The Basics of Quality Assurance in Social Franchising

Definitions

Donabedian defines quality assurance as “all the arrangements and activities that are meant to safeguard, maintain, and promote the quality of care.”

Ruelas and Frenk define it as “a systematic process for closing the gap between actual performance and the desirable outcomes. . . .”

Framework for Quality Assurance in Social Franchising

The model below depicts the various processes and tools that can be part of a quality assurance system.

- **Recruitment**
  - Ensure that providers meet qualifications to join network
  - Review certification of providers

- **Training**
  - Conduct initial training
  - Conduct follow up training

- **Monitoring of clinical and non-clinical quality**
  - Conduct monitoring visits
  - Conduct mystery client surveys

- **Monitoring of client experience**
  - Conduct client exit interviews
  - Engage in community outreach activities

- **Feedback Loop**
  - Benchmark providers
  - Have providers conduct self-assessments
  - Implement reward systems for high performers
  - Verify data
Recruitment

There are many ways in which quality performance can be assessed and assured beginning with the rigorous standards applied at the provider recruitment stage.

- **Certification**: Requirement that a provider have a valid operating license or certification.

- **Assessment of the physical quality of the clinic**:
  - Evaluation the ventilation system, lighting, cleanliness of the floors and power supply.
  - Assuring that the clinic has the proper space to ensure privacy, a functioning toilet, hand washing facilities, adequate drug storage and a locking cabinet for medical files.

- **Safety Assessment**:
  - Assessment of the supplies on hand to prevent cross infection like sterilizing equipment and disinfectants.
  - Assessment of the reference guides and emergency contact numbers that are available.

Training

Training and re-training are essential components by which franchisors assure quality. Many modules of training programs address quality assurance.

- **Practicum Period**: Requirement of franchisees to complete a practicum experience where new franchisees work alongside more experienced clinicians who are already part of the network.

- **Observation**: Inclusion of an observational component of training where franchisees conducting clinical procedures and are only allowed to begin treating patients independently once they have been observed conducting a minimum number of procedures.

Monitoring of Clinical Quality

Below is a description and discussion of the strengths and weaknesses of the tools most typically employed to assess provider clinical quality in low- and middle-income countries.

- **Direct Observation**:
  - Direct Observation has been shown to provide an effective, and non-biased, tool for evaluating a range of practices.
  - The limitation of direct observation is the time and cost required, particularly in assessing rare illnesses, or in evaluating low-volume clinics, attributes of many rural facilities. In both situations, observers may have to wait days to observe a single provider-patient interaction that meets the observation criteria (i.e. pediatric pneumonia or tuberculosis).

- **A Standardized Patient** (often called a patient actor, simulated patient, or mystery client):
  - A standardized patient “a person who has been carefully trained to take on the characteristics of a real patient in order to provide an opportunity for a student to learn or be evaluated firsthand”.
  - In standardized patient scenarios, the patient actor typically arrives unannounced to the practitioner and is responsible for completing an assessment checklist on the
performance of the practitioner. In clinic scenarios, the practitioner is not aware that s/he is being evaluated by this particular patient.

- Credibility and cost are barriers to application in rural areas where non-local standardized patients may be easily identified and the combinations of training multiple actors, travel times, and transport make this an expensive assessment method.
- There are significant challenges when using standardized patients to assess diseases with fever or other obvious physiological presentation, conditions requiring invasive examinations, and pediatric illnesses where ethical considerations prevent patient recruitment.

**Clinical Vignettes:**

- Clinical vignettes are hypothetical scenarios with questions or prompts for the course of action, given in stages to medical practitioners, with their responses noted for each stage before adding information. They have been shown to have high rates of internal validity. An advantage of vignettes over other evaluation tools is that they allow cost effective measurement of relatively rare illnesses.
- Vignette scores are strongly correlated to inputs provided during consultation (rational history taking, physical examination, and health education) and the ability of the clinician to properly diagnose the presented illness.
- The challenge is that growing evidence indicates that doctors do less with real patients than they say they would do in hypothetical scenario. Vignettes are, then, a valid instrument to measure provider knowledge, but a much less effective tool for measuring the quality of provider practice.

**Abstraction of Medical Records:**

- This is the most common way of evaluating physician practices, however application to outpatient care provided by rural practitioners has been limited, and data collection by trained professionals is expensive.
- There are questions about both the validity and feasibility of record abstractions as a tool for quality evaluation and tracking in non-hospital settings. In developing countries, medical record abstraction has been shown to be poorly correlated with standardized patient treatment – the gold standard for quality assessment.

**Monitoring of Non-Clinical Quality**

Regular monitoring visits should focus on the non-clinical aspects of quality as well. It is critical that providers understand why these aspects of quality are given importance, otherwise they will feel as if the monitors are on a fault-finding mission. It is advised that non-clinical quality be grouped into larger themes to help instill the importance of non-clinical quality among all staff. Create checklists in consultation with clients to monitor whether each clinic is a “Client Focused Center.” Examples of items to check include the following:

- **Assessment of the physical quality of the clinic:**
  - The procedure room has sufficient natural or electrical light with a back up arrangement in case of power failures.
Waiting and procedure rooms are visibly clean

- Communication with and respect for client:
  - Waiting times are reasonable and clients are effectively communicated with from the moment they enter the clinic
  - Visual and audible privacy and confidentiality are respected
  - Messaging on the walls of the waiting rooms and procedure rooms is appropriate and useful

**Monitoring of Client Experience**

Overall, systems to evaluate the perceived quality by patients are weaker than the systems to evaluate structural and clinical quality. In the coming months and years, we hope to see increased innovation in this area of quality assurance systems.

- **Exit Interviews:**
  - Client exit interviews are conducted with enough frequency that the results can be aggregated and analyzed.
  - Questions are asked in a way to get nuanced information that will allow the clinic to learn what can be improved. For example, don’t just ask yes/no questions which may ultimately provide limited information and value because patients have a tendency to rate the quality as *good* if the only other option is *bad*.

- **Focus Groups:** This activity may be underutilized and will allow franchises to understand how patients perceive the quality of care.

- **Community Outreach:** This activity will provide feedback from members of the community that may or may not be receiving healthcare at the franchise. This is a mechanism that will help franchises gain insight into community perceptions of the quality of health care delivered at the franchise and also to learn more about how the community itself defines quality.

**Feedback Loop**

A number of franchise quality assurance systems include not only the guidelines and monitoring on quality, but programs to motivate and engage providers in achieving high quality. Especially in settings where providers are starved for feedback as they are in many developing countries, public or print recognition is appealing and a useful tool for assuring quality.

- **Ranking Systems:**
  - Ranking system can track the progress of franchisees and motivate strong performance.
  - Announcing rankings publically at meetings and awarding the top performers with recognition or with financial incentives like a new computer or a vacation package will serve as additional motivation.
  - Distribution of periodic newsletters which feature high performers is another tool to highlight high performers and motivate the franchisees.
• **Provider Self-Assessment:**
  - A provider self-assessment program can motivate providers to achieve high quality standards. Using self assessment gives providers ownership over quality assurance.
  - Provider-run discussion groups where providers can meet to discuss difficult cases or new protocols aids in improving quality as providers can learn from each other and gain support.

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i Donabedian, Avedis, Explorations in Quality Assessment and Monitoring, Ann Arbor, MI: Health Administration Press, 1980, pp. 5-6.
iii Schlein et al., forthcoming
ix ibid