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Quality Assurance and Improvement Practice in Mental Health Agencies: Roles, Activities, Targets and Contributions

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Abstract

Accompanying the rise in the number of mental health agency personnel tasked with quality assurance and improvement (QA/I) responsibilities is an increased need to understand the nature of the work these professionals undertake. Four aspects of the work of quality assurance and improvement (QA/I) professionals in mental health were explored in this qualitative study: their perceived *roles*, their major *activities*, their QA/I *targets*, and their *contributions*. In-person interviews were conducted with QA/I professionals at 16 mental health agencies. Respondents perceived their roles at varying levels of complexity, focused on different targets, and used different methods to conduct their work. Few targets of QA/I work served as indicators of high quality care. Most QA/I professionals provided concrete descriptions of how they had improved agency services, while others could describe none. Accreditation framed much of agency QA/I work, perhaps to its detriment.

Quality Assurance and Improvement Practice in Mental Health Agencies: Roles, Activities, Targets and Contributions

A recent federal report identified quality as one of the most pressing issues in mental health services and the implementation of quality assurance and improvement (QA/I) systems as one of the most promising means to improved care (Institute of Medicine, 2006). Mental health agencies have been increasingly required by their accrediting bodies to specify and implement plans to continuously monitor and improve the quality of the services they provide (Commission on Accreditation of Rehabilitation Facilities, 2008; Council on Accreditation, 2008; Joint Commission, 2008). As a result, many mental health agencies have hired employees to conduct QA/I work, creating an unprecedented opportunity for service improvement.

Conceptually, modern QA/I models focus on determining which service processes and outcomes are most important, and determining how to measure and monitor them to identify areas for improvement. They concentrate on searching for key causes of identified quality problems, devising creative solutions to these problems, implementing these changes, and continuing to monitor and learn from these implementation efforts (Crosby, 1979; Deming, 1986; Donabedian, 2003; Harry, 1988; Pande, Neuman & Cavanagh, 2000 Walton, 1990; Zirps and Cassafer, 1986). In addition, Hermann et al. (2006) recently touted the important role that QA/I professionals could potentially play in monitoring fidelity to evidence-based mental

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health treatments, but noted the likely absence of this work to date. However, no research has been conducted that characterizes QA/I practice in mental health organizations, describes the targets for monitoring and improvement in these agencies and whether these efforts result in genuine service improvement. Some concern has been expressed that QA/I professionals may focus their efforts on targets not related to service quality (Hermann, 2005) or that these efforts are easily derailed by burdensome regulation and parochial views of what QA/I can accomplish (Shortell et al., 1998). In fact, it remains unclear from the conceptual literature where the boundaries exist in QA/I work. Since a broad number of things could result in improved services, what is and is not QA/I in mental health services?

Given that no prior research has been conducted, qualitative methods were determined appropriate to explore issues related to QA/I activities and targets. We interviewed QA/I professionals from mental health agencies in one U.S. geographic region to explore four questions: (1) How do QA/I professionals perceive their role? (2) What are their major work activities? (3) What are the targets of their activities (what they are monitoring, measuring, and improving)? And, (4) how do they perceive their perceived major contributions to the agencies they serve?

Methods

The study involved individual semi-structured interviews and a small secondary structured interview to collect demographic information with a purposeful sample of 16 QA/I professionals employed in private children's mental health services agencies in the St. Louis region. A maximum variation sampling strategy, which seeks to capture the broadest range of information and perspectives on the problem of study from diverse sources (Kuzel, 1999) was used to identify 23 local mental health agencies. Four of these agencies reported not having a designated QA/I employee. At one other agency, the position was vacant. One agency was unresponsive to our recruitment efforts and one agency QA/I professional declined to participate, leaving 16 agencies (of 18 eligible, 89%) and their designated QA/I professional. The sampling included three agencies that could be considered small (<US$2M annual budgets) and three agencies that could be considered large (>US$5M budgets). Four agencies were traditional community mental health centers, five included a residential treatment component and all provided mental health services to children and families. Fifteen of the 16 agencies were accredited, 10 by COA, four by the Joint Commission, and one by CARF. Five of the agencies had more than one QA/I professional. We interviewed the person in charge; if that person had been there less than six months, we interviewed the person with the most seniority, which was the case in one instance.

Recruitment of QA/I professionals was through mailed letters followed by phone calls between January–April of 2007. A $30 incentive was offered to participants. One QA/I professional was recruited per agency, and to be eligible had to be employed in that capacity for at least the past six months. Study participants had a mean of 7.81 (+/− 5.6) years of experience in QA/I. Three participants were male. One was African American; the others were Caucasian. To determine sample size based on the principle of data saturation (the point at which additional participants yield little new information), the process of data analysis ran concurrently with data collection. Saturation was reached by the 10th interview, but we decided to complete interviews for other agencies that we had contacted to capture greater depth and diversity of experience.

In person, in-depth qualitative interviewing was the main research strategy used, allowing us to explore the QA/I professionals' roles from their point of view without *a priori* demarcations (Miller & Crabtree, 1999). Interviews tended to last approximately 60 minutes. Of our nine initial interview questions, five (shown in the appendix) were germane to the focus in this

paper. We asked QA/I professionals (1) to describe their work and role, (2) to describe what they did last week (usually while reviewing their appointment calendar), (3) to describe routine tasks they undertake, (4) to describe what earned their supervisors' praises and (5) to specify what they had done as QA/I professionals that made a difference. The team's medical anthropologist conducted several interviews and trained and supervised two other interviewers. Interviews were conducted from Februaary to May 2007. All study participants provided informed consent to participate in this study, which was approved by an Institutional Review Board.

The interviews were audio recorded, professionally transcribed and transferred into NVivo 7 (QSR, 2006) for data management. The authors constituted the analytical team. The analysis followed a grounded theory approach, an inductive iterative process of open coding that involves breaking down, examining, and categorizing data (Strauss and Corbin, 1990). First, the analysts separately reviewed the first eight transcripts as they were prepared. They met weekly to discuss the content of these transcripts and to consider emerging categories in order to develop the codebook by consensus. After the codebook was completed, two analysts separately coded the first two transcripts and then compared and adjusted their coding patterns to standardize coding procedures before they coded remaining transcripts in NVivo7. Coding reports were then produced for further analyses. For some analyses, where the analytic task was to develop particular categories from coded data, multiple readers were involved and differences reconciled. For other analyses, where the purpose was to identify key illustrative passages, the lead author reported findings back to the team for interpretation, critique and synthesis.

Results

Results are organized by research question, focusing on role construction, activities, targets and major contributions of QA/I practice. The QA/I professionals perceived their roles differently, used different methods to carry out their responsibilities, focused on different targets and described different levels of contributions, but their regular tasks were often similar.

Perceptions of the QA/I Role

QA/I professionals portrayed their jobs in very different ways. Some professionals described their work in narrow terms, focusing on one major activity that encompassed most of their effort (5/16), while many others described their work in broad conceptual terms, mostly related to leading, organizing and managing the QA/I process (9/16). Two provided long lists of responsibilities (2/16) and resisted efforts to describe their role in more general terms.

Among the QA/I professionals who defined their work narrowly, the emphases varied. One stressed chart reviews. "Chart review is really about it. That's my main focus. We are a large agency [and] have a lot of charts, so it takes up a lot of time." Another respondent defined the work in terms of creating, administering and interpreting survey data. "Everyone who comes in contact with the agency gets a survey," said this professional. Another focused on writing, receiving and distributing reports on agency activities. "I make sure all this paperwork is being funneled through the channels." Another used a variety of strategies but said the job was all about monitoring. "I would say the main gist of what I do is monitoring and monitoring, the monitoring that goes on in the program." Several of the QA/I professionals who described their jobs narrowly worked at smaller agencies.

For those who defined the job more broadly, there was at least a partial focus on developing a program of QA/I activities for the agency. "Part of my scope of responsibility is to set the direction for quality activities at the agency," said one of these professionals. Yet the respondents defined this mission using different terms. Said one: "My job is to ensure that we

meet our [agency] objectives." Another respondent described leading the effort to make sure that clients achieved their outcomes: "I am responsible for collecting and managing the outcomes throughout the organization." Still another saw the work as finding processes that were not working and making them better: "My job now is almost 100% process improvement." Several of the QA/I professionals that described their jobs more broadly worked at larger agencies.

One professional saw her job largely as a fixer of problems, especially those that threaten the financial survivability of the agency. "My role relates to dealing with issues that might be problematic for the agency…The position was created to deal with survival issues… If we don't have proper documentation, we lose funding. Once, we had I think 1000 issues [from an external audit]. That's a lot of money [to lose] for a small agency. We were able to get that down to 80 questionable items. Billing is very important."

External requirements admittedly defined the work of some of the respondents who described their role broadly and conceptually. One of these professionals described the work as "aligning the agency's day-to-day work with the [requirements of] external sources that provide guidance about how we are supposed to do our work." Another described the work in terms of following the rules: "We make sure that all of our programs are doing what they are supposed to be doing according to their contract guidelines, their program plan guidelines, as well as accreditation and licensing standards, any kind of governing body." To this respondent, QA/I professionals "… become the experts on rule and procedure and how it applies to programs."

External requirements, especially accreditation, also framed the work of QA/I professions who described long lists of job responsibilities. Said one respondent, "I do many things at the agency for [QA/I]. The bulk of that I would say would be related to our national accreditation." Another said, "It's really making sure that everything we do helps us to meet our accreditation standards. This is a very important criterion for us." QA/I professionals at large and small agencies defined their jobs in terms of accreditation. Although implicit in several respondents' transcripts, two QA/I professionals explicitly described a dual function involving both meeting compliance standards and putting in place a QA/I system. "One of the major pieces that I'm involved in is making sure that we are in compliance with all of the accreditation standards. We are accredited by the Joint Commission. So, in many ways that's what frames my job…Then, also it's my responsibility to define what our process is for quality improvement."

Major Activities of QA/I Professionals

Despite describing their roles differently, these QA/I professionals reported spending substantial parts of their time in similar activities: leading and serving on committees, collecting and analyzing data, and writing various reports on the results of the data analyses. Fifteen of the 16 respondents talked about regularly attending and leading a number of meetings and committees. "A lot of the work is done via committees," said one respondent. Several QA/I professionals described an overall committee in charge of the agency's QA/I process, which the QA/I professional often led. Several also mentioned being part of an overall agency executive management or leadership committee. They also reported serving on committees related to employee credentialing, billing, forms, medical records, accreditation, safety, incident reports, security, building and grounds, HIPAA compliance and clinical care, as well as ad hoc committees created to address targeted problems. Some agencies had a process in which the administration reviewed QA/I monitoring information and developed committees to address identified quality problems.

> The administration comes up with a focus where they want a committee to look at possible improvements. Then, they come up with an opportunity statement, which is a broad statement of the problem, and what they kind of are about as a solution. They

> assign people to sit on that committee based on their information, and their knowledge about the particular thing. Then, they'll assign me to be the chairperson of that Ad Hoc committee, because I'm the one person who's trained in the process.

Although academics and institutional review boards often emphasize the difference between QA/I activities and research (e.g., Bellin & Dubler, 2001), the respondents classified much of their work as research, involving data collection, data management or data analysis. This work was reported by all but one respondent. Chart reviews, client interviews, mailed surveys, and use of agency administrative databases were described as routine methods of data collection.

The work varied substantially based on whether an agency had sophisticated electronic client record systems. One respondent said that with his/her agency's record system, "I can just generate reports…push a button, and it will tell me anything I need to know and categorize data any way I want." In these agencies, QA/I professionals reported being involved in developing and managing these systems.

> I'm not an information systems professional at all, I have a degree in social work. But, the task in the last five, six years has been for me to be the bridge between operational needs and the programmer, so that we create an information system that has value for our work here and allows us to do our work as efficiently as possible.

The process was quite different at agencies without an electronic client record, where they relied heavily on chart reviews: "We have these file reviews and program reviews…and we're taking that information and it moves up to me and then I do my tallying and aggregating and I create spreadsheets for that."

Communication activities that involved documenting and disseminating results were described by 13 of the 16 participants as part of their work routine. Several mentioned having various reports due each quarter: "Quarterly I need to draw all that information together to say, 'What have we been working on? What trends have we identified? What do we need to improve?'" Others mentioned reports required by accreditors, funders, and regulators, each in its own specified format. "We have an annual Maintenance of Accreditation Report. That is a year-end report that the Council on Accreditation requires. They say, 'tell us everything you did in 2006 that shows you do quality improvement work.' And you literally have to write a report saying everything you did in 2006." Others said that they created different versions of the same report for different audiences because "what's useful for the executive director is not useful for our ground staff."

In addition, several respondents described other responsibilities that were assigned to them in their QA/I role that would not be considered traditional QA/I work using classic formulations (e.g., Donabedian, 2003). This included, for example, being responsible for the agency policy and procedure manuals, developing disaster plans, managing information systems, or serving as the HIPPAA privacy officer. Two QA/I professionals mentioned that they were often pulled from their primary job to write grants. In addition, the QA/I professionals mentioned being assigned a variety of tasks that needed done, but there was no obvious person within the organization to whom to assign the task. For example, one QA/I professional was asked to lead an effort to develop a plan to respond to a bird flu pandemic. As one participant declared, "Everything falls within the QA rubric."

The Targets of QA/I Activities

QA/I professionals reported that their work was aimed at monitoring and improving (1) service provision, (2) safety, (3) consumer outcomes, (4) consumer perspectives, (5) staff perspectives and issues, (6) community perspectives, and (7) productivity and finances. Table one presents specific examples of expressed targets supporting each of these categories. No one participant

mentioned targets covering all of the seven categories. Some agencies focused primarily on outcomes, some on safety, and some on service provision. Some respondents, however, reported that their agencies were monitoring an enormous number of things, while other agencies appeared to be monitoring little or nothing. QA/I professionals that were monitoring many things said that this was due to accreditation and other external requirements. Some of the targets for monitoring were not things that would typically be included as part of the QA/I function (fundraising, finances, mileage).

Although most agencies were monitoring some aspect of service provision, few of their specific targets seemed to get at the core dimensions of quality as described in the conceptual literature (Martin, 1993; Megivern et al., 2007), even when reduced to its most common elements such as technical proficiency and interpersonal sensitivity (Megivern et al., 2007). The most common targets in this category, for example, were whether there was a treatment plan in the chart, whether it was signed by the client, and whether progress notes were present. One agency's QA/I department was reported as having procedures that judged whether the treatment received by clients was appropriate for their problems, and another had procedures to evaluate whether treatment received was appropriate to the psychiatric diagnosis. One respondent mentioned evidence-based services, but no one reported monitoring fidelity to evidence-based treatment.

Descriptions of what respondents were evaluated on and praised for by supervisors also informed our analyses. They reported being praised for and evaluated on three general areas: (a) achieving or maintaining accreditation (5/16), (b) improving the organization's efficiency (5/16), and (c) improving the organization's results (3/16). Accreditation was the primary yardstick against which several respondents were measured.

> "The criteria for evaluation… I don't want this to sound bad, but it's really making sure that everything we do helps us to meet our accreditation standards. This is a very important criterion for us and to not meet those standards and to have trouble with the site visit or to have major recommendations that put our accreditation at risk are critical."

Said another: "If we didn't get reaccredited, they'd look at me and say, 'What happened? What went wrong?…You lead that effort." Respondents were commended also for making systems work better. For example, one respondent earned praise for digitizing agency manuals and forms and placing them on the agency's intranet. Few QA/I professionals (3/16) reported that they were praised for or evaluated on changing results for clients or programs. An exception is a QA/I professional that was evaluated on "being able to foster … a culture within the organization that allowed us to reduce the use of locked isolation and physical restraints" (see example below).

Major Contributions

We asked participants to provide examples of how their work made a positive difference in client services or in the agency. Several provided multiple examples. Ten respondents provided at least one in-depth answer that appeared to involve a substantial contribution of one variety or another. We detail the two examples that we felt most directly demonstrate how QA/I can make a difference in agency practice and outcomes. The first involves reducing the use of physical restraints and locked isolation.

> We had collected enough data internally to feel that our own practices were out of control. We were using restraint too often, were placing kids in locked seclusion too often for too long, and staff were getting hurt in the process. So, it was real clear that we needed to do something. We went about the process of doing many, many things over the course of the next three or four years that ultimately had a good impact in

> this whole area. We embraced a new behavioral management model. We got trained on it. We brought in in-house trainers. We did extensive training with staff. We really worked to improve our data sets on the use of incidents, in general, but particularly the use of restraints and locked seclusions, so that we had a good sense of what our baseline activity was as we got started. …I was the champion for all this. I can't take full credit for everything that occurred, but we did some things structurally where we shifted around some staff responsibilities, added some staff, …we improved our documentation methods. We automated our incident reports system, all towards getting better data. We convened monthly a quality committee that looked at the data and had big thoughts about what we could do in response to it. Over the course of a few years, and not to sound too grandiose, but we changed the culture here, where locked seclusions and restraints became the exception to the rule, rather than an immediate response to aggression. And, we have the data to substantiate that because we've continued to track the data.

The second detailed example involved a sustained effort to markedly improve outcomes in a troubled program.

> One example that comes to mind is a program where they had a lot of turnover. Their supervisor left and in the middle of it all [the program's funder] came in to do a review. It was not good. We got put on an external corrective action plan that basically said, you have to make these improvements or we'll pull your contract. So, we totally ramped up the services that we provide through QI. We did weekly reviews of their records. We worked very closely with the new supervisor who was brought in, in terms of expectations and just helping her build on that corrective action plan and use that corrective action plan as a tool to focus her efforts and decide, okay these are the first five things we're going to work on; these are the next five things we're going to work on. Although it took some time, [the funder] was able to see that we had a plan. They were very pleased that QI was involved and it made a huge difference. The program was able to, within about eight months, get off that corrective action plan and now is probably one of the stronger programs in our agency.

One QA/I professional mentioned improving client outcomes in a specific program as a major contribution. Another talked about how they raised client satisfaction across the agency. "We raised client satisfaction scores last year. We spent a lot of time figuring out what clients want and how we could change the things we do." The other examples offered by respondents did not directly involve improving consumer outcomes. They included:

- Devising an electronic system that alerted supervisors when a client was not assigned a case manager, preventing clients from "falling through the cracks."
- Leading an effort to get the agency up-to-date on research in the field.
- Installing a new billing system that greatly reduced errors.
- Installing a new client data management system that reduced the recording burden on clinicians.
- Problem solving a way to reduce no-shows in an outpatient clinic.

One QA/I professional described how QA/I had improved the agency's financial bottom line by becoming more competitive in grant applications as a result of having documented consumer outcomes through a system that the respondent had designed. Several mentioned that their data collection and analysis activities uncovered problems that would never have been addressed if they did not have data from consumers. This included problems with food service, accessibility, and unappealing bathrooms.

In stark contrast, six QA/I professionals struggled to come up with a single concrete example of how they had made a difference. The respondent who defined her job as all about chart reviews said she/he once found a piece of information in a chart that an auditor could not find. A QA/I professional who defined the work as all about compliance with policies said, "Just, you know, leading the effort in dotting every 'i' and crossing every 't.'" Similarly, another said, "I don't know if I have one example, but just everyday, like doing the chart reviews. … So, basically if the charts are all in line, then we're fine from a billing standpoint." One listed redesigning the client satisfaction surveys as the major accomplishment. For another, it was redesigning the agency's progress note to make it easier for the QA/I team to find the information that they monitor. Another could not come up with an example from her current job, but said, "At my previous agency, I was able to get them nationally accredited."

Discussion

This is the first study to examine the activities and roles of QA/I professionals in mental health agencies. The results were illuminative in several regards. We focus this discussion on four issues: the difficulty several respondents had in identifying ways that QA/I had made a difference in their agencies, the substantial variation in QA/I activities across agencies, how accreditation frames QA/I work, and the lack of QA/I focus on quality service provision. Then, we offer specific recommendations for mental health administrators, policy makers and future research.

The fact that several QA/I professionals could not provide an example of how their work made a difference leads us to conclude that their agencies were not well-served by their QA/I work. Services and outcomes were not being improved despite a great deal of QA/I activity. Those QA/I professionals whose work focused on compliance with an array of external standards and internal policies appeared to be those least likely to detail how their work had improved services or outcomes. QA/I work as conceptualized by leading theorists is all about quality improvement, not compliance. When the focus in these frameworks is placed on monitoring (e.g., Donabedian, 2003), it is on monitoring as a means to finding quality problems that can be improved. Here, it appears that some agencies were monitoring to be able to report that they were monitoring.

QA/I professionals' activities varied substantially across organizations, focusing on different targets and methods and how they perceived their work. No uniform way of doing QA/I in mental health agencies has developed and no single profession or organization has taken on the task of preparing QA/I professionals for their roles. This variation may also reflect a developmental phenomenon. Agencies may get more sophisticated in their QA/I work over time, starting with collecting data on a few things in mostly manual ways, and gradually developing more systems to capture more and different kinds of data over time. But more systems to monitor more targets do not necessarily translate into effective QA/I interventions that improve quality care and consumer outcomes.

Several QA/I professionals reported that the foci of their work were largely determined by accreditation and other external requirements rather than being thoughtfully determined through priority-setting procedures that targeted problems that, if solved, would have substantial impact on consumers' lives. Few of the respondents' stories involved improved outcomes. Few of the professionals perceived that their main job responsibility was improving services. And few QA/I professionals reported earning praise for improving consumer outcomes. This focus away from improving care and outcomes appeared to be especially acute in agencies that were attempting to monitor a large number of things across many domains. Accreditation requires QA/I processes to be in place to monitor and improve quality (e.g., COA, 2008; CARF, 2008). But, instead of using QA/I systems to monitor for quality and shape

practice toward what the agency determines to be high quality service, some QA/I professionals monitor for compliance to accreditation and other external standards and work to shape practice toward meeting them. This is a corruption of QA/I frameworks. In order for QA/I professionals to have a substantial impact using a compliance-based strategy, agencies must trust that accreditors and regulators get it right, that promulgated standards focus on the aspects of service most likely to enhance consumer outcomes. This is a questionable assumption, given the lack of research to date on the effect of accreditation and regulation on consumer outcomes.

A second problem with focusing QA/I monitoring efforts on compliance with standards is that there are a lot of them. The Joint Commission, COA and CARF each have over 200 standards applicable to mental health programs for children and families. COA mandates quarterly reviews of case records, incidents, accidents, and grievances. It mandates the assessment of consumer satisfaction, consumer outcomes and evaluations of programs. It also requires monitoring of operations and management and includes financial viability, systems efficiency, and job satisfaction as examples of operations monitoring. The Joint Commission mandates the collection of consumers' perceptions of care, treatment and services, and measurement of medication management, restraint use, seclusion use and treatments. Although less prescriptive, CARF also mandates monitoring of business functions and service effectiveness, efficiency, access and satisfaction. This proliferation of standards is exacerbated by the need for some agencies to monitor the standards of multiple regulators. It may be costly yet intellectually easy to drift into a "monitor-everything, but improve little" mindset. Most mental health agencies have limited resources to devote to QA/I. Therefore, they can only focus their energies in a few areas at a time. These should be the areas where their work can create the greatest impact.

Seven primary domains of QA/I targets emerged from this research. All appear to be important aspects of agency life and most have the potential to affect the quality of consumer care. However, we were struck by how rarely a target for improvement or monitoring reflected high quality service processes. Noting the presence of a treatment plan is not an indicator of quality, although a lack of one may reflect poor quality. The lack of reported struggle about how to define quality service in meaningful ways is itself notable. For QA/I to improve the quality of mental health services, agencies may need to do a better job of defining quality care. Evidence-based treatment defines high quality care as care delivered with fidelity to the intervention. As Hermann and colleagues (2006) likely would have predicted, however, no QA/I professional reported monitoring treatment fidelity.

The QA/I role is impressive in its complexity. QA/I professionals reported a lot of responsibilities, from accreditation maintenance to improving consumer outcomes. Their work potentially covers a wide range of knowledge, from clinical processes, to research methods, to standards and rules, to management information science, and more. To support this important work in mental health, the QA/I role may benefit from professional academic preparation, intense continuing education, increased resourcing, and systematic research on the effectiveness of specific QA/I methodologies. The investment in these resources may depend on whether QA/I truly improves the care consumers receive and their clinical and functional outcomes. Some of the examples related by QA/I professionals in this study provides some preliminary suggestions that QA/I holds potential to improve care, but only if done well.

Implications for Administrators

The results from this study lead us to six recommendations for administrators in mental health agencies. (1) Since QA/I systems can look very different from one another, administrators should think about how they want the QA/I enterprise in their agencies to be constructed. For example, do they want QA/I systems focused on agency objectives, consumer outcomes, quality processes, or on external standards? (2) Administrators should also assess the breadth

of QA/I monitoring that is ongoing at their agencies and determine the breadth of focus that is ideal or feasible. A QA/I staff that is asked to monitor too many things may lose the ability to identify and respond to the most pressing quality problems. A QA/I staff that focuses solely on the most pressing problems may improve delivered services, but may not maintain the monitoring that external bodies require. Administrators can determine whether they want a QA/I system based on monitoring a wide number of things, or one that is based on identifying and fixing big problems with big impacts. (3) Administrators should ask their QA/I team to detail the major ways that they have improved services or agency functioning. If they cannot answer the question, as some of our respondents could not, the administrator likely has a dysfunctional QA/I team and may need to take steps to replace or retool the team. (4) Administrators should ask their QA/I professionals to detail the indicators of high quality mental health care that are monitored. If there are none, or the QA/I team thinks the presence of a treatment plan is an indication of quality, the administrator should spur efforts to develop some. (5) Agency administrators should resist the temptation to fill up the portfolio of QA/I professionals' responsibilities with "other duties as assigned." QA/I work has the potential to contribute in important ways, but only if QA/I professionals can devote themselves to monitoring and improving care. (6) Administrators should determine whether the skills and qualifications of their QA/I team meet the needs of what has become an evolving and increasingly complex enterprise.

Policy Implications

Accreditors and other external regulators of mental health services need to recognize the burden of the ever increasing number of standards that agencies are asked to monitor. Not only is it expensive to mount a system to monitor a high number of standards, it may take focus away from efforts to identify an agency's primary quality problems and to improve them. It is ironic that the same forces that led to the hiring of QA/I professionals in mental health services may hinder their effectiveness by diffusing their efforts.

Limitations and Research Implications

While this first look at QA/I professionals in mental health agencies is informative, it is based on results from QA/I professionals in one geographic region. Survey research on a larger, more representative scale is a logical next step to help determine what it is that QA/I professionals are asked to do in mental health agencies nationally and to better identify national goals for the training and education of QA/I professionals for mental health. This beginning effort was a necessary first step before this more representative work, as it identifies.ways the QA/I enterprise can be constructed and possible categories of QA/I activities and targets that can be used as the basis for survey content. This would allow, for example, estimations of the time spent on the different kinds of activities. In addition, the study collected views only from the QA/I professional. Although this professional is the best informant of what the QA/I professional does, the views of senior managers and clinicians could have been informative. Future work may wish to collect information on the QA/I enterprise from multiple viewpoints. The probes used in this study focused mostly on clarifying what the QA/I professionals did and how they perceived their roles, and less on why they did what they did. Future work may wish to delve into this issue more thoroughly.

Conclusions

This study found wide variation in how QA/I professionals in mental health agencies approach their jobs. This likely reflects the lack of standardization and training in this new, growing, and demanding field of mental health practice. QA/I work done well can likely make a difference in agency practice and outcomes. QA/I work done poorly can likely drive agency staff mad with requirements for excessive monitoring for little gain. The fault of excessive monitoring

may not lie with the QA/I team, but with external accreditors and regulators. While accreditation is spurring the QA/I movement, the focus on meeting a large number of accreditation and other regulatory standards may deter in-depth QA/I efforts that truly improve identified problems. The QA/I role in mental health deserves increased professional attention from researchers, academic institutions, and agency administrators.

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References

Bellin E, Dubler N. The quality improvement – research divide and the need for external oversight. American Journal of Public Health 2001;91:1512–1517. [PubMed: 11527790]

Commission on the Accreditation of Rehabilitation Facilities, International. Child and Youth Services Standards Manual. Tuscon, AZ: 2008.

Council on Accreditation. Council on Accreditation Standards: Private Organizations (8th edition). 2008. Available online at www.COAstandards.org

Crosby, PB. Quality is free: The art of making quality certain. New York: McGraw-Hill; 1979.

Deming, WE. Out of the crisis. Cambridge, MA: MIT Center for Advanced Engineering; 1986.

Donabedian, A. An introduction to quality assurance in health care. Oxford: Oxford University Press; 2003.

Harry, MJ. The nature of six sigma quality. Motorola University Press; 1988.

Hermann, RC. Improving mental health care: A guide to measurement-based quality improvement. Washington, D.C: American Psychiatric Press; 2005.

Hermann RC, Chan JA, Zazzali JL, Lerner D. Aligning measurement-based quality improvement with implementation of evidence-based practices. Administration and Policy in Mental Health and Mental Health Services Research 2006;33:636–645. [PubMed: 16775755]

Institute of Medicine. Improving the quality of health care for mental and substance-use conditions. Washington, DC: National Academy of Sciences; 2006.

Joint Commission. Standards for behavioral health care. Terrace, IL: Oakbrook; 2008.

Kuzel, AJ. Sampling in qualitative research. In: Crabtree, BF.; Miller, WL., editors. Doing Qualitative Research. Thousand Oaks, CA: Sage; p. 33-45.

Martin, LL. Total Quality Management in Human Service Organizations. Newbury Park, CA: Sage Publications; 1993.

Megivern DA, McMillen JC, Proctor EK, Striley CW, Cabassa LJ, Munson MR. Quality of care: Expanding the social work dialogue. Social Work 2007;52:115–124. [PubMed: 17580773]

Miller, WL.; Crabtree, BF. Depth interviewing. In: Crabtree, BF.; Miller, WL., editors. Doing Qualitative Research. Thousand Oaks, CA: Sage; p. 33-45.

Pande, PS.; Neuman, RP.; Cavanagh, RR. The six sigma way : How GE, Motorola, and other top companies are honing their performance. New York: McGraw-Hill; 2000.

Qualitative Solutions and Research [QSR]. NVivo 7.0.: Using NVivo in qualitative research [Computer software and manual]. Melbourne, Australia: QSR International; 2006.

Walton, M. Deming management at work. New York: Plenum; 1990.

Shortell SM, Bennett CL, Byck GR. Assessing the impact of continuous quality improvement on clinical practice: What it will take to accelerate progress. Millbank Quarterly 1998;76:593–624.

Strauss, A.; Corbin, J. Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage; 1990.

Appendix

APPENDIX

Initial questions used to elicit information about QA/I activities, targets and contributions

Please describe your work as a quality assurance professional.

What are the main priorities of your work, the things you focus attention on?

In general we are interested in things that quality assurance professionals have done that have really made a difference in terms of delivering quality services to patients or consumers. Could you give us an example of something that you have done that has made a difference?

What kinds of work or accomplishments would your supervisor praise you for?

What kinds of activities did you do at work last week? You may want to look at your work calendar to help you answer these questions.

---- What projects were you working on?

---- Who did you meet with?

---- What kinds of routine tasks did you do?

Table 1

Categories of QA/I Targets: What is Being Monitored and Changed in QA/I Efforts?

Category	Stated Targets	
Service Provision	• Presence of treatment plans	• Whether care meets regulators' requirements
	• Whether treatment plans are completed within specified time frames	• Level of family involvement
	• Whether treatment plans are signed by consumers	• Screening for specific conditions
	• Whether objectives are specified in the treatment plan	• Indications of required assessments (annual psychiatric evaluation, dental exam, physical exam)
	• Whether objectives are written for needs identified in assessments	• Evidence based practices
	• Whether plans are appropriate for the diagnosis	• Length of time clients served
	• Presence of progress notes	• Are consumers being seen (provider fraud detection)?
	• Whether referrals are made (when screening indicates a problem)	• Are consumers being seen within specified timeframes?
	• Whether follow ups are made with clients after missed appointments	• Were clients assisted with medication reminder lists?
	• Socialization opportunities	
	• Medication documentation	
Safety/Risk mgt.	• Adverse or critical events (general statements)	• Child maltreatment reports
	• Physical injuries to staff or consumers	• Presence of medication procedures
	• Suicidal behavior	• Infection surveillance
	• Facility safety	• Fire drills conducted
	• Medication errors	•Do staff know what to do in emergencies?
	• Medication tracking (in/out of agency)	• Staff CPR certifications
	• Use of restraints, locked isolation	• Staff TB testing, flu shots
		• HIPAA compliance
Outcomes	• Outcomes (general statements)	• Recidivism
	• Clients' perception of improvement	• School truancy, suspension, expulsion
	• Whether treatment plan objectives were met	• Hospitalization
		• Time remained sober
Consumer perspectives	• Consumer satisfaction	• Consumer perceptions of safety
	•Consumer complaints	• Food satisfaction
	•What clients wanted	
	•Whether treated respectfully	
Staff perspectives and issues	•Employee satisfaction	• Employee safety (incidents)
	•Employee retention	• Employee exit information
	• Employee perceptions of support, team relations, attitudes toward supervisors and administrators, etc.	• Credentialing (checking credentials)
	• Staff views of the functioning of other departments	• Training completion
		• Number of days to fill staff vacancies
Community Perspectives	• Community attitudes toward the agency	• Unmet community needs
		• Referral source satisfaction
Productivity/Finances	• Whether billing reports were submitted	•Number of clients served
	• Mileage	• Fundraising

Category	Stated Targets	
	• Productivity (billing) per worker	• Finances