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C. INTEGRATING M&E AND QUALITY IMPROVEMENT – PARTNERS IN HEALTH

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GP Area: Method/Tool

GP Level: Promising Practice

ABSTRACT

This article describes how Partners In Health (PIH) is utilizing its monitoring and evaluation data to improve the quality of its programs. PIH details how feedback loops can be improved within nonprofit organizations and makes the important

distinction, but also linkage, for project implementers between quality of data and quality of care. PIH also reviews the initial steps taken within the organization to continue to improve the quality of its programs.

Key Resources

Berwick, Don. Narrowing your focus- Using data to launch improvement activities. Retrieved from www.nationalqualitycenter.org/download_resource.cfm?fileID=19971

GOOD PRACTICE NARRATIVE:

The Problem Addressed

As PIH has expanded, both to new countries and to new sites within existing countries, maintaining a high level of service and quality of care remains a core value and an ongoing challenge. In the past few years, PIH has made a strategic decision—and significant investments—to increase M&E efforts across its program sites. As a result, momentum and enthusiasm for measurement has increased dramatically; from paper forms to electronic medical records, almost all PIH clinical and social services are quantified in some way. The challenge, therefore, is less one of measurement and reporting and more one of data utilization for understanding gaps and data-driven quality improvement.

Every nongovernmental organization collects data, typically for the purposes of reporting to headquarters, donors, or governments. Figure 1.6 depicts what can be described as the typical “feedback loop”—that is, a great deal of information is reported outward but very little information is fed back to promote a process of improvement. In addition, a large amount of data are collected at the site level but not used internally to examine volume or quality of services provided. As a result, the quality of the data collected suffers. This is not surprising, as stakeholders at all levels of data collection and aggregation, from data officers to managers, have no reason to collect and report high quality data if there is little or no incentive to do so. Changing this dynamic, which is tantamount to an organizational culture shift, is therefore a challenge of utmost importance.

The GP

Beginning in 2011, the PIH M&E team officially added “Quality” to its department title (now Monitoring, Evaluation and Quality, or MEQ). The reason for this change was to draw explicit attention to the core purpose

The Typical M and E Feedback Loop
National/donor/HQ

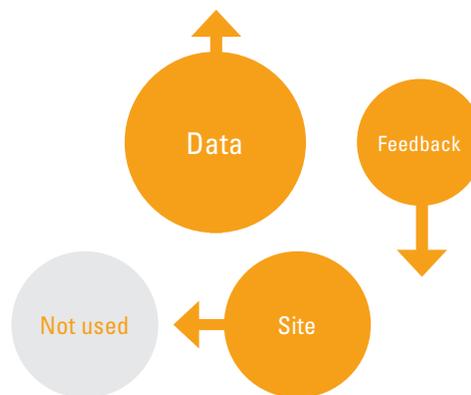


Figure 1.6—Typical Feedback Loop
(presentation from PIH MEQ team, 2011)

of data collection and measurement—the use of data to identify gaps in quality of care or services and to make concerted efforts to close those gaps through targeted action. In the true spirit of a nimble “learning organization,” the goal of the MEQ team is to build capacity and enable PIH programs to use data for mid-course correction. Identifying disparities in healthcare delivery and working as a team to find innovative solutions to improve quality is an enormous challenge, but it is also crucial for an organization like PIH, whose core mission is “to provide a preferential option for the poor.”

Data Stages

Having appreciated and accepted this challenge, PIH has found it useful to articulate a process for cultural transformation in data utilization practices. This consists of increasing the capacity for and belief in a collective ability to improve quality. Borrowing from Don Berwick’s “Stages of Coping with Data,”⁴ the PIH MEQ team has added three stages of its own. Figure 1.7 sets forth Berwick’s four stages, which begin with “the data are wrong,” an explicit reference to lack of confidence in data quality. PIH has added a stage zero (“What data?”) as an honest acknowledgement that many implementers are simply unaware that data on service delivery even exist. Berwick’s stages end at IV: “The data are right, it’s a problem, it’s my problem.” PIH then added two more stages to reflect collective ownership of service gaps and an explicit notion that positive change and quality improvement are possible.

Don Berwick's 4 Stages Plus 3

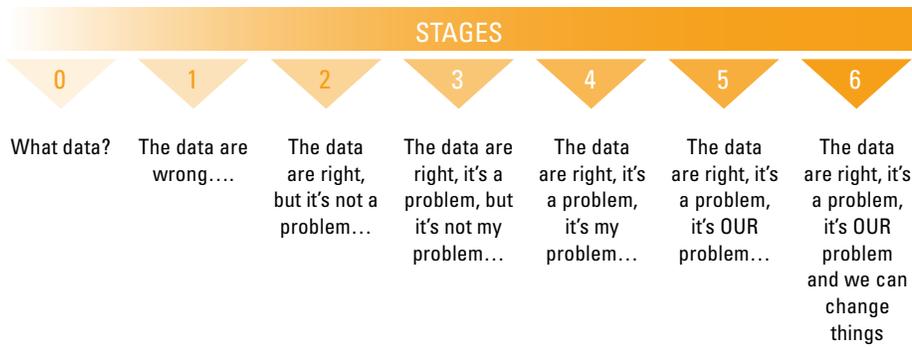


Figure 1.7—Data Stages (presentation from PIH MEQ team, 2011)

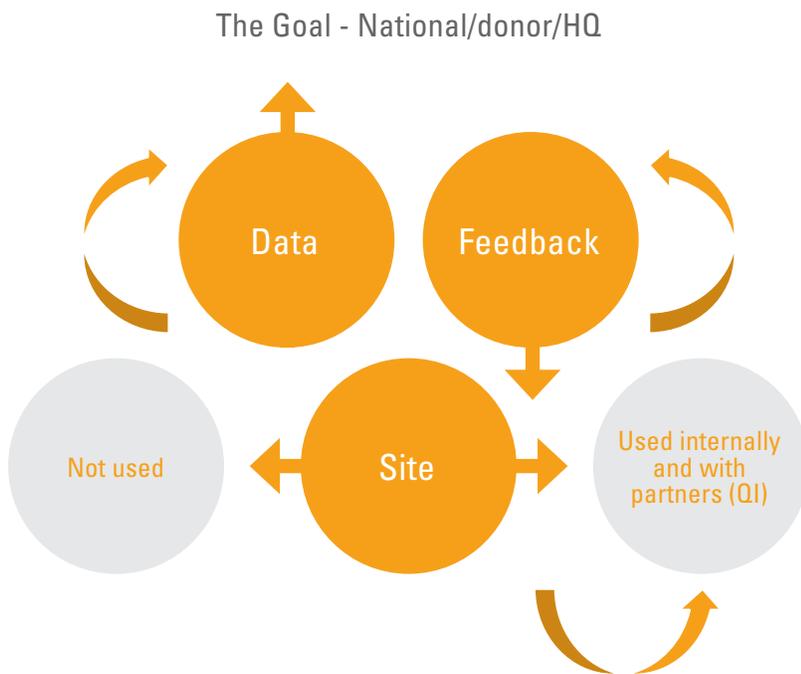


Figure 1.8—Model Feedback Loop (presentation from PIH MEQ team, 2011⁵)
*Data quality assurance & improvement

With a culture of data use and quality improvement in place, a more robust feedback loop can be achieved. As depicted in the model feedback loop in Figure 1.8, the amount of unused data is minimized. In addition, data reported up from the project is returned in a manner that maximizes communication of what results the data actually show. This creates a catalyst for internal data utilization for quality improvement, which can facilitate sharing of good practices and lessons learned with partners. Moreover, individual programs can examine other areas of focus (that are not externally-driven) and use the reported data to identify areas of gaps and success. Finally, the red arrows in Figure 1.8 represent continuous data quality assurance and improvement. This reflects the simple fact that if data are examined regularly and used to drive change, the quality of data will improve.

Quality of Data vs. Quality of Care

A crucial distinction in monitoring and evaluation is between Quality of Data and actual Quality of Care or service provided. As described in Figure 1.9 (using the example of Pap Smears for women), a Quality of Data issue occurs when the data do not accurately reflect reality—that is, the data are incomplete or simply incorrect. Conversely, if the data are indeed correct in accurately describing the care or service delivered, then implementers can be confident that the issue is Quality of Care. For data use and quality improvement efforts to commence, project staff must have a system in place to ensure Quality of Data.



photo by Partners In Health

Regular data quality assurance permits service indicators to be tracked over time, across health centers and relevant sub-populations (e.g., gender, age, ethnic groups, etc.). This allows gaps to be identified and measured, both for improvement and recognition of positive deviance for replication and dissemination of success. Quality improvement project teams can then use data to plan and set goals to eliminate disparities and improve quality.

Integrating MEQ Improvement at PIH

The MEQ team at PIH has made strides on integrating quality improvement components into its strategic priorities and has ensured that activities reflect this objective. The following approaches have been instrumental in facilitating this integration: (a) Coordination of complementary efforts between teams—Medical Informatics and MEQ; (b) Creation of PIH Cross-Site

Indicators; (c) Focus on data quality, data use, and communication of results; and (d) Use of innovative tools to facilitate rapid feedback. Each of these approaches is discussed in more detail.

Coordination of Complementary Efforts Between Teams—Medical Informatics and MEQ

At PIH, the Medical Informatics team works to create and support electronic data collection systems and reporting tools. One of the lessons learned was the need to explicitly design at project initiation how data will be extracted and used for M&E, reporting, and quality improvement. This year, the Medical Informatics and MEQ teams have intensified coordination efforts to facilitate regular extraction of data for review by the site and PIH core MEQ teams. By defining clear indicators and integrating a natural space for data consumption, the

Quality of Data	Quality of Care
50% of women received Pap Smears	Only 50% of women received Pap Smears
You know that you provide Pap test to 90% of women	Data accurately reflects service delivered
Data does not reflect service delivered	This is a quality of care issue
You may have a data quality issue	

Figure 1.9—Quality of Data (presentation from PIH MEQ team, 2011)

Currently Enrolled Patients with Recent Visits & CD4 Counts**

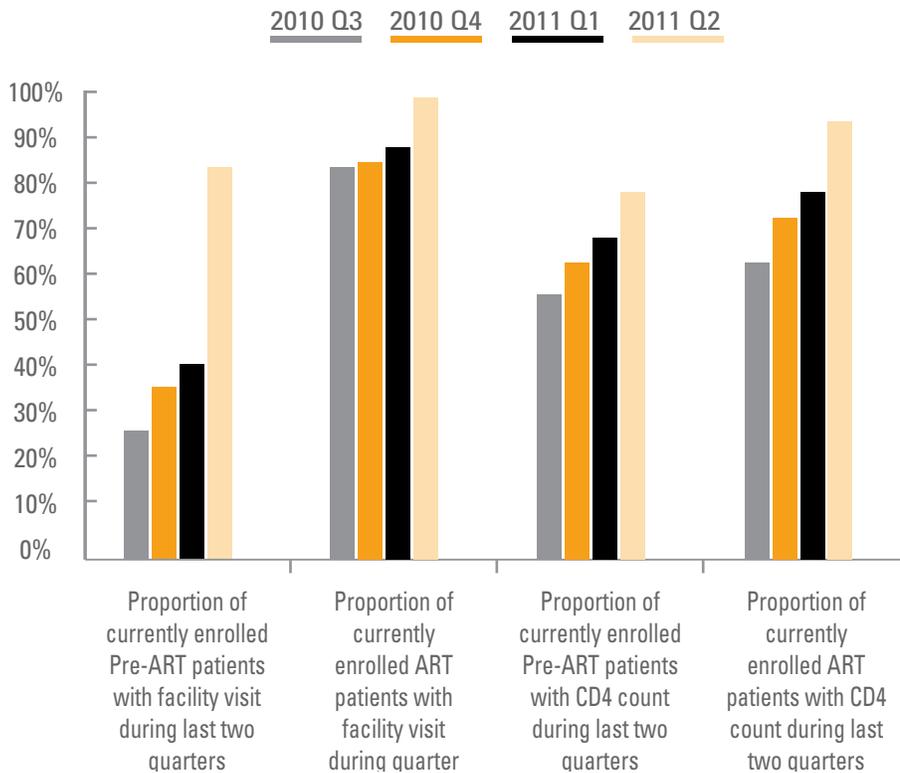


Figure 1.10—Dashboard Example (presentation from PIH MEQ team, 2011)

**Data in this graph is not real and is for illustrative purposes only.

Medical Informatics team has been able to use MEQ feedback, detect quality issues sooner, and work with the country programs to improve systems of data collection and entry.

Creation of Cross-Site Indicators

PIH recognized the importance and value of having different country programs look at quality and services across core thematic areas to understand where there were individual or cross-country challenges and identify areas for sharing of good and promising practices. In February 2011, the first PIH Cross-Site Indicator report was generated as a collaborative effort of headquarters and site-based Medical Informatics and MEQ teams. The report was circulated to senior management and PIH Country Directors. Phase I of these indicators has focused on HIV care and treatment and reports a common set of metrics across PIH's largest rural healthcare demonstration sites: Haiti, Rwanda, Lesotho, and Malawi. Data are aggregated to the country level but also are available at the facility level for individual country use. Plans are also underway to expand the indicators to other key service areas, including tuberculosis, maternal and child health, and community health workers. The report has facilitated sharing of good practices between and within sites and served as a platform from which to launch quality improvement activities.

HH Chart - PIH Malawi

Malawi Health Center	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total Households	2010	2015	2412	2365	2314	2451	2465	2451	2421	2501	2550	2523
Total Pregnant Women	99	96	82	80	78	76	75	64	60	55	52	78
Number Pregnant No HIV Test	55	65	52	34	30	25	24	20	17	8	11	4
Proportion Pregnant No HIV Test	56%	68%	148%	43%	38%	33%	32%	31%	28%	15%	21%	5%
Number Pregnant No ANC	45	40	30	22	20	24	23	15	18	5	6	4
Proportion Pregnant Not Started ANC	45%	42%	37%	28%	26%	32%	31	23%	30%	9%	12%	5%

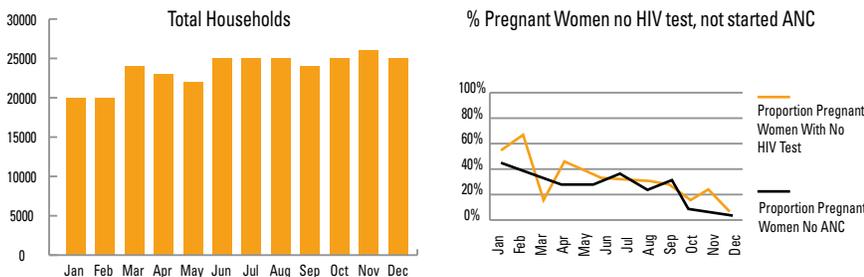


Figure 1.11—Dashboard Example (presentation from PIH MEQ team, 2011)

**Data in this graphic is not real and is for illustrative purposes only.

Focus on Data Quality, Data Use, and Communication of Results

As Cross-Site Indicator data are interpreted, it is often difficult to distinguish Quality of Data from Quality of Care issues. The MEQ team has used several different techniques to help countries take “deeper dives” into their data to ascertain the extent to which electronic data reflect services provided, as captured in paper registers and patient charts. Lot Quality Assurance Sampling is an example of a classification tool used by country teams to assess the concordance between paper and electronic sources, as well as proper aggregation of data at different levels.

Communication of data is also key for proper utilization and action. The MEQ team has focused on creating “dashboards” and other tools to communicate results quickly and effectively. Like a driver of a vehicle who can only process a few indicators while still driving safely, so too program implementers need rapid information to assess while making appropriate decisions to manage and strengthen health systems. Figures 1.10 and 1.11 provide examples from PIH’s Cross-Site Indicator report and Household Chart, respectively.

Use of Innovative Tools to Facilitate Rapid Feedback

The use of innovative tools, such as mobile data collection and Geographic Information Systems, has also served to increase data collection, use and quality improvement. PIH has piloted several programs to collect electronic data at the community level using cellular phones, which reduces turn-around time for submission and can improve data quality. Geographic Information Systems have been shown to increase engagement among data consumers at all levels of the organization by communicating information through maps. Both of these tools are described in greater detail in other PIH program documents (see also Chapter 6 of this Sourcebook).

Lessons Learned

- ▶ PIH has found that integrating M&E and quality improvement has increased the interest in and commitment to measurement and use of the results to understand both successes and challenges in PIH programs. Although PIH has made great strides in this area, the challenge is ongoing. Sustaining a culture of data use and quality improvement means keeping both a centerpiece of PIH efforts.

References

- 4 Berwick, Don. Narrowing your focus- Using data to launch improvement activities. Retrieved from www.nationalqualitycenter.org/download_resource.cfm?fileID=19971 (National Quality Center, Quality Academy, Session 10).
- 5 Adapted from <http://www.ihi.org/knowledge/Pages/ImprovementStories/ImprovementTipTakeTheJourneytoJiseki.aspx>, 2011.