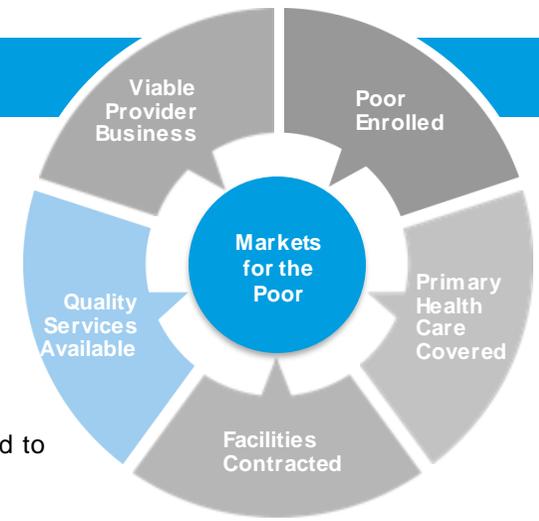


**Population Services Kenya (PSK) combined its vertical approach to quality assurance (QA) with SafeCare’s horizontal one to create a single, integrated QA system, meant to be more holistic and drive cost efficiencies.**



There is a great deal of interest in methods for consolidating quality assurance standards within healthcare provider organizations in ways that are both reliable and practical. This snapshot looks at how PSK has worked to merge its quality assurance approach with the globally recognized SafeCare standards and improvement program. It reviews key steps, challenges, and lessons learned from the process.



**Intervention**

Many PSK franchise providers have been using two parallel quality assurance systems: 1) the SafeCare Standards, a horizontal approach that evaluates the structure and processes guiding the delivery of healthcare, and 2) the PSK vertical approach, which evaluates processes and outcomes through in-depth assessment of specific franchised health areas. Recognizing that both approaches were important and complementary, PSK has been consolidating the two systems and assessment teams for a more streamlined, cohesive, and time/cost effective quality assurance (QA) system.

Initial implementation of the consolidation was time and resource intensive. One of the first steps was to create a single QA team from the two existing ones to improve efficiencies and expand QA reach and capacity. The organizational structure had to be changed to merge both teams, including alignment on territories and numbers of facilities to be covered by each. Trainings and refresher courses were offered to every QA team member to ensure that they had the skills to handle both systems.

**Challenges:** PSK QA staff experienced a steep learning curve, due to the complexity of SafeCare Standards. There were delays initially in the assessments and development of quality improvement plans (QIPs) for providers, but a designated SafeCare Coordinator and experienced assessors within the QA team addressed the backlog and provided guidance and mentorship to other QA staff.

The SafeCare Standards were initially too onerous and revised to suit small-scale health providers with fewer services. The Standards were trimmed from

834 criteria to 170 for basic assessments or 680 for advanced ones, and the complexity of both QIPs and monitoring/evaluation were reduced.

The SafeCare and PSK QA systems worked on different platforms, so PSK could not monitor and track the progress of SafeCare activities in the facilities. It had to rely instead on PhamAccess for the information. This was resolved when Population Services International (PSI) supported the hosting of SafeCare-related activities in an open source information system for health program data reporting and analysis, called **DHIS 2**.

**Opportunities:** Technology provided an alternative to the previous paper-based QA systems, with ways to automate and facilitate QA. PSI/PSK developed a tablet-based tool, called the Health Network Quality Improvement System (HNQIS), that will allow QA teams to assess, score, and monitor quality while providing consistent and immediate feedback to providers. The information will be uploaded into DHIS 2, which also houses the SafeCare data. For now, the system generates separate reports for HNQIS and SafeCare, but PSK is working to devise ways to generate a single report that consolidates and integrates the two sets of data.

The consolidation of the two systems is a work in progress – but should ultimately result in improved healthcare delivery for the poor. Providers should benefit from better feedback and a more holistic QA perspective to review their overall performance, and franchisors should be able to improve cost efficiencies that allow for further expansion of SafeCare and QA.

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**Results**

Early results show a significant increase (65%) in the numbers of first or basic assessments conducted after the consolidation of both QA activities, compared to previously (see Table 1). The numbers of QIPs developed nearly trebled. Meanwhile, the numbers of QA assessors have decreased, suggesting greater efficiencies and streamlining in the QA processes.



**Examples and Evidence**

The integration of the two QA systems reduces the need for multiple visits of assessors to providers. It is a significant step in setting standards for a health systems approach, which is at the core of AHME.



**Lessons Learned**

The internal politics of quality systems are challenging, and it is important to bring out the utility from this example through succinct case studies to inform other franchises of the usefulness of an integrated QA approach.

QA needs to be part of the monthly work plan, with a set number of assessments planned each month and the days clearly set aside.

A QA approach that is integrated from the beginning is preferable to parallel systems. It needs to be owned by the franchise and by the implementation team, with a firm understanding of its value addition.

**Table 1: Pre- and Post-Consolidation Comparisons**

Activity	Pre-Consolidation 2015- 2016	Post-Consolidation 2016- 2017	% Increase
1 <sup>st</sup> or Basic Assessments	38	63	65%
QIPs Developed	46	128	178%
Clinics with certification assessments	33	35	6%



**Outlook**

PSK is committed to an integrated QA strategy and efforts will continue to address challenges as it progresses. Work on consolidating and integrating the two approaches is on-going, with the aim of providing holistic quality of care and ultimately generating a single QA report and work plan. AHME is also exploring integration of vertical service audits and to add quality audits for a cross-program, cross-network process.

AHME can support the QA integration process by distributing learnings across networks and identifying and addressing gaps. AHME is working with national stakeholders to support the coordination of quality standards and to improve transparency. Our goal is to enabling strategic purchasers and clients to understand the quality of what they are buying.