monthly newlsetter);
- Community resources for providers (i.e., developing programs with county and community agencies to meet the ongoing needs of providers).

Thus, the consumer list provides an additional "screen," rather than merely listing providers with licenses, and is supported by a complementary program designed to support and improve provider quality.

Consumer Feedback Mechanisms. Consumers can play a role in creating useful evaluation information to be used by other consumers in selecting or assessing services. A model for such an approach can be found in the results of an experiment on **Consumer Assesment of Nursing Homes** conducted by the Urban Institute for the U.S. Department of Health, Education and Welfare, Administration on Aging. The aim of the study, conducted in two dozen communities across the country, was to determine whether volunteers could effectively supplement the limited information available on nursing homes from licensure boards and other regulatory agencies (Durman, Dunlop, Rogers, & Burt, 1979). The objectives of the study were: 1) to develop instruments and procedures that could be used by groups to gather and publish data not otherwise available about nursing homes, 2) to develop technical materials for use by local projects throughout the country, and 3) to assess the impact of the locally-produced information on consumers, long-term care professionals, and nursing home administrators. In each test community, four out of five nursing homes participated in the project. The final product in each of the local projects was to be a volunteer-produced guide to the long-term care resources in their city of town, intended for use by professionals needing information for nursing home placement and for individuals trying to locate a suitable nursing home for a friend or relative.

As a first step in instrument development, volunteers were asked to rank indicators of nursing home quality (information on staff ratio, medical care, cleanliness, and staff kindness were the items ranked most important). Volunteers made site visits to the nursing homes to develop ratings of home quality, using the locally developed instruments. From this information, local guides were prepared. Guides typically contained at least four sections:

- A discussion of alternatives to nursing homes;
- A discussion on how to choose a nursing home;
- Profiles of the characteristics of individual nursing homes;
- Comparative charts summarizing the profile information of each facility

The local projects were to decide whether or not to include the ratings of the homes made by the volunteers during their site visits in the published consumer information made available by the projects. The Urban Institute encouraged the use of the ratings but the final decision was up to the participating projects. Only one third of the projects used the ratings -- two thirds did not. The main reason for the project's decision not to use the ratings seemed to be a fear of repercussions from publishing subjective evaluations (Durman, et al., p. 46). Thus, involving consumers or volunteers in assessments is one thing; uisng the assessments to provide information and feedback for other consumers may be difficult to implement. And, while subjective ratings were omitted in most projects, the objective observations could still be published, so the projects did contribute to the availability of information on the homes.

Vouchers. Perhaps the ultimate in consumer empowerment is the transfer of service choice through vouchers. In recent years, the use of vouchers has been advanced as a way of solving the "crisis in the social services."

Essentially, vouchers allow the client or consumer to choose and purchase services, and guarantee payment of either the entire cost, or part of the cost. Vouchers attach some specific goods or services subsidy to the consumer rather than the service provider or vendor. Vouchers as a subsidy mechanism fall between the two poles of the service delivery continuum, between direct service on the one hand and undifferentiated cash grants on the other.

Voucher proponents argue that vouchers would introduce the "benefits of the market place" into service bureaucracies; the theory of vouchers suggests that by introducing consumer purchasing power, conditions of competitive markets can be achieved in service delivery systems. Responsiveness to the consumers, and thus improvement in service quality should result (Reid, 1972).

The voucher idea has been most extensively developed in education, but has achieved popularity in general social program service delivery reform as well. Currently, for instance, there are voucher schemes being tested by the Health Care Finance Administration (HCFA) in Medicare reimbursement projects in Minnesota and Florida. In child care, voucher or vendor payment schemes have been used in conjunction with AFDC, tested in the State of California (Department of Education, 1978), and introduced in public/private partnerhsips as in the city of Austin, Texas (American Planning Association, 1982). In Austin, participating employers provide partial support for employee child care costs. Those costs can be applied to any licensed center or registered family day care home the parent chooses. Vouchers provide flexiblity and, theoretically, responsiveness to consumer choice. However, the voucher idea has been discussed far more widely than it has been applied. We can speculate that, because vouchers actually might provide real client empowerment by transfering responsibility for the purchase decision, that social service

organizations resist this degree of power being transfered to the client.

Program Dimensions. Consumers (clients) may participate in quality assurance at a number of different points in the service process. As the chart below shows, there are a number of decisions to be made at various stages in the typical service process.

Point in Service Process	Relevant Consumer Decisions
entry	--whether to use a service
planning	--which service to use --how much to use
vendor selection	--which provider/vendor to use
licensing, certification	--which providers obtain licenses or certification --which providers retain licenses or certification
completion, exit	--where, or how, to exit the service, or complete

Depending on the service and on the type of client, different consumer empowerment mechanisms may be used at different points in the process. The first point of consumer intervention is client entry. In corrective or mandatory services, entry decisions are not left to the client. But particiaption or entry into many social programs is voluntary. In service planning, there is another opportunity for empowerment. Some programs have institutionalized a joint plan-making process -- the individualized habilitation plan (IHP) in developmental disabilities, and the service tailoring plans in long term care service delivery demonstrations. Vendor selection may provide another opportunity for client empowerment. Which

service provider should be used? A related question has to do with licensing or certification of providers. Which providers may be used by consumers? Consumers/clients may play a positive role in establishing the eligibility of service providers, or may influence the renewal or retention of a license or certificate. Finally, the client may participate in the decision to complete a service or to leave a program. Thus, there are many opportunity points for consumer empowerment. At any of these points, mechanisms may be established that affect or reflect service quality.

Technical Considerations. For true inclusion of consumer empowerment techniques in quality control mechanisms, such a scheme should meet the criteria of power or persuasive ability and reasonableness.

By power or persuasive ability we mean that the consumer's (client's) actions or decisions do actually represent empowerment. By reasonableness we mean that the approach should be acceptable to funding sources, providers, and consumers alike. A review of the problems confronted in a number of national voucher experiments underscores the importance of investing the consumer's role with enough power to influence the system in order to achieve desired results, but also points out how difficult such power is to implement given provider resistance. In the education voucher experiments in Alum Rock, a number of compromises in the consumer empowerment "free choice" model were made in negotiations with the Alum Rock school district prior to implementation. The model to be tested evolved into a "transition model." The rules of the transition model compromised the voucher concept. The demonstration would involve public schools only, with six of the district's 24 schools particpating. Each participating school would offer two or more district program options. Teacher's job tenure and seniority rights were guaranteed, as was survival of the participating schools themselves. Thus, by

the time "choice" was offered to consumers, the system had protected itself from many of the possible effects of client choice. More power for parents had not seemed reasonable to providers in this case. The restrictions on consumer empowerment in the resulting model limited consumer ability to influence quality.

Chapter IV
Putting the Methods to Use

This chapter describes a general procedure for assessing the combined effect or synergy of quality assurance methods that make up the quality assurance system, and for analyzing the overlaps, duplication, and gaps in quality assurance systems, and for determining the efficacy of existing quality assurance methods or techniques. It also describes a general procedure for deciding on appropriate organizational or methodological alternatives, and for managing the implementation of these alternatives. Put another way it describes a procedure for analyzing the existing quality assurance system, designing an improved system (organizational and substantive), and implementing the changes necessary to move from the existing system to the new one.

Systems Analysis

In most states there are a myriad of organized efforts, innovative and traditional, to assure the quality of human service programs (e.g., licensing programs, reporting systems, purchase of service contracting procedures, state and local evaluation office activites, and legislative hearing process). Many of these efforts originated in a piecemeal fashion in accordance with federal program funding provisions, as part of state legislative acts, from different administrative initiatives, and in response to judicial imperatives. The responsibilities are typically spread among a number of agencies: state health, labor, human services or welfare, fiscal offices, and offices of local

government in the state. Some of the methods are reasonably efficient and effective; others are less so. Some serve legitimate quality assurance requirements; others do not. The quality assurance responsibilities and methods are heavily concentrated, overlapping and duplicative for some types of service providers and target populations, and absent for others.

Before moving to eliminate, modify or add to an existing set of quality assurance methods, it is prudent to: (1) analyze the existing methods as a whole, assessing their combined effect; (2) analyze the coverage of the methods in terms of the five quality assurance responsibilities described in Chapter II, and in terms of those areas where coverage is overlapping, duplicative or absent, and (3) analyze whether existing methods are being employed appropriately and effectively.

Quality Assurance System Balance

Quality assurance methods and techniques, such as those presented in Chapter III represent the "mechanics" of quality assurance. Taken together, they should represent a comprehensive system for assuring the quality of human development services to persons targeted to receive these services, and should be comprehensive in terms of the five quality assurance responsibilities.

Taken together these methods have a "gestalt" or combined effect which should be synergistic in nature -- that is, where the combined effect is greater than the sum of the effects of the methods individually. Unfortunately, as discussed in the introduction of this manual, the distinct impression in most states visited during the course of this project and related projects is that the combined effect is less, often far less, than the effects of methods singly. We would suggest that the anti-synergistic character of state quality assurance systems is commonly traced to four

underlying problems:

1. On balance, quality assurance mechanisms tilt significantly toward minimum standards that represent little or no challenge to most providers.

2. The bulk of quality measures are formal, rely heavily on paper compliance, and demand a mountain of documentation to assure overseers that quality services are being provided.

3. Monitoring procedures are decidedly reactive as opposed to proactive in nature, that is they involve the post facto review of provider operations as opposed to an ongoing process of formative review and technical assistance.

4. Techniques are dependent on legal and fiscal sanctions (i.e., coercive levers) as a means of obtaining provider compliance as opposed to less formal, more persuasive measures.

Considered individually, there is nothing inherently wrong with a method that focuses solely on minimum standards, requires the documentation of policies and procedures, is reactive as opposed to proactive, or that holds out the threat of formal sanctions in order to force provider compliance. However:

- A quality assurance system comprised of methods focusing heavily or exclusively on minimum standards will ensure only that providers are in compliance with such minimum standards and will not lead providers toward higher levels of achievement.

- A quality assurance system that includes a concentration of methods (e.g., management information and reporting systems, pre-survey reports, individual client plans and progress notes, standing operating procedures, program plans etc.) that require providers to document virtually all aspects of their operation can overwhelm providers and build resentment between the organizations charged with quality assurance responsibilities and those providers subject to such procedures. Providers in such a system view quality assurance officials as overly demanding bureaucrats out of touch with reality; quality assurance officials view the providers as uncooperative.

- A quality assurance system where most methods involve post facto monitoring tends to uncover only those problems that have reached critical proportions. Monitoring done on a more frequent albeit less formal basis is likely to uncover problems before they reach a critical stage. This latter approach can go hand in hand with state supported staff development efforts and technical assistance to ameliorate emerging problems.

- A quality assurance program comprised of methods that rely on the

threat of legal or fiscal sanctions to force provider compliance inevitably colors the relationship between providers and quality assurance officials. The providers become viewed as suspect and the quality assurance agents as police. The communication between quality assurance staff and provider staff is strained and unproductive since providers may be afraid to open up for fear of sanction. An unhealthy "we/they" attitude grows up between service providers and quality assurance agents that can eventually undermine the relationship and blunt attempts by the public agencies to influence provider practice.

Quality Assurance System Coverage

Second, the analyst should examine the comprehensiveness of the method and analyze the extent to which the methods cover:

- the five basic quality assurance responsibilities, specifically:
    - -- to assure that providers have the capability to provide an acceptable level of service;
    - -- to assure that client services are provided consistent with accepted beliefs about what constitutes good practice;
    - -- to assure that a commitment of resources produces a reasonable level of service;
    - -- to assure that the services that are provided have the intended effect; and
    - -- to assure that the limited supply of services is provided to the most needy clients.

- target populations of concern, including:
    - -- developmentally disabled persons
    - -- aging persons
    - -- native americans
    - -- dependent and neglected children
    - -- runaway youth
    - -- others for whom the state agency carries responsibility for protection and support

- The range of services or service providers utilized by the target populations, including:
    - -- residential long-term
    - -- residential interim
    - -- counseling
    - -- information and referral
    - -- education and training
    - -- day programs/activites/nutrition
    - -- homemaker/chore services
    - -- emergency services -- child and adult protection
    - -- case management
    - -- other (transportation)

Other questions that should be asked include: Are any of these methods overlapping or duplicative? Are there quality assurance responsibilities that are currently unassigned and/or lacking a basis in law, executive order, or judicial decree?

Appropriateness and Effectiveness of Individual Methods

The third stage of the analysis pertains to existing individual quality assurance methods. Questions at this juncture might include: Is each method achieving its intended purpose (i.e., fulfilling particular quality assurance responsibilities)? Is the method acceptable to those involved with its application? Could the same effect be achieved at a lesser cost and with less disruption or burden to the service provider?

Data Collection

The information needed for the analyses of the existing quality assurance system will derive from documents and from interviews with key informants. The document review should be conducted first in order to educate interviewers so that they are able to conduct insightful and productive interviews. The document review would cover current laws governing services for retarded population(s) as well as pertinent regulations, policies, plans, purchase-of-service procedures, quality standards, and other relevant procedures thought to affect the quality of services provided.

Interviews should be conducted with knowledgeable representatives of service providers, consumers, quality assurance agencies, and user groups including the following:

- **Providers** -- agencies providing human development services to the target populations of concern;

- **Quality assurance agencies** -- state and local human development agencies that set standards, monitor and evaluate programs, provide technical assistance and training, and enforce program policies;
- **User groups** -- decision-making entities within the legislature, governor's office, judiciary, and so forth that are in a position to act on the information supplied as part of the quality assurance system;
- **Consumers** -- clients, parents, guardians, advocates, and public interest groups.

The users should be queried concerning what information is currently received that is indicative of service quality, under what authority it is received, and how it is used. They should also be asked to identify quality information needed but not currently received, under what authority they might receive it, and how they would make use of it.

The providers should be asked to identify and describe, from their perspectives, the existing quality assurance requirements to which they are subject. They should be asked to comment on the methods' practicality, burden, accuracy, simplicity (technical skills and training required) and utility. They should also be asked to suggest how the method might be improved.

The providers should also be asked questions designed to gain an understanding of the relative health of the major quality assurance mechanisms and quality assurance system generally. Their views are critical since all quality assurance mechanisms are essentially designed to influence the manner in which they provide services. While the responses to such questions are necessarily subjective and impressionistic in nature, the answers can provide a good indication of the relative effectiveness of the quality assurance efforts in the state. Too many answers on the negative side would signal the need to revamp the system and not simply tamper with a few isolated methods.

The quality assurance agencies should be asked parallel questions to

those posed to the users and providers. They should also be asked to elaborate on system duplications, gaps, and overlaps in terms of the state quality assurance responsibilities, providers covered, and measures of service quality employed. The consumer group representatives should be asked to assess their current and desired role in assuring service quality either apart from or as part of governmental and private quality assurance mechanisms.

A sample interview schedule is shown on the next page. The schedule is made up from a number of schedules used in Human Services Research Institute analyses of quality assurance systems in several states (Ashbaugh, et. al., 1983). It is included only by way of illustration and is not intended to serve as a model.

Interview Schedule

Interviewees:

____

____

____

____

Organization

____

date

____

Interviewer

-- ALL RESPONDENTS --

1. **Service Quality Dimensions**

a. What are the dimensions of service quality of most concern to you/your organization?

2. **Roles and Responsibilities**

a. What organization(s) or individual(s) (self-included) do you believe have a role to play in assuring the quality of services provided to (target groups)?

b. Please describe the roles of each party identified.

c. To what extent are these roles presently fulfilled?

d. Are any of these organizational roles overlapping or duplicative? How so?

3. **Existing Quality Assurance Mechanisms**

a. Please identify those quality assurance activities in which you (or your organization) are currently involved.

b. To what extent do you believe each of these activities have an impact on service quality?

c. Is it worth continuing?

d. Could it be improved? If so, how?

e. Are these activities overlapping or duplicative? If so, how?

4. **Alternative Mechanisms**

a. Do you believe there are other things that could be done to better assure service quality?

b. If so, please explain.

5. **Quality Information Detail**

a. What information do you receive reflecting the quality of services?

b. Do you use it?

c. If not, why not?

d. If so, how?

e. What information would you like to have that you do not currently receive?

f. How would you use it?

6. Our charge is to make recommendations for improving the quality assurance efforts in ________.

a. Are there any recommendations you feel strongly that we should make? Please explain.

b. Are there any recommendations you feel strongly that we should not make? Please explain.

-- QUESTIONS FOR PROVIDERS ONLY --

Please mark the point along the continuum that best reflects your situation.

Standards

- Most of the standards against which our performance is rated represent:

minimum achievement	optimum achievement

____

- The achievement of most of the standards:

has no bearing on service quality	are significantly related to service quality

____

Measures

- What % of staff time is spent in records keeping and reporting?

____
0% 100%

- What % of these record keeping and reporting activities are a necessary and important part of doing a "good" job.

____
0% 100%

Monitoring

- Note the number of days per month in which persons from outside the program (e.g., parents, client advocates, surveyers) are present who have an interest in the quality of services we provided.

____
0 30

- Note the extent to which the quality assurance mechanisms influence our administrative practices:

very little very much

____

- Note the extent to which the quality assurance mechanisms influence the way services are provided:

very little very much

____

- We feel we can be open with quality assurance surveyers about practical problems without the threat of sanction: ______yes ______no ______not sure

- Please rate the ways in which information is fedback to your agency from surveyers or others reviewing your performance: spontaneous--delayed; constructive--not constructive; not at all helpful (few good ideas)--helpful (good ideas)

spontaneous delayed

____

constructive   not contstructive

____

- What form does feedback take?

  ____ informal/verbal -- ____ written/formal -- other describe

Control

- Perceived state interest in and support for staff development activities designed to improve the quality of services is:

  note nearly enough   more than enough

  ____

- State recognition of staff and programs for "work well done" is: done rarely, ____done regularly.

- Check those statements, if any, that best characterize your relationship with the state: (1) _______we are in this together; (2) ______ we share common goals; (3) ______we are working toward the same ends; (4) ________the state is more of a hindrance than a help in so far as providing quality services; (5) _______state quality assurance efforts tend to obstruct and hamper our ability to provide quality services.

Documenting the Results

A working paper should be prepared for reference by those persons involved in the design of the quality assurance system. The working paper should document the existing quality assurance system and component methods in operation or planned in the state. More importantly, the working paper should identify the major areas of overlap, duplication, and gaps as drawn from the document reviews and key informant surveys. Finally, the paper should include an assessment of the balance of synergy of the quality assurance system.

Quality Assurance System Design

Having generally assessed the viability of the system of the quality assurance system overall, and having identified gaps, inconsistencies, and inefficiencies in the existing quality assurance system, alternative approaches may be designed to improve the situation. These changes might be system-wide, relative to a particular quality assurance method (e.g., licensing of day care programs), or confined to a particular monitoring, evaluation, or control technique (e.g., the use of unannounced site visiting procedures, or ombudsman control mechanism).

The benefit and cost of each of these alternatives should be estimated (i.e., the expected improvements in service quality or savings in operational costs or benefits relative to the cost of the quality assurance alternative).

System-Level Alternatives

Changes might be proposed in the distribution of organizational responsibilities, and relationships of the quality assurance agencies. For instance, a quasi-governmental quality assurance commission might assume the

scattered responsibilities previously held by a battery of state program offices. Changes might also be proposed in the scope or reach of the existing quality assurance system. For instance, board and care homes might become subject to quality assurance procedures, or family day care programs might be freed of formal public oversight in exchange for consumer discretion. Stronger, more formal ties might be established between the offices responsible for staff development and those offices responsible for monitoring the performance of service providers.

Alternative Methods and Techniques

Changes might be proposed to improve the system balance in terms of the relative concentration of minimum as opposed to higher level standards, in terms of reliance on formal documentation versus less formal feedback on the quality of services provided, in terms of proactive versus reactive monitoring procedures, and in terms of the relative emphasis on persuasive versus coercive approaches to influencing provider practice.

Alternative methods and techniques might also be proposed. For instance, a voluntary accreditation procedure might be more cost/beneficial than the existing state licensing procedure; an on-site review procedure may be more cost/beneficial than the existing reporting procedure, or the use of volunteers for on-site monitoring of programs might be more cost/beneficial than the use of paid on site reviewers.

Management of the Implementation of Change

If the implementation of the planned changes to the quality assurance system is to be successful it should have at least the tacit support and

preferably the outspoken support of those key individuals or organizations whose cooperation is required to establish and maintain the quality assurance alternative. Of course the more far reaching the change in terms of the individuals and organizations involved, the more difficult it is to achieve consensus. System-level changes that entail changes in organizational responsibilities can be the most difficult of all. The political feasibility of each of the alternatives should be thought through before proceeding. Consideration must be given to the major advantages and disadvantages accruing to the key individuals and organizations, and the power each can wield to inhibit or assist with the implementation of the change.

Taken together the changes may be too sweeping to secure the wide-spread support necessary for their adoption; selected changes may be more politically tenable. In this case, the prudent course may be to proceed incrementally with those changes most likely to succeed.

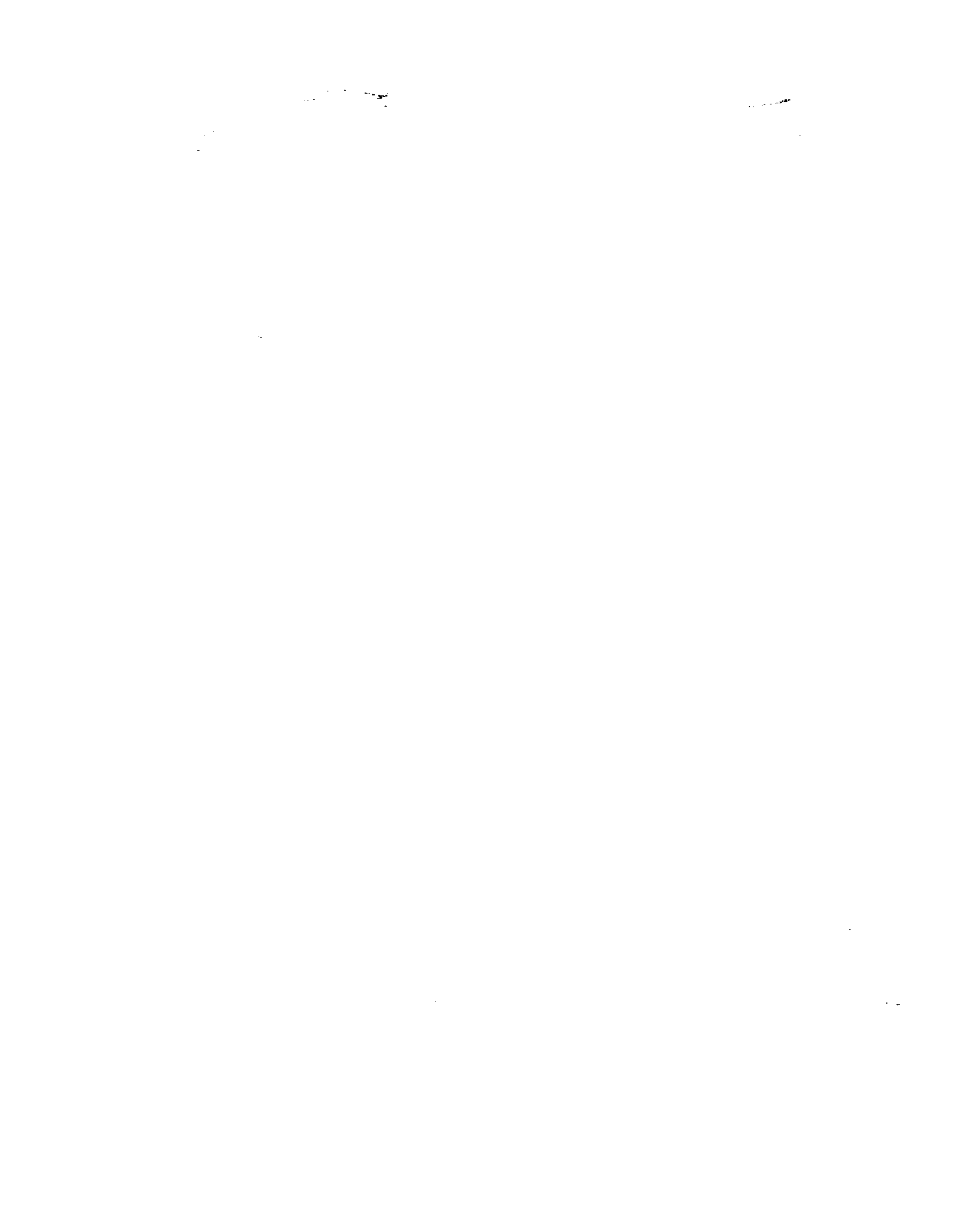
The responsibility for the implementation of the selected changes could logically rest with any number of agencies depending on the organization of the human service programs and related quality assurance functions in the state, and on the scope and direction of the quality assurance changes planned. The lead responsibility for implementing changes confined to the programs administered by a single agency would of course fall to that agency. However, few quality assurance methods lie exclusively within the province of a single agency and necessarily invlove the coordinated efforts of multiple agencies. Accordingly, it is generally a good idea to organize a steering committee to help plan and coordinate the implementation process. The steering committee should include representatives of each of the organizations that are to play a role in the implementation or operation of the quality assurance alternatives planned. In the case of major quality

assurance system reforms, particularly those entailing the redefinition of organizational responsibilities, the most efficacious implementation mechanism may well be to assign an implementation manager or management team full time to supervise the implementation process. By design, the managers or management teams are devoted exclusively to the implementation of the changes and their attention is not diverted to day to day crises. They are accountable for system change.

Chapter V
Methods

The following Chapter includes 22 methods for assessing and enchancing the quality of human development services which exemplify a range of techniques, settings, target groups, and service dimensions. The methods encompass approaches as broad as an entire state service delivery system and as small as one agency. They involve professional quality monitors as well as citizen volunteers, family members and consumers themselves. These methods were chosen from a pool of approaches identified by direct solicitation through human development newsletters and through a review of the literature. Following the selection of a method, site visits were conducted to obtain more information in most instances. The methods were selected because they are reasonably cost effective, have qualities that are likely to enhance as well as regulate quality, and have utility -- in many instances -- across human development programs.

Each method is divided into several components including the purpose of the quality assurance approach, the scope (e.g., one agency, a system of programs etc.), the implementation history of the method, the monitoring process, the analysis process, the use of the quality information for control purposes and the strengths and weaknesses of the approach. Following each method are references (e.g., instruments, reports, etc.), and the name of a contact person from whom further information can be obtained.



1. System for Monitoring Community Residential Services in the State of Colorado

a. Purpose:

To assure the quality of services to developmentally disabled persons residing in community residences.

b. Scope:

The method applies to an estimated 120 adult residential services and Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) in the state. Site visits are made annually to obtain service input and process information. The findings are formally reported to the service provider and the provider is asked for a plan of correction. Follow-up visits are conducted to assure that the corrections have been made.

c. Implementation History:

The method was devised several years ago; it has been in operation since 1978. It is administered by the State of Colorado's Division for Developmental Disabilities.

d. Monitoring Process:

Annual on-site visits are conducted by teams of knowledgeable and concerned volunteers. Most of the volunteers are recruited from local associations for retarded citizens, community center boards, residential service provider staff, state institutions, and the state developmental disabilities council. Volunteers may not review programs in their respective counties and catchment areas. The volunteers are offered one day's in-service training in the use of the monitoring instrument and survey techniques. The instrument is completed through observation, staff interviews, and administrative records review.

e. Analytic Process:

The survey covers the facilities' condition and accessibility, resident programs and services, and management and administrative procedures. Survey items are dichotomous in nature; and the team members must reach a consensus on each item before submitting the survey results to the state office for review and action.

f. Control Process:

The state office prepares a report highlighting those items (service dimensions) rated unsatisfactory. The report is forwarded to the provider along with a request for a formal commitment to improve on those service dimensions. Special follow-up visits may be conducted to assure that critical actions

have been taken, though normally the follow-ups are conducted as part of the subsequent annual review.

The quality assurance mechanisms' influence is a function of the state agency's control over provider funding. However, the use of knowledgeable and concerned citizens and especially peers has reportedly enhanced the provider's acceptance of the review procedure and findings.

g. Strengths:

The use of trained volunteers is an economical approach. The use of knowledgeable peers and citizens enhances the provider's and community's acceptance of the quality assurance procedure and any service changes recommended. The monitoring checklist appears reasonably comprehensive yet straightforward and easy to use. The method has reportedly led to visible improvements in the program and administrative areas since its inception.

h. Limitations:

The method is tailored for use in adult community residences and is not directly applicable to other types of social services. Recommended improvements in the provider's physical plants have not been forthcoming, reportedly due to capital budget limitations over which the state agency has little influence. The monitoring cycle of one year is not sufficient to monitor the service process.

i. Contact: Ray Del Turco
Residential Services
Division of Developmental Disabilities
State of Colorado
3824 West Princeton Circle
Denver, CO 80236
(303) 761-5990 Ext. 370

j. Reference(s): "Checklist for Monitoring Community Residential Services," Colorado Division of Developmental Disabilities, Adopted September 1978 (revised September 1980).

2. New York State Commission on Quality of Care for the Mentally Disabled

a. Purpose:

The Commission was established to:

- advise and assist the Governor in developing policies, plans and programs for improving the administration of mental hygiene facilities and the delivery of services of a uniformly high quality;
- review the cost effectiveness of mental hygiene programs;
- assure the effective investigation of complaints of patients,residents and employees of mental hygiene facilities, including allegations of patient abuse and mistreatment; and
- conduct orientation and training programs for boards of visitors--independent gubernatorial appointees confirmed by the Senate, oversee the quality of care in State psychiatric and developmental centers and provide background and knowledge to the Commission on special problems and issues that arise in these facilities.

b. Scope:

The Commission provides for the monitoring of service quality by a semi-autonomous agency whose functions include client advocacy. The Commission is concerned only with the state mental hygiene system. However, this system encompasses community-based residential care arrangements as well as institutional care arrangements for developmentally disabled persons. The Commission is empowered to monitor all service dimensions on a routine or ad hoc basis. Its routine avenues of control include training or technical assistance, and recommendations for state administrative or legislative action.

c. Implementation History:

The permanent New York State Commission on Quality of Care for the Mentally Disabled was established by Chapter 655 of the Laws of 1977 effective April 1, 1978 to provide independent oversight of all facilities and programs serving the mentally ill, the mentally retarded and developmentally disabled, alcoholics and substance abusers.

The Commission consists of three commissioners supported by a professional staff of 28 and a clerical support staff of 22. The Commission is divided into four bureaus: policy development and analysis, investigations, quality assurance, and legal services.

d. Monitoring Process:

The professional staff of the Investigations Bureau look into client deaths and complaints of abuse. The Quality Assurance Bureau looks into other problems and complaints. The staff conducts site visits of programs to investigate specific complaints, or as part of in-depth studies of more complex problems or issues pertaining to service quality. The visits may be announced or unannounced. The reviews are structured to address particular incidents, complaints, or problems of interest. The reviewers have legal sanction to demand access to all facilities and records.

Members of Boards-of-Visitors (volunteers) also investigate individual complaints of problems arising in state-administered psychiatric and developmental centers. The Commission staff provide technical assistance and legal support to these individuals on request. In addition, the Commission staff conduct workshops and mini-training sessions, and have prepared manuals designed to improve the basic skills of the Boards-of-Visitors in conducting site visits, and in reviewing facility incident reports. The skills relate to the planning and conducting of the visits, exercising reasonable judgments about the quality of care being provided, writing site visit reports, and understanding the incident reporting and review procedures.

e. Analytic Process:

The results of each investigation or study are documented in report form and circulated to each of the bureau chiefs concerned and to each of the three commissioners for review and consideration.

f. Control Process:

The report includes suggested corrective actions. The Commission then meets and decides on the actions necessary to remedy the situation on the part of the provider, administrative agencies, or legislature and makes recommendations accordingly. The providers are required to formally respond to the Commission's findings and recommendations within 90 days. The Commission reports having had much success in gaining the acceptance of its recommendations by the Governor, legislature, and providers.

g. Strengths:

One strength of the Commission's structure is its perceived access to the gubernatorial and legislative decision-makers. A second, is the Commission's wherewithal (professional staff) to conduct the in-depth studies and investigations often required to render a reasonable judgment concerning the quality-of-care and necessary corrections. A third is the Commission's reported power to persuade decision-makers to adopt their recommendations.

This power is thought to be largely attributed to its independent status, reasoned judgments, and perceived objectivity.

h. Limitations:

The Commission represents a major commitment to service quality assurance; it is a costly arrangement.

i. Contact: Gary Masline
Executive Assistant to the Commissioners
New York State Commission on the Quality of Care for the Mentally Disabled
Albany, NY
(518) 473-4090

j. Reference(s): New York State Commission on the Quality of Care for the Mentally Disabled, Annual Report, 1979-80.

3. Evaluation Model of the Rhode Island Council for Community Services (CSS)

a. Purpose:

The method is used to conduct ad hoc, short-term evaluations of human service providers at a minimal cost to inform budget-making, policy-making, and program administrative decisions.

b. Scope:

The method is generic in nature and could conceivably cover the full range of human service arrangements. By design, it can address service outcomes as well as process and input variables. The method does not include a "control" function per se as that is within the province of the agency(ies) requesting the evaluation.

c. Implementation History:

The evaluative method was developed in 1974 using seed money from the Law Enforcement Assistance Administration. It has been applied in the succeeding years to evaluate a variety of human service programs. The Council conducts these evaluations on request from administrative agencies and from providers themselves.

d. Monitoring Process:

The monitoring is completed by a team of two to three volunteers. These volunteers are selected according to their knowledge and skills relating to the program slated for evaluation. The teams typically visit a provider a half dozen times during the evaluation period. Depending on the evaluation requirements, team members will conduct staff and client interviews, observe the service delivery process, and review administrative and case records.

e. Analytic Process:

The evaluative process consists of a formative and a summative stage. In the formative stage, the CSS "evaluator" prepares a synopsis of the program objectives, methods, and evaluation feasibility (parameters) based on available information and discussions with the program director. Then an evaluation design is constructed in collaboration with the program director(s) and volunteer team members at an initial site visit. The analysis generally includes findings relative to

project outputs, processes (management and operations), and client outcomes. The results of each site visit are fed back to the program directors as the evaluation proceeds for their review and comment. The evaluator prepares report(s) based on the findings of the survey team and according to the agreed-upon performance measures contained in the evaluation design. The volunteers have the power to approve, revise, or even reject the report(s). Similarly, the project director(s) and funding agency may review and negotiate how the findings and recommendations are presented and to whom.

f. Control Process:

As noted earlier, the method does not encompass a formal control element. However, the on-site review team is encouraged as a matter-of-course to provide technical assistance as appropriate during the on-site visits.

g. Strengths:

The method is well suited for obtaining quality information in a timely fashion for decision making purposes. The method is economical to employ. An evaluation generally costs between $5,000 and $10,000. The method can be designed to include the research controls necessary to assess client outcomes in a reasonably reliable fashion; such controls are often not feasible to employ in a continual, less intense, monitoring process. The participation of the project managers in the design, the continual feedback provisions, and the ability to review and negotiate with the CSS evaluator on how the findings and recommendations are finally reported induces more providers to accept and cooperate in the evaluation process than would otherwise be the case. The formative stage of the evaluative method can bring into focus some of the more important and problematic service dimensions; this is in contrast to many monitoring procedures that routinely hold to less important and even extraneous dimensions.

h. Limitations:

As an exception-oriented method, the method is not designed to actively uncover service quality problems; the method is passive. The evaluator has little autonomy and may find it difficult, if not impossible, to attempt to identify and air critical service faults. This may be precluded in the design, or in the report-review stages.

i. <u>Contact</u>: Richard Graefe
Council for Community Services, Inc.
229 Waterman Street
Providence, RI 02906

(401) 861-5550

j. <u>Reference</u>: Unpublished paper, Beverly Kreis, "Evaluations by the Council for Community Services, Inc.," 5 pages, May 1980.

4. Program Review Process of the San Diego County United Way Office

a. Purpose:

To direct United Way funds and other support to those providers "responding to the most urgent needs of the community as identified by research and study techniques," and to those programs that "are efficiently using the money to provide effective programs of service to the community."

b. Scope:

The program review process applies to all providers funded by United Way. This includes a broad spectrum of social service agencies.

c. Implementation History:

Annual program reviews have been in operation since 1972 at the San Diego United Way, as they have in most other United Way offices around the country. In 1980, the San Diego office, in consideration of the service providers need for a stable funding base of at least three years and to make the most effective use of the volunteer reviewers' time, moved to a format of one in-depth review every three years with limited reviews in the interceding two years.

d. Monitoring Process:

A panel of four to six volunteers are organized each year and are given a short training session on how to conduct the on-site reviews. Each panel conducts one in-depth review and two limited reviews each year. The in-depth reviews entail at least one on-site visit by the panel as a group, and three or four meetings (off-site) to discuss the provider's achievements relative to the service objectives established, service needs (priorities), and United Way management guidelines. The primary purpose of the in-depth review is to determine the provider's eligibility for continued support by United Way, and to decide the amount of their base allocation for the following three years. Panels may call on volunteers with specific expertise relative to the program in question to advise them concerning the in-depth review. The limited reviews entail more informal, pre-arranged visits by the individual panel members during the year.

The member agencies are required to provide the following programmatic information to assist the volunteers in their review:

- Program objectives achievement report (annually);

- Management self-evaluation study done according to a United Way guideline (every third year);

- Description of program objectives and services (annually).

e. Analytic Process:

The volunteers' judgment is informed by the program achievement report, management self-evaluation study, as well as by their on-site observations and interviews. However, volunteers are allowed considerable latitude in judging the quality of the services being provided, and concerning the community's need for (appropriateness of) the services--factors central to their recommendations for continued United Way support. In other words there is no formalized scoring regimen.

f. Control Process:

The decisions regarding agency funding are entirely in the hands of the volunteers organized into three decision making levels: program review panels, allocations committee, and planning-allocations-research council. The panels make formal recommendations to the allocations committee regarding the agencies under review and their allocations for the coming year.

The Allocations Committee is composed of a chairperson, (appointed by the chairperson of the Planning Allocations Research Council), and the chairperson (or his/her representative) of each Program Review Panel. The Allocations Committee coordinates the activity of the Review of Panels and acts on all recommendations regarding agency allocations. One third of the member agencies will be eligible for Base Allocation adjustment each year. Two thirds will have recommendations made concerning the automatic increment (in accordance with the multi-year funding policy).

The Planning Allocations Research Council makes the final decisions regarding all annual allocation recommendations. The Chairperson of the Allocations Committee is a member of this Council.

g. Strengths:

The method is quite economical to employ as it relies entirely on volunteers. Further, because funding allocation decisions are made by volunteers from the communities served, it's logical to assume that the decisions would be consistent with the community's interests. The method has been operational for many years at the United Way agencies throughout the country.

h. Limitations:

The effectiveness of the program review process depends heavily on the knowledge and experience of the volunteers, and on the caliber of the training and technical support provided them. The United Way has reportedly had a difficult time recruiting qualified volunteers, and recognizes the need to strengthen the volunteer training and review techniques and performance standards or guidelines.

i. Contact:

Debrah M. Elliott
Director
Allocations and Agency Relations
7510 Clairement Mesa Boulevard
San Diego, CA 92101
(619) 292-4455

j. Reference(s):

Planning, Allocations, and Research Divison, "Allocations Procedures: Five Manuals," United Way of San Diego County, San Diego, California (1980).

5. Citizen Evaluation with Program Analysis of Service Systems (PASS) in Lancaster County, Pennsylvania

a. Purpose:

To assure the quality of services being provided to persons who are mentally retarded, mentally ill, or substance abusers in accordance with a state law requiring county administrators to conduct annual reviews of these services.

b. Scope:

The method is currently applied to providers of services to the mentally ill, the developmentally disabled, and substance abusers. According to the authors, the PASS method also could be applied to services provided other disadvantaged groups. The quality measures are based on the ideological principle of "normalization." They center on the extent to which the program enhances each individual's growth and sense of worth both from his or her own standpoint and that of the larger community. More specifically, the method attempts to capture the extent to which the lives of the clients are physically and socially integrated with the lives of the members of the larger community, the normalcy of the program's physical and social environment, and the opportunities for client growth and development. The measures cover service processes and products, as well as the administrative, staffing, and financial aspects of the provider's operation.

c. Implementation History:

The annual citizen reviews were begun in 1975. The citizen review methodology was developed by the Lancaster County Mental Health/Mental Retardation Program office. Approximately 400 local citizens have volunteered to serve as evaluators to date with many returning year after year.

d. Monitoring Process:

Each year volunteers are recruited through the press to serve as program evaluators. Each evaluator receives two days of training on the values embraced by the concept of normalization, and on the use of the PASS instrument in evaluating programs.

Each year at least five programs are selected for evaluation, and on-site review teams comprised of 5-6 volunteers are formed to do the evaluations. The team leader makes a preliminary visit to the provider to establish the review protocols. The agency director is asked to complete a pre-site questionnaire and this is shared with site teams members prior to the site visit. Each team member uses the PASS instrument to rate the agency based on what s/he heard and saw during the site visit.

e. Analytic Process:

After the visit, the team gets together and completes the agency rating. Team members discuss each element and rating and attempt to arrive at a group consensus.

When the team completes the rating, a narrative is written describing the agency's strengths and areas where improvement is needed. This narrative is prepared in draft form and is sent to the agency. Subsequently, the agency has a chance to correct any misconceptions.

The PASS ratings are criteria-based, the criteria having been established by the founders of PASS. The ratings purportedly can be compared across settings.

f. Control Process:

The team leader conducts a final review of the agency report. This is sent to the agency and a debriefing occurs. Following this session, the report is forwarded to the Program Evaluation Committee of the community MH/MR board. THe Program Evaluation Committee receives and reviews the reports. The committee comments are added to the site report and the whole set of site visit reports are forwarded to the MH/MR board. After the Board takes action, a letter is sent to the agency evaluated listing recommendations and findings along with a request that the agency file an action plan and a response. The County Administrator of the Mental Health and Mental Retardation (MH/MR) program is responsible for follow-up.

The County MH/MR Administrator and Board also consider the results in making funding decisions.

g. Strengths:

- The PASS instrument has been extensively pre-tested.
- The method has reportedly engendered much community support.
- The PASS scores can be compared between like providers.
- The method is relatively economic to employ.

h. Limitations:

Site visits are scheduled less than once per year.

i. Contact: Stanley M. Nelson
Administrator
Lancaster County Office of Mental Health and Mental Retardation
Drug and Alcohol Abuse Programs
50 North Duke Street
P. O. Box 3480
Lancaster, PA 17604
(717) 299-8021

j. Reference(s):

Wolfensberger, Wolf and Glenn, Linda, Program Analysis of Service Systems 3: A method for the Quantitative Evaluation of Human Services, Field Manual. National Institute on Mental Retardation, Downsview, Toronto, Canada, Third Edition (1975).

PASS III Workshop Materials, Lancaster County Office of MH/MR-DA (January 1980).

Hinkle, John, and Hinkle, Kathy, PASS 3 Workbook, Lancaster County Office of Mental Health/Mental Retardation and Drug Abuse (January 1979)

Olds, Maryilyn Lee, and Hinkle, Kathy, Citizen Evaluation: Family Counseling Center for Lancaster General HOspital and St. Joseph Hospital Alcohol Detoxification Unit, Lancaster County Office of Mental Health/Mental Retardation and Drug Abuse (April 1978).

Bonfield, Marilyn B., and Olds, Marilyn Lee, et. al., 1978 Citizen Evaluation: MH/MR Service Unit 1 and 2, Community Services, Inc., Conestoga West Apartment Program, Londis Homes Friendship Community, and Prospects Associates, Inc., Children Group HOme, Lancaster County Office of Mental Health/Mental Retardation and Drug Abuse (1978).

Blue, Susan, and Olds, Marilyn Lee, 1978-1979 Citizen Evaluation, Crisis Intervention Center, Lancaster County Office of Mental Health/Mental Retardation and Drug Abuse (1979).

6. Client Follow-up System of the Family Service Association of America

a. Purpose:

To track the satisfaction of family service agency clients with the quality of services received, to help agency staff improve the quality of their services, and to support agency funding requests.

b. Scope:

The method was developed for use by family service agencies, but according to the authors could be adopted for use in other service agencies as well. The client survey focuses on the clients' perceptions of the problem(s) that brought them to the agency, client satisfaction and global evaluations of service-related outcomes, and client suggestions for improving the service.

c. Implementation History:

The method was developed by the Family Service Association of America (FSAA) based primarily on their experience in completing a client census in 1970. It has been implemented for several years by some of the larger family service agencies throughout the country, e.g., Boston, New Orleans and Miami. Agencies are free to to use whatever segment of the methodology they choose.

d. Monitoring Process:

Follow-up interviews or questionnaires are completed with a random sample of recent cases closed. Case-workers (active and retired), students, board members, and volunteers are responsible for conducting interviews and/or monitoring questionnaire returns.

Both long and short interview/questionnaire forms have been developed for use by local agencies.

e. Analytic Process:

To the extent that an agency uses the standard questions, its findings may be compared to the FSAA's accumulated national findings as part of a normative analysis. There is no charge for this FSAA service. The agency also may assess the findings based on their own performance criteria.

f. Control Process

Agencies may choose to share the results of with members of the staff, board, press and others, or they may simply use the results to improve their practice.

g. Strengths:

- The FSAA has developed response norms, a must for the meaningful interpretation of subjective client survey information.
- The method is relatively simple and economic to employ.

h. Limitations:

- The instrument is tailored to FSAA services.
- The method is applied routinely by relatively few Family Service Agencies.
- The method represents a self-monitoring rather than outside-monitoring tool.

i. Contact: Dr. Dorothy Fahs Beck
Family Service of America
44 East 23rd Street
New York, NY 10010

(212) 674-6100

j. Reference: Beck Dorothy F., and Jones, Mary Ann, How to Conduct a Client Follow-up Study. Family Service Association of America, New York, NY, Second Edition (1980).

7. Commission on Accreditation of Rehabilitation Facilities (CARF)

a. Purpose:

This independent, non-profit organization was created to accomplish the following objectives on a nationwide basis:

(1) To upgrade the rehabilitation facility movement and improve the quality of services provided to people with disabilities.

(2) To offer, through accreditation, to the general public and providers, purchasers, and recipients of facility services a single means of identifying throughout the nation those facilities in terms of concepts and services which are rehabilitative in nature and competent in performance.

(3) To develop and maintain relevant standards which can be used by facilities and programs serving people with disabilities in order to measure their level of performance and strengthen their programs.

(4) To provide through the accreditation process an independent, impartial, and objective system by which facilities and programs can have the benefit of a total organizational review.

(5) To offer to the facility, the community and consumers a mechanism of program accountability, and assurance of a continuing high level of performance.

(6) To feed back information to facilities and other organizations based upon aggregate findings obtained in site surveys in order to share basic data on common strengths and weaknesses of facility operations.

(7) To provide an organized forum through which all involved in serving people with disabilities can participate in standard-setting and program improvement.

b. Scope:

The CARF review covers program inputs, processes and outcomes of rehabilitation and habilitation facilities. It has standards for facilities in hospital-based rehabilitation, spinal cord injury programs, chronic pain management programs, outpatient medical rehabilitation, infant and early childhood developmental programs, vocational evaluation, work adjustment, occupational skill training, job placement, work services, activity services, residential services, independent living programs, and psychosocial programs. The settings of programs which the Commission surveys and accredits include: both

freestanding facilities and rehabilitation programs operated as units of larger institutions such as hospitals and medical centers; and private non-profit proprietary and public agency-operated facility programs. CARF is currently developing standards for brain injury programs.

c. Implementation History:

CARF was created in 1966 by the merger of two previously separate rehabilitation facility organizations. It is sponsored by six national voluntary organizations: American Hospital Association, American Occupational Therapy Association, Goodwill Industries of America, National Association of Jewish Vocational Services, National Easter Seal Society, and United Cerebral Palsy Association. Associate Members include: American Academy of Physical Medicine and Rehabilitation, National Association of Rehabilitation Facilities, American Spinal Injury Association, and National Rehabilitation Association. During the first seven years of its operation, CARF focused on the inputs of rehabilitation facilities, number and levels of staff, types and levels of service provided, and physical plant. In 1973, CARF began to develop standards for evaluating the outcomes of rehabilitation facilities. Between 1974 and 1979, CARF was actively engaged in planning, resource development, and training activities to further the growth of results-oriented evaluation in a wide range of rehabilitation settings. Based on this work, CARF has developed standards for assessing the evaluation programs of rehabilitation facilities.

d. Monitoring Process:

Participation in a CARF review is voluntary. CARF will review a facility only on request by that agency. The facility under review bears all the costs of the review. The review is started when the facility contacts CARF in Tucson, Arizona. The facility orders from CARF a copy of the Standards Manual For Facilities Serving People With Disabilities and if they so choose the accompanying Self-Study Questionnaire. The facility staff reviews the standards and may conduct a self-assessment using the questionnaire developed by CARF. If the facility believes it is ready for a site survey, it makes a formal request to the Commission. Approximately 90 days after the formal request, a site survey is conducted. CARF maintains a list of survey consultants with various specialties in services to people with disabilities. The site survey team is drawn from this list and an effort is made to use specialists in the same geographical area as the facility, but not in the same state.

The team spends about one and one-half days in the facility applying the CARF standards, and making determinations of the strengths and weaknesses of the facility's programs. Direct observation and staff interviews are the chief data collection methods. The survey team prepares a report and submits it to the

CARF Board of Trustees which makes the final accreditation decision. The facility is then notified of the action taken by the Board and receives a written report summarizing the survey findings. This report identifies facility strengths as well as contains specific recommendations for improving program deficiencies. All information obtained in the accreditation process is held in confidence by CARF.

e. Analytic Process:

Since 1966, the Commission on Accreditation of Rehabilitation Facilities has been refining its review standards. The standards are qualitative. Facility practices are compared with the standards for that type of facility contained in the CARF Standards Manual.

f. Control Process:

Participation is voluntary; that is to say, control is elective. However, a number of public agencies and insurers require CARF accreditation as a condition for third party payments to the facility, so CARF does exercise a degree of indirect control. Based on the site survey results, CARF can make one of the following determinations:

- Three-Year Accreditation. Although there are deficiencies, the facility shows substantial fulfillment of the standards, and its program personnel, the documentation clearly indicates that present conditions represent an established pattern of total facility operation so as to give confidence that these conditions are likely to be maintained and/or improved over the foreseeable future.

- One-Year Accreditation. The facility has significant deficiencies, but shows evidence of capability, commitment, and progress in their correction. On balance, the program is benefiting its clientele and there is no serious threat to their health, welfare, and safety.

- No Accreditation. The facility has major deficiencies in several areas of standards, to the extent that there is serious question as to the rehabilitation benefits, health, welfare, or safety of its clientele, or the facility has failed to bring itself over time into substantial conformance with the standards.

- Twelve-Month Abeyance. A facility may be found to approximate, but fall short of, one-year accreditation because of the presence of certain critical conditions affecting the service benefits, health, welfare, or safety of persons served. If, in the judgment of the Commission, there is both a willingness and a capability on the part of the facility to correct these conditions, then the decisicn

of the Commission's Board of Trustees to accredit or not accredit will not be made until the facility is provided up to twelve months to correct these problems. Verification of corrective action is made via the mail or through a return visit, as appropriate. The final decision on accreditation is then made on the baiss of the basic survey visit and corrective action findings.

The Commission does not expect a facility to be in full compliance with every applicable standard.

g. Strengths:

- CARF uses standards that are well-established and accepted by the rehabilitation and habilitation field.
- The Commission provides materials to help a facility decide whether it is ready for a formal review.
- It is inexpensive. The average cost to the facility is reported to be about $2160.
- The method can be applied to a wide range of rehabilitation and habilitation programs and settings.

h. Limitations:

- Participation in the accreditation process is voluntary unless there is a state mandate. If there is no mandate requiring accreditation, substandard facilities not wishing to be reviewed are not subject to the CARF process.
- Direct client or community involvement in the review process is limited to interviews with board members, representatives of third party funding agencies and to clients, with facility approval.

i. Contact

Alan H. Toppel, Executive Director
Commission on Accreditation of Rehabilitation Facilities
2500 North Pantano Road
Tucson, Arizona 85715
(602) 886-8575

j. References: (all published by CARF)

Standards Manual For Facilities Serving People with Disabilities, 1984
Self-Study Questionnaire, 1984
Directory of Accredited Facilities, 1984
Program Evaluation: A First Step

Program Evaluation in Inpatient Medical Rehabilitation Facilities
Program Evaluation in Outpatient Medical Rehabilitation Facilities
Program Evaluation in Speech-Language & Audiology Facilities
Program Evaluation in Vocational Rehabilitation Facilities
Program Evaluation in Work Activity Facilities
Program Evaluation: Utilization & Assessment Principles
Program Evaluation: A Guide to Utilization
Program Evaluation: An Outline for Rehabilitation Educators

Brochures

The CARF Report
The CARF Story
Serving People With Disabilities...An Investment in Results
Developmental Disabilities and CARF...A Commitment to Quality Services
The Issue is Industrially Disabled Workers

8. Home Care Quality Control Project, New York City Human Resources Administration

a. Purpose:

To ascertain whether home care services (homemaker, housekeeping and personal care) are being delivered by vendor agencies as specified by contract, and once delivered, whether the nature and quality of those services are at an acceptable level. The method is also being used to establish the relationship between the quality of service provided and the number of hours of care authorized. This will help HRA in negotiating contracts with vendors once standards have been set.

b. Scope:

The Home Care Quality Control Project covers the following components of home care:

- cleaning/laundry/meals
- personal care
- home management
- overall client satisfaction

The method is concerned with inputs (assessment of provider), process (what happens when provider is present?), and outcomes (how good a job does the provider do?). The method does not cover home health services. Its applicability to other service areas is very limited, although within the range of home care services it appears to have wide applicability.

c. Implementation History:

This method is still being tested. The design work was completed in April, 1981. Quality Control Unit was established in the Office of Home Care Services (OHCS) and a monitoring questionnaire was developed. The questionnaire was based on a literature review, regulatory analysis, and the experience of OHCS staff. The method was pre-tested in May and June, 1981. Based on this pre-test, the monitoring instrument was revised and full-scale pilot testing began on June 8, 1981. Concurrently with the pilot testing, written standards are being developed so that the questionnaire's validity and reliability can be documented.

In October, 1981, the project went to automated tabulation and analysis of field data. Also at that time, the field staff expanded to twenty-five from its original size of ten. The project has the enthusiastic support of the agency director.

d. Monitoring Process:

Monitoring is conducted by senior homemakers, who have delivered home care services themselves for an average of 17 years. Their experience as homemakers enhances their ability to evaluate the efforts of home care vendors. Unannounced visits are made to

clients currently receiving homemaker/housekeeper services from the vendors under review (seven vendors serving over 1300 clients were included in the pre-test). Neither the vendor agencies nor the individual providers know when the visit will occur. Although these unannounced visits mean a somewhat lower percentage of completed interviews than would be possible if appointments were made, OHCS believes it can obtain a more realistic appraisal this way. The monitor goes through the questionnaire with the client, asking how satisfied the client is with the aspects of care provided. The monitor also examines the premises and assesses the quality of care provided. The method does not require the vendor to fill out any forms or disrupt its operations in any way. The validity and reliability of the instruments have not been documented.

e. Analytic Process:

The results are tabulated and analyzed by computer. The analysis plan is still under development. There is no numerical score for each of the questions covered by the instrument. OHCS hopes to establish a numerical rating system over the next year of field testing. Their intention is to be able to produce a single summary statistic for each individual provider monitored and then aggregate those ratings into an overall measure for the vendor agency. They will also develop numerical ratings and standards for each component of the home care service (e.g. cleaning, personal care, provider attendance) so that vendors can be evaluated and compared on the performance of specific tasks. The year of field testing is designed for the collection of baseline data which will be used to establish service standards.

f. Control Process:

The intent of the method is to monitor vendor agencies, not individual providers. OHCS will develop a statistical description of the performance of its vendors on the ratings of the individual providers employed by these vendors. Vendors found to be performing below standards will have opportunities to discuss performance problems with OHCS staff, and receive additional training. Cancellation of a vendor contract will be the possible outcome of continued below-standard performance but OHCS prefers to encourage rather than punish its vendors,if possible.

g. Costs:

The annual cost of the project is approximately $500,000.

h. Strengths:

- The method is particularly simple and has the potential to be quite cost-effective. It uses the work experience of senior homemakers to provide a basis for monitoring the performance of home care vendors. The monitoring is done in the client's home so service outcomes can be observed directly.

- Client satisfaction data is also obtained through client interviews.

- The questionnaire is relatively straight-forward and requires relatively little training to administer.

- Once validated in the New York field test, the Home Care Quality Control project can be easily adopted by other agencies who are able to obtain experienced homemakers as monitors.

i. Limitations:

- The method is probably not transferable beyond the broad category of home services.

- By relying on unannounced visits, OHCS has decided to accept a low rate of successfully completed visits (60% in the pre-test) in exchange for the chance to observe actual daily conditions.

- By relying solely on the observations of one person, there is a possibility of some rater bias in assessing the cleanliness (or any other aspect) of the client's home. OHCS has assigned ten homemakers to the Quality Control Unit. With this number of monitors, the impact of any individual rater bias should be greatly reduced.

- The method is still in the demonstration stage, it has not been fully tested and validated so its ultimate utility has not been proved.

- OCHS staff developed the questionnaire without any input from clients or the vendor agencies to be monitored.

j. Contact: Carol Raphael
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Human Resources Administration
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New York, N.Y. 10003
(212) 420-7499

k. Reference(s): Home Care Quality Control, Pre-pilot Questionnaires: Summary and Results

9. Child Development Program Evaluation System of the Commonwealth of Pennsylvania

a. Purpose:

To license, monitor and evaluate private, state and federally-funded child day care programs in Pennsylvania. These programs include day care centers and family day care homes.

b. Scope:

The Instrument-Based Program Monitoring/Child Development Program Evaluation (IPM/CDPE) is used exclusively for child day care programs. Its applicability to other services is limited to service areas in which the physical setting for service provision is an important element. In fact, the state is considering using the the method to monitor the quality of care in day programs for developmentally disabled individuals. All the items on the instruments have been validated in child day care settings. Federally-sponsored research is underway to validate the IPM/CDPE in other states. The instruments cover the following day care components:

- administration
- environmental safety
- first aid
- nutrition
- emergency preparedness
- transportation
- training
- record processing
- record content
- dental health
- staff health
- health services
- child development
- special needs
- social services
- parent involvement

c. Implementation History:

IPM/CDPE was developed in response to the 1977 Federal Interagency Day Care Requirement for states to monitor child day care programs using federal funds. CDPE was eventually adopted as the state licensing instrument for all child day care providers in Pennsylvania. Two separate tools were developed, one to monitor day care centers and one to monitor family day care homes. Participation was solicited from professional organizations, administrators and providers of day care services, and regional and central office Pennsylvania Department of Public Welfare (DPW) Staff.

The initial draft of items began with a review of the prototype instruments by the instrument developers with day care program staff of the Northeast and Southeast Regional Offices. Then, there were reviews by DPW Regions, content and format consultants, day care providers and administrators, and task force groups that included representatives of DPW staff, providers and content consultants. Based on the participation and suggestions of these individuals, and on the results of two sets of field trials, the instruments underwent three complete revisions. Field tests were completed in 1979. The method is now generally accepted by providers across the state. Staff believe that the clarity and objectivity of the IPM/CDPE were major factors in generating this acceptance.

d. Monitoring Process:

Monitoring consists of the application of the CDPE instrument. The instrument has four major parts. Part 1 is a general background section to be completed by the DPW program specialist prior to the site visit. It includes a pre-site visit mail-out that is sent to the program to be monitored. Self-administered questionnaires make up Part 2. This part includes instruments for the day care center program staff, and for Title XX programs, for the chief officer of each policy or advisory group which directly influences the program. Part 3 consists of two components, a review of program records and a self-administered questionnaire for parents of program clients. The last part includes a site observation protocol and a caregiver questionnaire to be administered by the DPW program specialist. Administration of the CDPE takes approximately eight hours. Separate CDPE instruments have been developed for day centers and family day care home providers.

The program was developed and is administered at the state level. The rating of facilities, however, is performed by regional office staff.

e. Analytic Process:

The scores are tabulated manually. Each program receives a summary numerical score as well as a score in each of the sixteen child day care components. Each component is "risk-weighted," given a weight that reflects the importance of that component to the safety and well being of the child. Each provider receives a copy of the scored instruments with an analysis by the DPW program specialist. Regional and central staff receive aggregated ratings.

f. Control Process:

Successful completion of the CDPE is necessary for day care licensure in Pennsylvania. Licenses must be renewed every year so all providers are assessed annually. As part of the analysis of early providers CDPE performance, a training and technical

assistance plan is developed. Providers can be put on "probation" until they come into compliance with the standards reflected in the CDPE. Licenses are rarely revoked; the emphasis is on improving provider practice.

Analysis of summary numerical scores rating degree of compliance shows substantial improvement in the level of compliance. The professional staff performing the evaluations also feel that they have seen marked improvement in the overall quality of day care.

g. Costs:

The initial development costs of the monitoring system in Pennsylvania were about $400,000. Annual incremental costs of running the instrument based monitoring system are about $50,000. While no formal cost-venefit analysis of the program has been completed, there is evidence to suggest that these added costs are more than justified by other cost savings in the overall cay care monitoring. For example, the number of licensure evaluators has been reduced; the average time needed for an evaluation has decreased; and there are fewer reassessments required.

h. Strengths:

- Every item in the CDPE has been validated in field tests.
- The method uses a variety of techniques: observation, desk audits, agency records and client and staff interviews.
- All day care providers are monitored annually.
- CDPE covers all aspects of child day care programs.
- A strong control process is built in.

i. Limitations:

- CDPE itself can only be used in child day care, although the approach could be used in other areas.
- Much of the instrument is devoted to regulatory compliance (input-related) issues.
- Use of CDPE requires special training.

j. Contact:

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Office of Children and Youth
Department of Public Welfare
Harrisburg, PA 17120
(717) 787-2724

k. Reference(s): Child Development Program Evaluation - Data Collection Manual

Child Development Program Evaluation - CDPE Report 1978-1980

CDPE Instruments For Child Day Care Centers

A series of theoretical papers by Richard Fiene, Director of Information Systems, Office of Children and Youth

(Please see page 267 for a more recent update on this method)

10. Voluntary Family Day Care Training Program of Fairfax County, Virginia

a. Purpose:

To provide voluntary training to family day care providers who serve five or fewer children, to identify these providers who have received training in the community, and to encourage family day care users to select trained providers.

b. Scope:

Only unlicensed family day care providers are included in the program. They receive a 40-hour course in child development, parent-provider relations and Red Cross health and safety guidelines. The county does not have an estimate of what percent of all family day providers have received this training.

c. Implementation History:

Under Virginia law, family day care providers serving five or fewer children are not required to be licensed by the state. Fairfax County recognized in 1975 a need for improving the quality of care offered by unlicensed providers and for helping consumers choose providers who offer high quality day care. The county chose not to pursue a regulatory compliance approach for improving care for children. The county created the Office for Children in 1976 to plan for, direct and coordinate present and proposed child care programs. The Office for Children developed a curriculum for providers and 95 providers volunteered for training in the first year. The Office for Children prepared a register of these trained providers that is distributed, on request, to parents seeking family day care. The number of providers trained has increased annually to the current figure of over 200.

Since its inception in 1976 over 650 providers have been trained in the program. Two to three hundred additional workers have been similarly trained under a Title XX contract. They receive at least 500 calls per year from persons who would like to attend classes, but can only train about one hundred per year. There is always an active waiting list of 50 persons waiting to take the class.

d. Monitoring Process:

This method does not provide any monitoring.

e. Analytic Process:

This method does not involve any analysis.

f. Control Process:

There is no direct control in the Fairfax County Voluntary Family Day Care Training Program. Indirect control of providers is obtained through the compilation and dissemination of a list of providers who have received training, along with a brochure from the Office for Children on how to select a family day care provider. Quality of care is not monitored and no inspections are made of the provider's home. Providers are removed from the list only if child abuse is reported or suspected. The method has been widely accepted in Fairfax County with approximately 350 requests monthly for the list of trained providers. The Office for Children has no information on how often trained providers are selected over untrained providers. Providers, and the provider network, the Virginia Family Day Care Association, have accepted the method and there is now a long waiting list for training.

g. Costs:

Costs of the program are minimal. The single County funded position for a family day care trainer can be used to train about 110 providers annually. The trainer handles two classes, which meet twice a week for two and a half hour sessions. The instructor uses the remainder of the time to provide continuing assistance to former participants in the program. An additional cost of $15,000 per year is incurred by the program to cover child care costs of participants while they are training.

h. Strengths:

- The method relies on the operation of the market for day care to assure the quality of care. It informs consumer choice which affects provider behavior rather than directly regulating provider activities.

- Since the county only employs one full-time family day care trainer and does no follow-up or on-site monitoring, it is relatively inexpensive.

- It gives consumers a way of judging the quality of providers in that part of the day care industry which is not licensed by the state.

i. Limitations:

- There is not necessarily a connection between participation in the training and the provision of quality services.

- As long as demand exceeds supply of family day care, untrained providers will most likely not suffer any adverse market effects from not participating in the voluntary training.

- Not all day care consumers use the list of trained providers from which to select providers.

- The county does not collect any data on the effectiveness of the program.

j. Contact: Judith Rosen, Director
Bonnie Arnold, Family Day Care Trainer
Fairfax County Office for Children
10396 Democracy Lane
Fairfax, VA 22030

(703) 691-3175

k. Reference: "Fairfax County, Family Day Care Training Program," Case study prepared for 1978 National Association of Counties Achievement Award Program. (no longer in print)

11. Self Evaluation Manual for Human Services Organizations of the Greater New York Fund/United Way

a. Purpose

The self evaluation manual was developed to improve agency evaluation. The specific purposes of the manual are to:

- improve effectiveness of services provided by human service organizations;
- facilitate development of improved information for management decision making, orientation of new staff and presentation to external funding agencies;
- promote expanded communication among agencies about program effectiveness by sharing evaluation information developed according to a common format.

b. Scope:

The self evaluation manual is generic in nature and its use is voluntary. Its design allows for use by the full range of human service agencies and addresses the program dimensions of input, output, process and outcome. Its focus is on evaluation at the program level with an emphasis on individual case outcome assessment. The manual provides a generalized framework furnishing step-by-step procedures for agencies and programs to identify and define their mission, goals and objectives and to apply measurement instruments at the agency, program and case levels. Its common format allows for cross-agency comparison.

c. Implementation History:

The Greater New York Fund/United Way is the funding agency for the United Way of New York City which is comprised of 350 member agencies. In 1976, in response to concern about accountability and a need for improved management and planning, the Fund's board of directors established an evaluation assistance committee to develop a plan for a self evaluation system. In 1977, a pilot project of three agencies was launched to test the newly developed system using the self evaluation manual. The manual proved to be a success and is now available for use by all United Way human services agencies in the Greater New York Area.

d. Monitoring Process:

Monitoring takes place by means of a work group comprised of representatives from all levels of the organization -- board of directors, agency administrators and professional staff. Their role may vary from an oversight committee to an action committee. The purpose of the work group is to:

- adapt the methodology suggested in the manual to meet the unique characteristics of the organization;

- share the experience of developing self evaluation with board members, administration and staff;

- provide direct assistance to administrators and staff in implementing the evaluation process.

e. Analytic Process:

Data that has been collected by the staff over a designated period of time is aggregated either manually or by automated systems. A comparison of actual results with pre-defined objectives is conducted. The comparative data is then combined with staff experience during the evaluation period to assess:

1. the degree of success and/or failure in meeting the objectives;

2. the extent to which each case and program has progressed toward its goals;

3. the significant factors contributing to these results.

The work group analyzes this information and prepares its conclusions for use in the agency's planning process.

f. Control Process:

Since particpation in self evaluation is voluntary, control is elective. However, once an organization chooses to participate in the United Way self evaluation, the agency's board of directors becomes responsible for continuity in the self evaluation process and holds the executive accountable for the control process. The control process commences with a list of the problems identified in the analytic process. Strategies to overcome the problems are developed by the work group. Methods for possible program improvements are also defined. The executive then ensures that these are taken into account in planning and budgeting for the future. The Greater New York Fund/United Way does not take an active role in overseeing the use of the data produced for planning and management.

g. Strengths:

The self evaluation manual provides the following benefits:

- a better and shared understanding of what an agency is expected to achieve;

- a more specific definition of progress or success for individual cases;

- a more pronounced focus on outcomes and results;
- better information for planning and decision making;
- increased accountability to funding sources through documented benefits to clients;
- improved ability to demonstrate to consumers and the public a real concern about program effectiveness.

h. Limitations:

- Particpation is voluntary, therefore, programs not wishing to participate are not subject to the self evaluation process. Programs are neither compelled to act based on information gathered nor are agencies compelled to give themselves poor ratings.
- Use of the instrument can be time-consuming since each agency is assigned the tasks of identifying its own issues of concern regarding clarification of agency mission, program description, identification of program goals, objectives and measures as well as defining case objectives and measures.
- Once the agency does the definitional and identification work, the instrument may not be suited for interagency comparisons unless other agencies collaborate on its finished design.
- There is no direct client or community involvement in the process.

i. Contact: Harvey Newman, Greater New York Fund/United Way (212) 557-1076

j. References: "Self Evaluation for Human Service Organizations", Institute for Management Improvements of Nonprofit Organizations, (May 1980) 2699 South Bayshore Drive, Coconut Grove, Florida 33133.

12. A Modular Approach for Training and Orienting Staff in Community Based Programs for Developmentally Disabled Persons

a. Purpose:

To improve the performance of newly-hired staff by helping them to understand their roles and responsibilities, and the program's philosophy, administrative procedure and service procedures through the use of a self-orientation/training manual.

b. Scope:

The orientation and training manual is designed for use by newly hired staff in community residential and day programs serving persons with developmental disabilities. While almost all sections of this training manual would be relevant for staff in programs serving developmentally disabled persons in any area of the country, some are tailored to the service system west of Boston.

c. Implementation History:

The inspiration for the orientation and training manual came from a pre-service training program for respite care workers used in the Newton-Wellesley-Weston-Needham Area in Massachusetts. The Director of Mental Retardation Services the Area Board, and the Family Counseling Resource Team Coordinator decided to expand the scope of the manual to cover all services for developmentally disabled persons, and to design the manual for in-service as opposed to pre-service training. The manual was written and reviewed by experienced caregivers including a clinical psychologist and the director of a large residential agency.

d. Process:

The orientation and training program is only recently underway. The use of the manual is at the option of the community program director and staff. The program is comprised of dozens of self-instructional modules each designed to be completed in short blocks of time. The staff member first reads the information presented and then tests the amount of knowledge gained by attempting to answer the questions listed at the end of the section. Correct answers are provided on the last page. The modules are presented in the order they are to be employed. A new staff member is expected to be able to complete the training program within his or her first three months on the job.

The current plan is to evaluate the usefulness of the training program. At the very least, the area board plans to conduct a survey of program staff for whom the training program was designed to assess the level of use and its usefulness. The officers of the training program also would like to have the impact of the training programs on staff practice evaluated, and are searching for a willing doctoral student or research group to

undertake it. The authors plan to modify the training program based on the evaluative feedback, and to update and expand the model over time.

e. Strengths and Limitations:

Community residential programs serving developmentally disabled persons rely heavily on inexperienced, junior staff. Staff turnover is high. It is not unusual in such situations to find that staff are deficient in a variety of performance domains including instructional methodology, behavior analysis, preparation of individual program plans, reaction to emergency situations and basic home repairs. Untrained staff act in ways that violate generally accepted standards of good practice and may undermine interventions with particular program clients. The on-site time demands and thin staffing patterns in many programs combine to diminish the chances of staff attending formalized training sessions outside the home. While these modules certainly may be used as part of an in-service training program, they may also be applied at times fitting the schedules of the individual staff members.

The training program has yet to be field tested. However, in view of the commitment of the area mental health/mental retardation board to evaluate and improve upon the training program over time, this should not be a problem. Its use is voluntary which means that some programs may opt not to use it -- perhaps these programs are those that stand to gain the most from its use. Nonetheless, there presently is no enforceable way to mandate such in-house programs of training from on-high. Such programs must have the enthusiastic commitment of the program directors if they are to be at all effective.

f. Contacts:

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Mental Retardation Services, Newton-Wellesley-Weston-Needham Area Mental Health/Retardation Board,
429 Watertown Street, Newton, Massachusetts 02158
(617) 969-3360

Roberta Jaro, Coordinator
Family Counseling Service Region West,
Newton, Massachusetts 02158

g. References:

Quiram Jan, & Jaro, Roberta. Orientation and training: A modular approach for services providers of developmentally disabled individuals in community-based programs. Newton-Wellesley-Weston-Needham Area MH/MR Board (2/84).

13. Case Management Services for Seniors, Santa Clara County, California

a. Purpose:

To enable functionally impaired older persons to obtain services that promote and maintain their optimum level of functioning in the least restrictive setting. Using paid and volunteer case managers, the project assesses the needs of the elderly, links them with appropriate services and monitors the delivery of these services.

b. Scope:

Using Title III-B funding from the Older Americans Act, the Council on Aging (the local area agency on aging) purchases case management services from community organizations in those parts of the county that have the highest levels of need. The Council on Aging issues annually a series of RFPs for case management services. Case managers may become involved in all stages of service delivery. The case managers are located in senior centers throughout the county. Home-health care, nutrition, transportation, day programs and homemaker services are coordinated and monitored by the case manager. Volunteer case managers may perform a variety of functions including establishing a rapport with reluctant clients, conducting simple assessments (i.e., need for transportation) and client follow-up.

c. Implementation History:

The case management program was established in 1981. Advisory council volunteers, staff, and service providers developed the grant program in response to issues raised by the federal government. Nine senior centers employ 14 case managers (10 full-time), with approximately 60 volunteers providing assistance.

d. Monitoring Process:

Case managers monitor services provided to seniors by a variety of means. Volunteers telephone clients several weeks after services were ordered to assess client satisfaction with the service. No standard format is used for this purpose. In addition, the case managers mail brief questionnaires to each client on a regular basis. The questionnaires solicit information about client statisfaction with the services arranged by the case managers as well as with the case management services themselves. The case manager also calls the service provider to discuss the client and assess the provider's perspective on the need for services. Finally, volunteers under the case manager's supervision routinely visit the client to determine the appropriateness of the services currently delivered and any changes in the client's status.

In addition to the activities initiated by the case manager, the case manager also receives reports on service quality from other sources. Senior center staff, public health nurses and the families of clients often come to the case manager with problems. Clients themselves frequently complain to the case manager if they believe they are not being treated appropriately by service providers.

e. Analytic Process:

There is no formal analytic process used to assess service quality. The case manager's professional judgement is the standard against which quality is measured.

f. Control Process:

There are a number of control mechanisms available to the case manager. The case managers submit monthly reports to the Council on Aging detailing problems encountered. If the Council staff see that particular types of problems occur regularly, they will meet with the provider agency to identify the source of the problem and possible solutions. One common solution is to have someone from the provider agency address a meeting of all case managers and answer their questions. Many quality problems are handled informally. The case manager calls a supervisor at the provider agency and asks for help with a particular worker. Most case managers in Santa Clara County are on a first name basis with agency managers. At the policy level, the Council on Aging notifies the director or board chairman of a provider agency if a quality problem remains unresolved. Members of the Council sit on the boards of most agencies serving the elderly in the County. Negotiations are then conducted at the board level. Finally, if the problem is with a contract agency, the Council notifies the county board of supervisors when the contract comes up for renewal. The board then uses the case managers' quality assessment, as reported by the Council, in its contracting decisions.

g. Strengths:

By locating the case managers in senior centers throughout the county, the program has access to many older persons. Furthermore, the case manager becomes familiar with the resources available in each community. By relying on volunteers, the case managers can provide case tracking and follow-up that would otherwise be unavailable. The method used a variety of approaches to obtain data on service quality, including mail surveys, client interviews and agency contracts. There is also a wide range of control mechanisms available from informal, negotiation to action by the county board.

h. Limitations

No explicit service quality standards are used. None of the methods used to collect information on service quality have been

tested for validity or reliability.

i. Contact:

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Council on Aging of Santa Clara, Inc.
2131 The Alameda
San Jose, CA 95126

j. References:

Request for Prosposal for
(Older Americans Act Funding)

Contract Assessment Guide

Proposal Evaluation Instrument

14. Court Appointed Special Advocate (CASA) Program in Las Vegas (Clark County), Nevada

a. Purpose:

To provide volunteer advocates for abused and neglected children coming before the juvinile court, as well as for delinquent and predelinquent youths.

b. Scope:

As a Las Vegas-based project of a National Junior League program, the CASA volunteers are recruited from diverse community backgrounds to conduct independent assessments of foster care placements. Issues addressed by the volunteers include appropriateness of placement, permanent placement, and parental rights. The CASAs work with case managers from the county welfare department but give their own independent assessments to the court in twice-yearly reviews. Since foster placements and case managers often change, a CASA acts as an objective monitor for the child, often following cases for two to four years until permanent placements are found.

The Clark County program recently formed a nonprofit foundation, the CASA Foundation, to help promote and support child advocacy. The first such foundation in the national CASA network, it provides a mechanism by which the communtiy can help address those individual and training needs not being met by public agencies. The Junior League is operating CASA programs in over 80 locations around the country.

c. Implementation History

The local program was initiated by a Las Vegas juvenile court judge in September 1980. While the nation-wide projects are generally funded by the Junior League and with Foundation funds, the Las Vegas project is wholly funded by the county's juvenile court. Current caseloads of approximately 200 children are monitored by 114 volunteers. A project director and support person make up the paid staff.

d. Monitoring Process:

Volunteers receive eight hours of intensive training, with ongoing supervision by the project directors. After training, the volunteers (or CASAs) receive both juvenile court and welfare department case files. They then visit the child, conducting an informal assessment. Ongoing visits are made as needed. State statutes require progress reports to be presented every six months. The CASA presents her/his perceptions and recommendations at these sessions.

The CASA meets with the foster parents and others concerned with the child's welfare. Assessing the appropriateness of the

placement is the primary objective of the CASA's involvement which includes working with the case manager to see that the child's needs are met. The CASA is not a volunteer case manager. The CASA often serves as a buffer between the child, the foster parents and the case manager. The CASA maintains an ongoing relationship with the child that grows in value because foster parents and case managers often change. The CASA volunteer can recommend services for child and family (i.e., counseling, budgeting assistance), but the case manager is responsible for securing the services.

e. Analytical Process:

The CASA files regular reports which become court records. There is a set format followed by the volunteer to record observations and assessments. The judge analyzes the CASAs recommendations.

f. Control Process:

A primary control method is the court progress reports, required by state law at least every six months. The project director follows up cases with individual volunteers, but not in a regular or formal evaluative structure. A more formal review occurs after a case is closed. Reports of social workers are also used as control methods.

g. Strengths:

The program pushes the system to provide more timely resolution of problems in foster families. Time constraints of the paid staff (i.e., case managers) restrict their ability to gain the detailed knowledge of child and family placements by the CASA volunteer over long periods of time. The volunteers follow the child through the welfare and court systems, catching many who would otherwise fall through the cracks.

h. Limitations:

The formal evaluation process of the volunteers' work with the cases is not very strong. Funding limits both the number of volunteers and their supervision/training by professionals. Case managers and the County Welfare Department can be resistant to the CASA's involvement, viewing the project as another layer of bureaucracy. The case managers do not always communicate with the CASAs regarding court date changes, and so forth. Finally, the volunteers can only advise the court -- corrective action is left to the judge.

i. Contact:

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15. Client Outcome Evaluation System, Community Human Services Department, Ramsey County, Minnesota

a. Purpose:

To assess progress toward meeting the stated service objectives of all programs, purchased or directly provided, using a formative evaluation model that concentrates on measuring client outcomes.

b. Scope:

This evaluation system will eventually cover all human services provided or purchased by Ramsey County program staff, county planning staff, the county board and the Minneosta Department of Public Welfare. The system focuses on assessing client outcomes.

c. Implementation History:

The 1979 Minnesota Community Social Services Act requires that all programs funded through the Act be evaluated, and that the evaluation be based on measurable objectives. County Board members have also requested that evaluation results be presented to them to assist in making decisions regarding all service programs. Consequently, an evaluation clause is included in all Purchase of Service Contracts.

After exploring and pilot testing a variety of evaluation approaches, the Department, with county board approval, selected a "formative" evaluation model for application to all direct purchased service programs. The Office of Evaluation of the Community Human Services Department has been gradually implementing the system as they develop outcome measures for each program area. Part of the measurement development has been the creation of levels of functioning scales for impaired adults.

d. Monitoring Process:

The County Office of Evaluation designs an evaluation plan and data collection procedures for every county and purchased human service program. Planners, contract managers and program staff also assist in developing the design. Negotiation among all the interested parties is an integral part of this process. The evaluation design consists of a goal statement, target population and service objectives for each program. The objectives are broken into measures that include to whom the measure applies, the time period covered by the measure and a range of expected outcomes for the measure. The range identifies the minimal, goal and optimal performnace standards for each service. These standards are derived through negotiation and reflect past performance, client types, environmental factors and the experience of other programs. The evaluator may design new data collection forms if required by the data requirements of the

plan.

After the plan is completed, the program staff collects the data as specified in the design. The evaluator compiles the first quarterly report and assists in preparing subsequent reports until the program staff is able to prepare them on their own. After that point the evaluator will meet annually with the program staff to examine the on-going data system.

e. Analytic Process:

Program performance is analyzed by comparing actual outcome levels with the standards specified in the evaluation plan. Each measure has three possible target levels, as described above. The data is analyzed first by the program staff who compile the results. After that, departmental planning and evaluation staff analyze the completed reports.

f. Control Process:

For purchased service programs, contract managers attach the evaluation reports to contract materials which are presented to the County Board when contract renewal is requested. Evaluation findings for all direct service programs are included in the Department's annual budget for review by the county executive director and the board. These findings become one of the factors considered by the county board in making funding decisions. According to the Director of Evaluation at the Ramsey County Community Human Services Department, the board has found the outcome data very helpful in contracting decisions and in making recommendations on direct service programs.

g. Strengths:

This method has a number of strengths. The outcome measures used are the result of negotiation among program staff (direct and purchased), planning staff and the evaluators. Development of the mesures requires clear articulation of program goals, objectives, target groups and expected outcomes. The expected outcomes are the explicit standards against which program performance and quality are measured. The findings are assessed by program staff for internal management purposes and then by senior staff and the county board. This permits review by elected officials who represent the community. According to the office of evaluation, the cost of this outcome montoring is lower that the quality assurance approach used formerly, case record reviews. Some of the client functioning scales in use have been tested for validity and reliability. The remainder of the instruments are currently being tested.

h. Limitations:

The rigor with which Ramsey County is using this system has produced its major limitation -- the method is very time-

consuming. It can take up to one year to collect all the necessary program data. Developing new measures and data collection instruments for each program also takes time. Finally, although data on program quality is subject to high level review, there is no mandatory correction of deficiencies.

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160 E. Kellog Boulevard
St. Paul, MN 55101

j. References: "Program Evaluation Manual" (undated), Community Human Services Department, Ramsey County, MN.

16. Nursing Home Information Project, The Urban Institute

a. Purpose:

To determine whether volunteers can effectively supplement the limited information regarding nursing home services available from licensure boards and other regulatory agencies.

To develop innovative methods, instruments and materials for assessing nursing home care which could be used by volunteer groups to gather and publish such information not otherwise available.

To develop technical materials sufficient to allow projects to operate independently.

To assess the impact of locally produced information on consumers, long-term care professionals and nursing home adminsitrators.

b. Scope:

In a joint effort between the Administration on Aging and The Urban Institute, volunteers demonstrated that they could play an important role in providing meaningful monitoring information for potential clients of local nursing homes using professionally developed materials. 85% of local volunteer groups in 22 sites successfully completed the project and published or will publish local guides to nursing homes. The vast majority of nursing home administrators, consumers and professionals viewed local guides as valuable.

Average time to complete the planning, site visit monitoring and preparation of the guide was approximately one year.

The data collection instruments that were developed were uniquely designed for volunteer assessments of nursing home environments. Instruments measure inputs almost exclusively with a few process observation measures by the rater. Although the instruments as designed for this project are limited in their applicability to long-term medically-oriented residential care, they would be appropriate for disability groups as well as the elderly. Of broader interest, however is the model for combining professional and volunteer manpower. Professional expertise in evaluation, interviewing, field test design and materials development was combined with volunteer enthusiasm and dedication to a cause, namely improved long term care for the elderly. The formality, standardization and field testing which the professionals contributed to the project enhanced the crediblity and accpetance of a local volunteer assessment effort. The data collection and development of a local guide to services frequently led to ongoing advocacy or ombudsman services within the local area by the same group of volunteers. The project served as a catalyst to increased community concern and

particpation in protecting the rights of nursing home residents. This process can be used for many other service types as a model for influencing the quality of local service.

c. Implementation History:

The Nursing Home Information Project was conducted over a three years by the Urban Institute under a grant from the Administration on Aging. During this period, 22 local projects were initiated in various sites across the country. The Urban Institute developed all of the technical and training materials, monitored local volunteer group efforts, studied the implementation process in the sites and examined the short-run impact of the newly produced information guides, but did not get involved in operations, local decision-making or direction of the projects. Each group of local volunteers implemented its own version of the Nursing Home Information Project in its own locality.

d. Monitoring Process:

After receiving three to six hours of training, a team of two or three volunteers using two data collection instruments visit each nursing home to gather information. Participation by individual nursing homes is voluntary and dependent upon administrator approval. Local nursing home associations play a major role in influencing administrator attitudes toward participation. (In the 22 project sites, four out of five nursing homes participated in the project.) Upon arrival at the facility, team members conduct an on-site administrator interview and each team member makes an independent tour of the facility completing an Observational Record. The team later completes a consensus rating form to reconcile its findings. Administrators of local nursing homes are asked to review the information regarding their facility prior to guide publication.

Two final revised manuals were developed by The Urban Institue to facilitate the independent administration of local projects and the training of volunteer participants. A Coordinator's Manual includes suggestions for carrying out each phase. It includes the training curriculum and resources for providing three to six hours of training for volunteers. A Volunteer's Manual defines the site visit procedures and instruments, and provides background information on nursing homes.

e. Strengths and Limitations:

Most governmental standards for long term care facilities regulate medical, health and sanitary dimensions of care and tend to neglect important social and quality of life aspects of long term care. The materials developed for the Nursing Home Information Project emphasize aspects of care that are of vital interest to nursing home residents and their families. A

significant effort was made to incorporate consumer preferences regarding care into the data collection tools.

f. <u>References:</u> <u>Volunteers in Social Services: Consumer Assessment of Nursing Homes</u>, Eugene C. Durman, Burton D. Dunlop, Cheryl Rogers, Geraldine Burt, The Urban Institute, August 1979.

g. <u>Contact</u>

The Urban Institute
2100 M Street, NW
Washington, DC 20037

17. Purchased Services Monitoring Program of Milwaukee County

a. Purpose:

To assure vendor compliance with Title XX regulations; to secure consumer opinion, satisfaction level and problem identification; to assure that services billed were provided; and to confirm contract specification compliance.

b. Scope:

The method relies on limited input data (inspection of office space), process data (regulatory compliance review) and limited outcome data (client satisfaction). It covers a wide range of services: group day care (adult and child), work assistance, and general Title XX services.

c. Implementation History:

The Milwaukee County purchased service program began in 1972. They county ordinance enacting the program made consumer surveys for purchased services a condition of the program. The Department of Social Services was required to collect data on "the adequacy and quality of the care" provided to them by vendor agencies. Consumer surveys have been conducted annually since 1974, as have most of the other data collection methods.

d. Monitoring Process:

The monitoring process consists of four major information-gathering efforts:

(1) Title XX compliance review -- a random sample (up to 50%) of cases are reviewed monthly by departmental staff to determine if federal, state and local regulatory requirements are being met.

(2) Consumer response -- consumer surveys are conducted annually by mail in every area were services are purchased. In the past, all consumers were surveyed. Since 1978, random samples have been used due to the high cost of 100% coverage. Separate questionnaires have been designed for each type of purchased service.

(3) Service verification review -- consumer survey data is compared with the providers statement-of-services delivered to determine if payment for the service is correct and appreciated.

(4) Agency evaluation visits -- semi-annual site visits are conducted by department staff at the vendor agency to verify the provider's compliance with contract specifications for a Title XX purchase agency.

There is minimal disruption of provider operations in this system. Providers do not have to full out any forms. Quality assurance monitors spend approximately one day per year on-site interviewing agency staff and observing operations. The County has not documented the validity or reliability of any of its instruments.

e. Analytic Process:

The analysis of the Milwaukee County purchase-of-service data does not rely on any local performance standards. Under state Title XX policy, 100% compliance is expected on all regulatory requirements, so the county has not developed its own standards in those areas. One reason for this is that the design and coverage of the consumer satisfaction questionnaires vary from year to year, making trend analysis difficult. The regulatory compliance and consumer satisfaction data are tabulated by computer. The results are used to develop a picture of overall service delivery by vendor agencies and service delivery within major program areas. There is no analysis of individual provider agencies unless the county is conducting a special investigation in response to community complaints.

f. Control Process:

Vendors are required to correct regulatory compliance deficiencies found in the sample of cases that are reviewed monthly. Consumer satisfaction data is used to alert providers to problems in their service delivery. In one instance, the survey was used to identify a case worker who was defrauding the county and the vendor. The vendor was required to make restitution for the payments it had received for clients who were never helped. While there is no systematic use of the survey data to control vendor performance, the vendors know that their activities are being monitored by the county. In addition, county quality assurance staff believe that the survey helps to reassure the community that they have a voice, albeit indirect, in service planning and resource allocation.

g. Costs:

While the county did not provide any cost data, the small size of the staff (3 monitors and 1 supervisor) indicates that the costs are probably not excessive.

h. Strengths:

- The method operates under a county ordinance requiring client satisfaction surveys.

- Client satisfaction surveys are combined with regulatory compliance reviews.

- The county's quality assurance staff has a great deal of program experience and rapport with providers.

i. Limitations:

- The county has not developed its own standards by which it can assess provider performance.

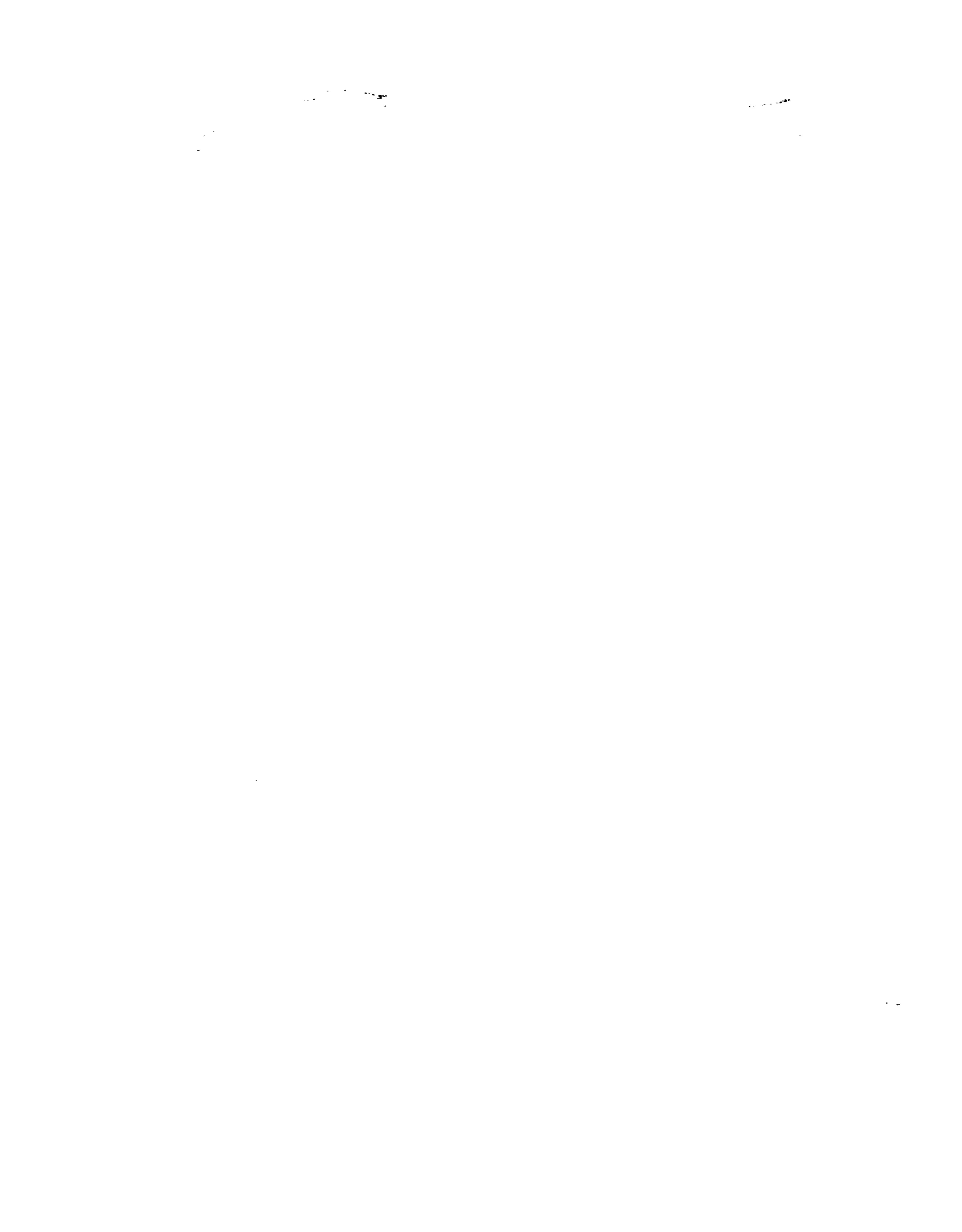
- The only outcome data is client satisfaction data. No information on changes in client functioning are collected although the county would like to collect this type of data.

- Due to changes in the survey instrument, there can be no year-to-year comparison of the client satisfaction scores.

j. Contacts: David Titus, Caseworker
Milwaukee County Department of Social Services
1220 West Vliet Street
Milwaukee, Wisconsin 53205

k. References: Title XX Compliance Review Instruments
Semi-Annual Site Visit Protocol Consumer Satisfaction Surveys for:

- Adult day care
- Transportation services
- Victim/witness services
- Supportive home care
- Homemaker services
- Home detention
- Advocacy services
- Substitute care
- Home-delivered meals
- General social services



18. Volunteer Foster Care Review in Fulton County, Georgia

a. Purpose:

To increase the focus on permanency planning in foster care and to ensure provision of quality services through the use of volunteers to review case plans and to recommend action when necessary.

b. Scope:

This method is used exclusively in the child foster care program but could be used in any social service program where the duration of treatment is relatively long. This project is concerned with children who have been in foster care at least six years. The focus is on process and, in a limited sense, outcomes.

c. Implementation History:

The Foster Care Review Project is a demonstration currently in its second year. It is funded jointly by the Fulton County Department of Family and Children Services, the Council for Children, Inc, and three local private foundations. It was initiated jointly by a local resident who was concerned about children becoming "lost" in the foster care system and the Director of the Department.

d. Monitoring process:

Volunteers are recruited by project staff and given 15 hours of training in child welfare practice, functions of the juvenile court, and maintaining confidentiality. The volunteers are then organized into six-member review teams. There are currently six review teams in operation. A child welfare agency worker, assigned to the project, abstracts the case record and presents a summary sheet and social history narrative to the review team. The team reviews the case, identifies obstacles to developing a permanent plan and proposes ways to overcome those obstacles. Public agency case workers may participate in these review sessions but participation is not mandatory. Case workers attend for about one-third of the cases.

Following the review, the project director writes up the review teams' recommendations and forwards them to the Fulton County child welfare worker responsible for the case. Each is reviewed every six months.

To date the project has reviewed 48% of the long-term foster care cases in Fulton County. Having started with young children, they are now in the process of reviewing adolescent cases.

e. Analytic Process:

This method does not involve a tightly structured system of analysis. The volunteer reviewers assess the progress of each case against the principles learned in their brief training sessions and apply their own judgment. There are no written standards of "appropriate" care used.

f. Control Process:

There is no formal control exercised in this project. The review teams' conclusions are expressed as recommendations. The teams receive feedback on the consequences of their recommendations every six months. If their recommendations are not accepted, they may make the same recommendations in the hope they will be accepted in the future.

g. Costs:

The annual cost of the project is approximately $70,000. This covers the salaries of the Project Manager, Project Coordinator and a secretary.

h. Strengths:

The method relies primarily on volunteers, there is a paid professional staff of three. They have the cooperation of the child welfare agency so case data is available. Since no formal data collection is involved, the validity and reliability of instruments is not an issue.

i. Limitations:

The review teams do not have the authority to enforce their recommendations. Implementation is left to the public agency child welfare worker. Participation in the review process by case workers is voluntary so the review team may not be able to obtain necessary data that is not included in the case record. Opinions of the project vary among the caseworkers. Some support it and appreciate the volunteers' efforts, some are neutral and others oppose it. The ability of the review teams to influence case decisions depends on the cooperativeness of the caseworker. Finally, the project is time-limited. It will end in February, 1982, unless alternate funding is located.

j. Contact: Kathryn M. Gannon, Project Manager
Volunteer Foster Care Review Project
2001 Martin Luther King, Jr. Drive
Atlanta, Georgia 30310
(404) 755-0532

k. Reference: "Volunteer Foster Care Review Project" prepared for the National Association of Counties, Second Year Report, Atlanta Georgia, August 1981.

19. Child Development Quality Review System of the State of California

a. Purpose:

To assure the quality of service provided by child day care centers in the state of California.

b. Scope:

All day care programs funded by the Office of Child Development, California State Department of Education are subject to review by this method. The specific program elements identified for review are:

- administration
- developmental program
- staffing
- support services
- family community involvement

c. Implementation History

In 1980, the California Legislature enacted Senate Bill 863 which required the Superintendent of Public Instruction to develop standards for the implementation of quality programs and to identify indicators of program quality. The State Department of Education convened a Consortium on Program Quality Standards in 1981. The Consortium consisted of state officials, day care consultants and the administrators of 17 day care programs from around the state. The Consortium met for a year and a half to develop the approach and the specific indicators. The instrument was field tested, revisions made and the revised instrument is now being pilot-tested on a random sample of one-third of California's child day care programs.

d. Monitoring Process:

The Program Quality Review Instrument is used in two ways. First it is used by the state to monitor and score programs for program quality. For this purpose, the agency is notified at least one month prior to the review and told what materials and which individuals (parents, staff, board members) should be available. The agency is also asked to designate a small working space for the review team. The average review takes approximately two days and consists of the following steps:

- entry meeting
- tour of the center

- observation periods
- review of written materials
- interviews
- exit meeting

The review team rates the program on each of the 45 quality indicators included in the instrument. For each indicator, there are five levels of compliance of quality with a specific definition for each. The reviewer selects the level that best describes the program under review.

The second use of instrument is for self-assessment. In this case, there is no formal monitoring process. The instrument is available to governing or advisory boards and program staff to review their own program. This can be done in preparation for a formal review or to assess particular program aspects of special concern to the agency.

e. Analytic Process:

The scores are tabulated by hand on a score sheet. Scores are shown for each indicator as well as combined to produce a total score. Level three (of five possible levels) is the minimum acceptable score for each indicator. Programs scoring less than level three in any area are considered to be out of compliance with state standards. A copy of the score is left with the agency during the exit meeting and a copy is submitted by the review team to the state for computer aggregation and analysis.

f. Control Process:

When an agency has been identified as being out of compliance (receiving a score of less than three) in any area, the agency is required to produce a written plan for correcting the deficiency within thirty days. Deficiencies in the developmental program area are considered to be the most important and are given the highest priority for correction. Although no technical assistance is available during pilot testing, the state intends to provide technical assistance to those agencies needing help once the method becomes fully implemented. This will come in the form of either consultants or peers (staff of other programs) whom the state feels are particularly strong in those areas where deficiencies exist.

g. Costs:

No cost data is available for the development stage of this method. The major operating cost is two days of consultant time to conduct the review.

h. Strengths:

The Child Development Program Quality Review System involves parents, program staff and governing boards in the review process. The review uses interviews, on-site observations and examination of written materials. The instrument was developed with the cooperation and assistance of provider representatives. The method is relatively simple and inexpensive to employ and can be used by both outside reviewers and in-house staff. The approach could be adopted by other states fairly easily.

i. Limitations:

The major limitation of this approach is that the items and levels on the instrument have not been tested for statistical reliability and validity. The State Department of Education hopes to validate the instrument during the pilot test stage. A less significant limitation is the method's broad scope. By including administration staffing, support services and family/community involvement, as well as program content, the approach may stretch the expertise of the reviewers in identifying problems and the resources of the program in correcting them.

j. Contact: Kathryn Witcher or Jerry Frields, Office of Child Development State Department of Education 721 Capitol Mall Sacramento, California 95814. (916) 323-1343

k. Reference: California State Department of Education, Office of Child Development. Child development program quality review. Sacramento, 1982.

(Please see page 267 for a more recent update on this method)

20. Board and Care Survey Sponsored by the Mental Health Advocacy Project of Santa Clara County

a. Purpose:

To solicit the client perspective on the adequacy of board and care facilities in Santa Clara County, so that board and care residents can become more active consumers of service.

b. Scope:

The board and care survey targeted facilities that met the following criteria:

- located in Santa Clara County
- serving mentally ill or developmentally disabled persons
- not serving alcoholics, drug abusers, senior citizens, or children

Homes surveyed ranged in size from 2 to 45-50 residents, with the majority housing 15-20 persons. Eighty per cent were for-profit organizations. Ratings were developed on over 75% of the homes surveyed, and only where surveyors were able to contact a large enough sample of residents

c. Implementation History:

The board and care survey was sponsored in 1981, by the Mental Health Advocacy Project (MHAP) of Santa Clara County. It was supported by a $25,000 program development grant from the State of California, Department of Developmental Services. The purpose of the survey was to develop ratings on board and care services available to mentally ill and developmentally disabled persons. Input and process dimensions were evaluated according to five aspects of board and care facilities:

- quality of the physical plant
- food
- the atmosphere of the home (i.e. the extent to which it was homelike or institutional)
- the fairness of the house rules
- the extent to which residents were encouraged to be independent

The final product of the survey was a guide intended for use by board and care consumers. Although the guide was advertised in newsletters and copies were made available in the MHAP offices, few have been distributed (due mainly to limited funding).

d. Monitoring process:

As a one time assessment, the board and care survey did not serve an ongoing monitoring role. An advisory body, composed of

concerned groups in the county, provided input throughout the project. After designing, field testing and revising the questionnaire, MHAP staff trained volunteer social work students and consumers of the service to conduct the interviews. Residents were surveyed at their homes whenever possible. Some were reached through day programs if home operators denied interviewers access to the facility. In fact, gaining access to some of the facilities represented a significant problem at this stage of the assessment. Operators were given the opportunity to prepare a rebuttal to resident ratings, and to have the response included in the catalogue; none took advantage of this offer.

e. Analytic Process:

Upon completion of the survey, MHAP formed three person teams to develop ratings for each facility, resulting in a one page digest of responses per facility. At the top of each page, the operator of the home was given an opportunity to describe his or her facility. In order to make the guide as accessible as possible, MHAP staff spent time designing and field testing rating symbols that could be understood by semi-literate clients. For instance, the symbol for food was a plate and silverware and the level of the rating was indicated by one to four stars underneath the food symbol.

f. Control Process:

There is no formal control process included in this method. The survey is linked neither to funding nor to licensing mechanisms, although it may have some effect on services as a function of consumer awareness.

g. Strengths:

- The method probably could be applied to board and care facilities serving other groups, and to other types of service altogether
- The method relies on resident-consumers both to evaluate and to provide information about services
- Instruments were field tested
- Data were presented in a fair and accessible manner
- The survey was relatively inexpensive and required a moderate amount of time to complete

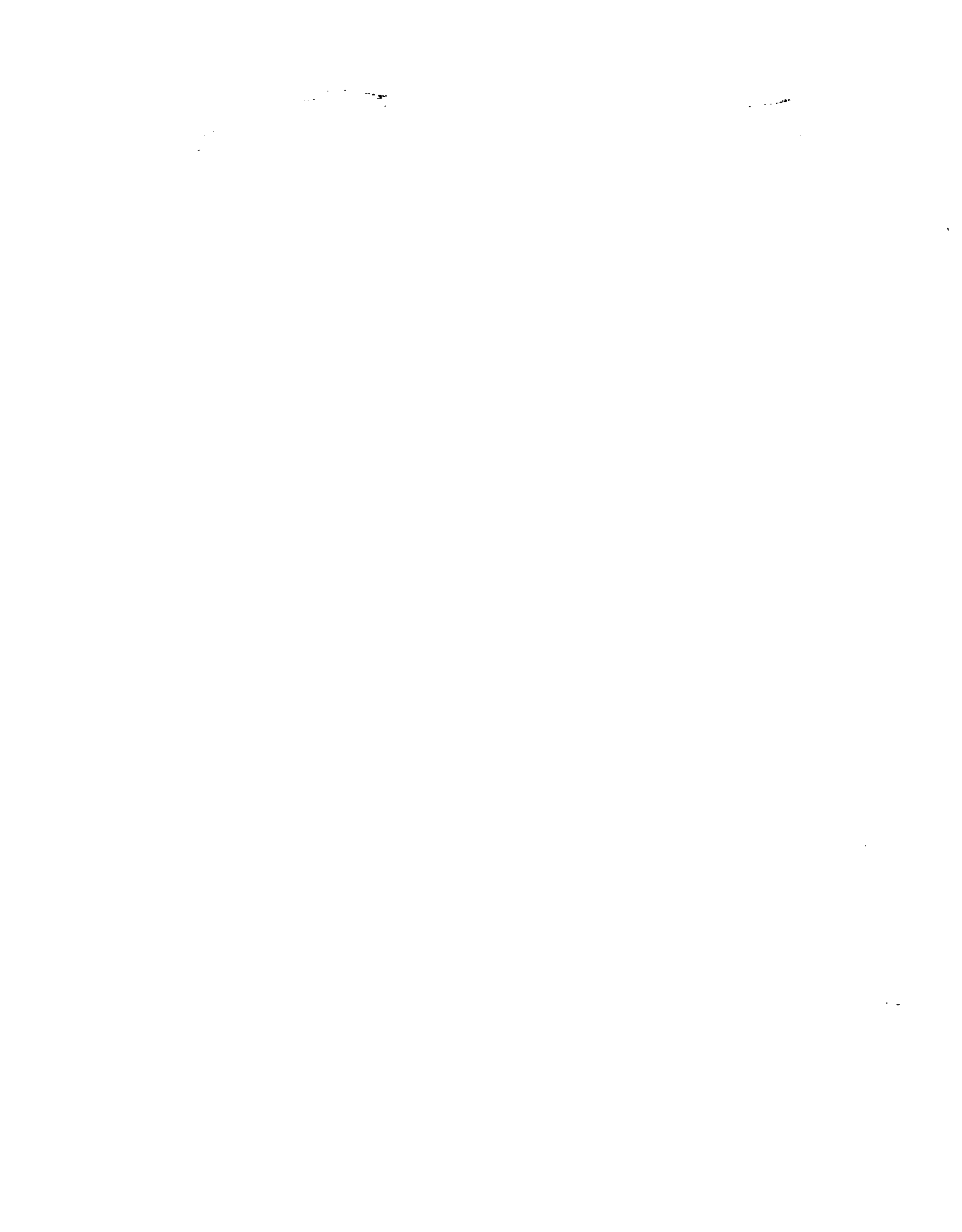
h. Limitations:

- Gaining access to facilities proved to be a major obstacle to conducting the interviews
- To be effective, the survey plan needs to include adequate funding for publishing and distributing the information
- There is no control process whereby evaluations are linked to licensing or funding mechanisms
- As a one time assessment, the survey data became out-

dated. The method could be improved by incorporating periodic assessments to update the information.

i. Contact

David Schott
Housing Specialist
Mental Health Advocacy Project
711 East San Fernando Sstreet
San Jose, California 95112
(408) 294-9730



21. Association for Macomb-Oakland Regional Center Parent Monitoring Committee

a. Purpose:

To monitor Macomb-Oakland Regional Center (MORC) group homes, to ensure that the persons living in those homes are receiving the best services possible in an environment that enhances and motivates individual growth.

b. Scope:

The Parent Monitoring Committee monitors group homes administered by MORC (under contract with non-profit corporations). Typically the number of residents per home ranges from four to 12. The evaluation encompasses primarily input and process dimensions of service, including:

- general quality of life and environment issues
- health
- nutrition
- client rights

c. Implementation History:

The Association of Macomb-Oakland Region Center (AMORC), a parent advocacy organization, decided early in 1980 to form a committee to monitor community group homes served through the Center. The Committee was formed in part, as a response to parental concerns regarding the continuation of quality community homes once parents are no longer living. In addition, the committee served as a complement to two other monitoring efforts already used by MORC: (1) Quality of Life Review Teams, and (2) case managers who visit the homes on a weekly basis.

After organizing the Parent Monitoring Committee and seven member core committee, the program was presented to the director of MORC who sanctioned it and notified the group home administrators of its purpose. Guidelines and monitoring procedures were established by the agency and core committee.

Monitoring began in June, 1980, and focused specifically on the following areas of service:

- nutrition
- inside and outside appearance of the home
- client-staff ratios and compatability
- barrier free accessiblity for multi-handicapped persons
- proper storage of medications
- program implementation
- client participation in community social and support systems

After conducting unannounced visits to over 70 group homes, members decided that the monitoring system was an asset and should be made a permanent part of the agency's function.

d. Monitoring Process:

The Parent Monitoring Committee is composed of 30 volunteers who have developmentally disabled relatives living either in the natural home or in a community group home. Within the Committee there is a core committee of seven persons who, together with other monitors, visit the community homes.

Home visits are conducted by a monitoring committee core person (who is responsible for his or her own geographical area), and one other monitor. Unannounced visits are used so that the monitor can view the conditions in and around the homes in a candid and open manner. Before entering each home, monitors make note of the security measures and the upkeep of the grounds. Further, each core person staggers the schedule for the home visits so that each home is observed under different circumstances.

e. Analytic Process

An evaluation form is filled out by the monitors after each visit, and the home reports are evaluated by the core committee during their monthly meetings. A core person then attends a monthly meeting with the director of MORC and the case management supervisors to debrief them on the results of the monitoring visits.

After reviewing the home visit overviews written by all core committee monitors, the chairperson of the committee compiled an annual report for 1981.

f. Control Process

A copy of the annual report was sent to MORC and shared with the group home administrators. A copy also was forwarded to the director of the Michigan Department of Mental Health.

If a monitoring report should highlight a particular concern in a group home, the MORC director has 10 days in which to take corrective action. If the Committee believes that approrpriate corrective actions are not being taken, it can then contact the Office of Recipient Rights, Michigan Protective and Advocacy Services, or other appropriate agencies.

g. Strengths:

- The method involves parents in monitoring services
- Monitoring is conducted frequently and on a regular basis
- By using volunteers the method is relatively inexpensive to conduct

- The method could be applied to a variety of community residential service programs
- The method encourages accurate reporting and includes effective control mechanisms

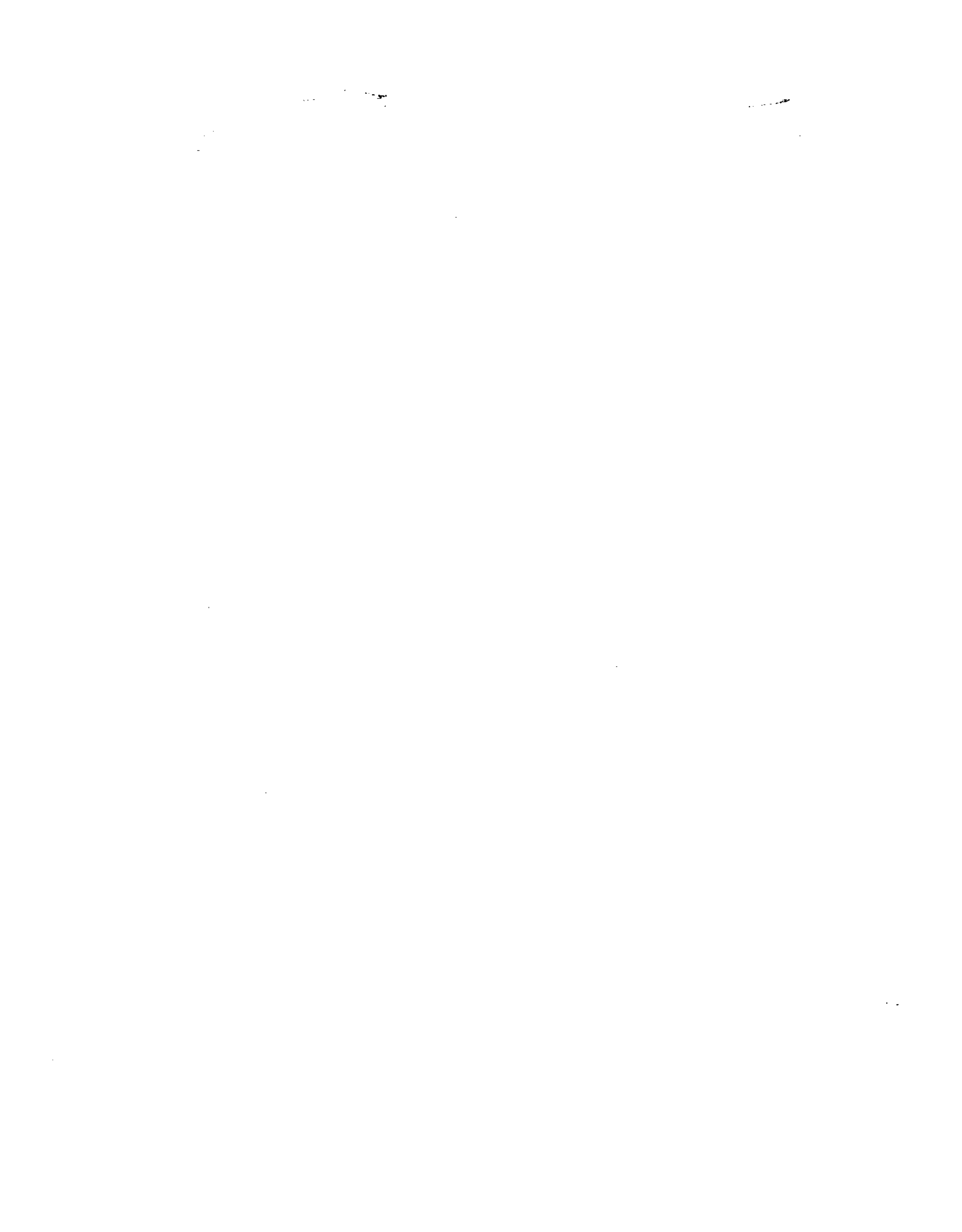
h. Limitations:

- Much of the evaluation is oriented toward input-type issues, with less attention devoted to process or ouput dimensions
- Apparently little attention has been paid to standardizing instruments or procedures

i. Contact:

Ruth M. Taylor, Chairperson
Monitoring Committee
Association for Macomb-Oakland Regional Center
P.O. Box 471
New Haven, Michigan 48048

(313) 749-3038



22. Commonwealth of Pennsylvania Quality Assurance System for Pennhurst Class Members (Operated by Temple University Developmental Disabilities Center, University Affiliated Facility)

a. Purpose:

To assure that Pennhurst class members placed from Pennhurst into group homes/apartments (three or fewer residents in Pennsylvania), small ICFs (six or fewer residents), waiver program arrangements, family living program arrangements, or other settings, are:

- receiving written individual plans of high quality and appropriateness
- receiving all services specified in the plans
- living in settings that are no more restrictive and regimented than necessary
- living in settings that are as normalized as possible, and are also physically pleasent and safe
- free from, and protected from, abuse and neglect
- able to have relatives express any concerns freely, without worrying about provider resentment
- benefiting from their services in terms of outcome: continual increase in adaptive behavior, decrease in maladaptive behavior, family perception of resident happiness, family satisfaction, and the person's satisfaction and comfort where that can be expressed verbally.

b. Scope:

The system is active for all Pennhurst class members in community settings. In Spring 1984 this included just over 600 people. By 1986 it will include over 1100 people. Extensions to other people in community settings (and in public institutions) are in progress.

c. Implementation History:

The system grew out of the Pennhurst Longitudinal Study, funded by the Department of Health and Human Services in 1979, and other court-related developments. The study enabled development of an automated tracking system and development, testing, and refinement of an entire series of data collection instruments and procedures. In 1981, the Commonwealth of Pennsylvania contracted with Temple to become part of the official monitoring system of the Pennhurst Court Order. By

1984, arrangements were being made to expand the system statewide. Other essential components of quality assurance include: case managers with caseloads no larger than 30 who must visit each person at his/her home once a month: professional review and approval of each IHP; onsite IHP checkups by a special team of state employees once a year, and unannounced visits when necessary; fiscal monitoring by county offices; and the usual array of licensing, health, and fire inspections.

d. Monitoring Process:

Each year, 20 to 40 candidate site reviewers are trained or retrained in a two to four day workshop. To come to the training, candidates must have been through PASS training previously (see below). They are then tested via videotape and field exercises. Those who meet the criteria then receive monitoring assignments. In most cases, one site reviewer is assigned to cover all the residential service sites operated by one provider agency. In Pennsylvania, the average community living arrangement has three residents, and the average provider operates six sites.

The site reviewer makes all scheduling arrangements with the providers and with the sites. Scheduling is at the provider's convenience to avoid interference with program activities as much as possible. A typical review begins at 2:00 p.m., while the residents are away at their day programs. The Behavior Development Survey, which contains a short form of the Adaptive Behavior Scale, (as well as items on demographics, status of written plan, health, family contact, goals, and developmental services rendered), is collected by interview for each resident. Next, the reviewer begins the environmental rating instruments:

1) a short measure of normalization derived from Wolfensberger & Glenn's Program Analysis of Service Systems (PASS) III;

2) a physical quality rating scale, room-by-room;

3) a measure of individualization versus regimentation derived from the residential management practices inventory;

4) a life safety checklist;

5) subjective one to ten ratings of five areas of program quality

6) space to record situations of concern.

The average site review takes four hours on site and two hours off site. The reviewer must see (and if possible, interact with) every person living there. Typically, residents return

home during the review, so that the reviewer can meet each person and observe interactions.

The final component of the monitoring is a brief mail survey, sent to the next of kin of each person visited. The survey allows families to express their current levels of satisfaction, and to note any concerns or dissatisfaction.

e. Analytic Process:

All software for analysis is developed and running. The Statistical Package for the Social Sciences is used for most analyses. The most general analyses are at the systems level, looking for evidence of average growth and development, for changes in services rendered across the whole system, and for other factors such as correspondence between most frequent resident goals and most frequent services rendered. These analyses are run by region, county, and provider.

The more specific analyses are performed for each site and each person. These analyses are used to generate a series of "flags." A red flag (e.g., resident has lost more than 12% of his/her previous adaptive behavior score, or family expresses serious dissatisfaction, or resident is not attending a day program away from the residence) requires immediate personal attention from state and county employees. A pink flag (e.g., case manager has not visited in past four weeks, or fire detector has lead batteries) requires a written response, with assurance of correction, usually within 60 days. An emergency situation (e.g., physical danger such as rotted stairs, or visual evidence of injuries that are not explained) requires that a state employee conduct an unannounced site visit within 24 hours. A green flag (e.g., a resident has gained more than 12% in adaptive behavior, or all staff at a site are trained in first aid and CPR) is communicated in writing as a commendation to state, county, and provider.

f. Control Process

The state requires the counties to present evidence and/or assurance of correction of each red or pink flag. The counties require the correction evidence and/or assurance from the providers. The counties hold the contracts with providers, and hence have the necessary authority.

g. Strengths:

- outcome orientation;
- both systems level problems and individual resident on site problems can be uncovered;
- families are an integral part of the system;
- process is inexpensive (always less that $200 per person per year);
- system is also useful for state, counties, and providers

to compile population statistics, etc., for reports or proposals;

- because this system contains baseline data from the time when people were in the institution, most of the comparisons are very favorable for the community programs, that is, much of the news is good;
- in the long run, the system is designed to reveal which environmental and programmatic qualities (e.g., normalization or type of day programs) are most associated with personal growth and development, thus helping to guide future program directions;
- the use of highly experienced people currently working in the field, but in other counties, as monitors, is functionally similar to a peer review system, which benefits all parties (including reviewers and their programs);
- the system is operated by a major university with strong ties to the community, which lends an aura of non-threatening objectivity, independence, and intellectual integrity to the endeavor;
- the environmental review is readily adaptable and flexible, so that a different checklist or licensing review form could easily be substituted for one or more of the current instruments.

h. Limitations

- By itself, this once-a-year system is not a complete quality assurance system. Frequent case manager and state authority involvement is crucial;
- The Temple site reviewers are forbidden to give detailed evaluative feedback on site -- they are hired as fact finders, and not to give their impressions of how programs might be improved;
- a few flags, naturally, turn out to be false alarms, usually caused by a knowledge gap among provider staff present for the visit, or (rarely) by coding or keypunch errors;
- because the University is a third party, states would need to examine confidentiality issues before implementing this (or perhaps any) monitoring process (in Pennsylvania, statutes and regulations are clear in enabling officially sanctioned third parties to access confidential information for the purpose of evaluating the well-being of of service recipients).

i. Contact:

James W. Conroy or Celia S. Feinstein
Temple University Developmental
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9th Floor Ritter Annex 004-00
Philadelphia, PA 19122
(215) 787-6560 or 6561

j. References

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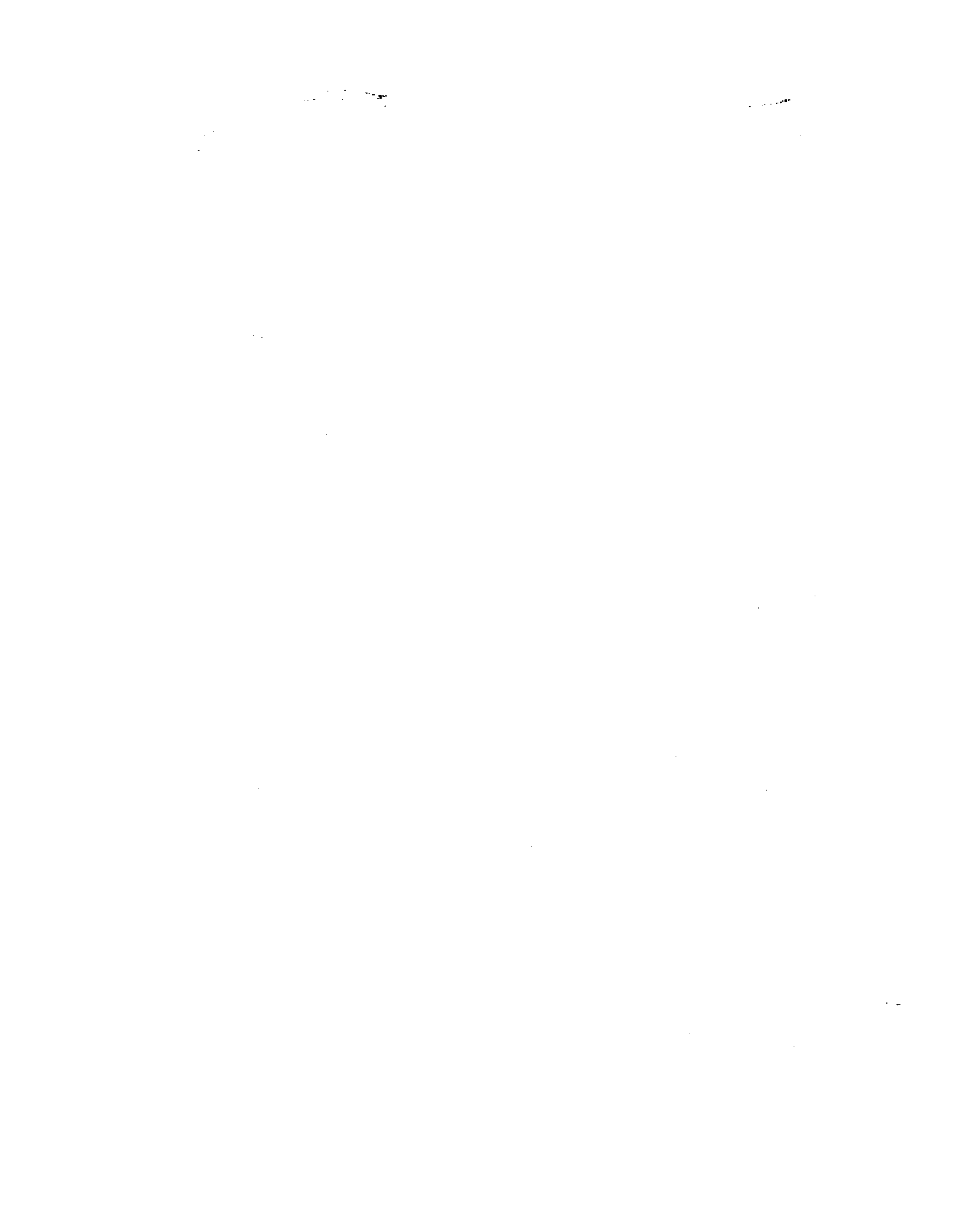

Update

Quality assurance techniques for child day care and welfare program:

9. Child Development Program Evaluation System of the Commonwealth of Pennsylvania

19. Child Development Quality Review System of the State of California

The Child Development Program Evaluation (CDPE) System was developed first in Pennsylvania and then in California under the aegis of a consortium of five states and New York City -- a consortium staffed by Gibson-Hunt Associates of Washington, D.C. The consortium efforts have been funded for three years under a grant from the Office of Human Development Services.

Through the efforts of the consortium, an abbreviated version of the day care monitoring instrument, called the Indicator Checklist, has since been developed in Pennsylvania and West Virginia, and is under development in California, Texas, Michigan and New York City. The abbreviated version takes less time to apply and has been prased by administrators and providers alike as a productivity tool and for its power to signal problem operations where some form of corrective action appears to be needed.

The development of the checklist in these and other states will be facilitated by a micro-computer software package developed by Gibson-Hunt Associates. The IBM-PC software package derives those indicators that are statistically most highly associated with overall good or bad performance by providers in the state. Pennsylvania has recently applied the same methodology to child welfare agencies as well as child development agencies and is currently developing an indicator checklist for this broader instrument.

The California Quality Review System was developed simultaneously with the CDPE indicator checklist. Presently, California is using the checklist methodology to develop a quality indicator checklist form the comprehensive instrument. These indicators will be merged with indicator checklist data from other consortium states to form a generic checklist, to be written up by the consortium at the end of this phase. In the fall of 1984, under the aegis of the consortium, California will be transferring the Quality Review system to Pennsylvania where it will be pilot tested and modified, before being implemented.

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An Instrument-Based Program Monitoring System: A New Tool for Day Care Monitoring

Volume I: Guide for Policymakers
Volume II: Guide for Developing the Indicator Checklist (Revised Edition)

by Richard Fiene and Mark Nixon, Children's Services Monitoring Transfer Consortium, August 1983. Funded under HHS/HDS Grant No. 90-PD-10005.

Child Development Program Quality Review

Prepared under the direction of the Office of Child Development, California State Department of Education, 721 Capital Mall, Sacramento, CA 95814. 1982.

Appendix

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