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Dear Board Members, Managers, and Staff of Catholic Charities

Our mission statement says, “Catholic Charities is committed to manifesting Christ’s spirit through collaboration with diverse communities, by providing services to the poor and vulnerable, by promoting human dignity, and by advocating for social justice.” True social work must always come, not only from our ingenious words, but also from the simple implementation of our mission.

Catholic Charities is committed to providing the highest quality of services for those who are most vulnerable. One of the ways that we determine the fulfillment of our mission is through the Continuous Quality Improvement (CQI) process.

Continuous Quality Improvement is an integrated and ongoing process to assess and improve organizational efficiency and performance and to meet standards for quality outcomes. CQI requires appropriate resources, training, equipment, and personnel to accomplish its stated goals of providing high quality services and desired outcomes to our clients and other stakeholders.

On behalf of the clients of Catholic Charities, I thank you for your full cooperation in the CQI process. The better we serve those in need, the better we fulfill our “mission.”

Rev. Monsignor Gregory A. Cox
Executive Director
Catholic Charities of Los Angeles, Inc

February 10, 2010
WHAT IS CONTINUOUS QUALITY IMPROVEMENT?

Continuous Quality Improvement (CQI) started in the Japanese and American business community as companies looked for better ways to produce better products and services for their customers. More recently, CQI has spread into healthcare, education and human services. An increasing number of human service providers have turned to CQI to improve the service delivery of their operations. CQI principles have helped to accomplish the following:

- Improve processes and outcomes for persons served and other stakeholders
- Improve stakeholder satisfaction
- Improve workforce retention and satisfaction
- Increase the use of preventive interventions
- Improve the organization/program defined outcomes
- Increase best practices
- Prevent loss of funding
- Reduce waste and errors
- Manage internal and external resources more effectively

What are the Steps in CQI?

There are three basic questions that need to be addressed in any improvement process. These are:

- What are the goals we are trying to accomplish;
- How will we know that a change is an actual improvement; and
- What change can we make that will result in improvement?

One procedure for assessing improvement is called the Ten-Step Quality Improvement Cycle. This provides a framework that encourages change.

COA’s 10-Step Quality Improvement Cycle

1. Identify a process
2. Define the purpose of the process
3. Identify primary stakeholders
4. Determine stakeholders expectations about the process
5. Determine if expectations are being met and identify opportunities for improvement
6. Identify causes of problems, challenges, and any deficiencies
7. Plan improvements
8. Implement improvements
9. Evaluate improvements
10. Repeat the cycle to maintain and strengthen improvements

CQI, of course, does not end after a change has been enacted. To help focus these efforts, Catholic Charities of Los Angeles has adopted the following quality improvement goals:
Continuous Quality Improvement Goals

1. To provide and promote appropriate quality services to the clients of Catholic Charities

2. To provide consumers a way to actively participate in the service planning and evaluation of their services

3. To promote program effectiveness for positive consumer outcomes

4. To promote and maintain access to affordable quality services

5. To create, maintain and improve quality improvement guidelines to ensure the continuous monitoring of program operation services

6. To provide a mechanism to communicate recommendations for systemic growth with consensus between programs and agency administration

7. To ensure that adequate documentation exists for all services

8. To demonstrate that internal and external resources are used efficiently and effectively through ongoing evaluation

9. To ensure that program activities and outputs meet the required outcomes of our internal and external resources
CONTINUOUS QUALITY IMPROVEMENT PLAN

A service plan is to the individual or family just as a Continuous Quality Improvement (CQI) Plan is to an organization or program. A CQI Plan is an integrated and ongoing process to assess, monitor, evaluate and improve organizational performance and to meet standards that ensure quality outcomes for consumers and other stakeholders.

The CQI plan adopted by Catholic Charities of Los Angeles, Inc. involves a series of action steps for creating a system designed to meet the needs of all programs. The action steps also address accreditation requirements to guide personnel responsible for service provision. The CQI plan features a team approach, roles and process that are clearly defined, a description of stakeholder input and involvement, service delivery process, and program goals and expected outcomes.

BASIC REQUIREMENTS

The CQI Plan consists of a series of Six Action Steps, described below, that outline the basic approach.

- **Six Action Steps:**
  1. Identify the target population of persons served and level of service provided
  2. Develop output and outcome objectives and customer evaluations of service
  3. Develop a case record review process that evaluates the adequacy of documentation in client records and the implementation of best practice standards
  4. Prepare a case review report that documents the outcome of all case reviews and that provide directions for improvement
  5. Prepare an action plan of correction in response to problem areas addressed in all case review reports, when needed
  6. Prepare an annual program evaluation report for senior management

AGENCY-WIDE IMPLEMENTATION

CQI begins, at the program level, with the designation of one or more team leaders who are responsible for the coordination and implementation of the organization’s plan for quality improvement. Regional, departmental, or program directors select CQI team leaders and team members, as applicable. Each team consists, at minimum, of one or two members. The CQI team leaders are responsible for ensuring that the team completes quarterly case reviews and prepares a case review report in response.

Case review reports address all findings, including program and client outcomes, service delivery, the implementation of accreditation standards, the adequacy of case file documentation, and the outcome of any Action Plan of correction. The intent in forming teams is to include staff most familiar with the program’s operations, whenever possible. Teams may be drawn from a variety of staff working in the same type of program at different sites, or from other appropriate staff members. Team members must not have contributed in any way to the case files selected for review. The CQI director is responsible
for coordinating CQI activities agency-wide and for providing ongoing training to programs and their designated CQI teams, as needed

**CQI COMMITTEE**

Membership on the CQI Committee may include representatives from both agency programs and management. The organization’s Regional and Departmental Directors may recommend members to the committee by submitting the names of prospective CQI committee members to the CAO. Due to the distance of many programs from corporate offices, CQI Committee members may participate in meeting via a conference phone.

The CQI Committee meets quarterly or more frequently, as needed. Together, the Committee is responsible for the following:

1. Reviewing the organization’s policies and procedures, as applicable
2. Examining CQI processes and reviewing changes to the organization’s CQI Plan
3. Assisting in the implementation of accreditation standards of best practice
4. Examining staff training issues
5. Examining stakeholder participation and satisfaction
6. Reviewing the strategic and short-term quality improvement planning

**CQI PLANNING FOR PROGRAMS**

Each program is responsible for implementing CQI review procedures based upon the Six Action Steps, described above. Program planning may be designed to meet individual program requirements, including specific outcome measures for funders, etc. Programs should be guided by the Six Action Steps and by COA standards for best practice.

1. Programs may use peer or external reviewers to conduct case reviews that examine record content and quality of service provided, outcomes obtained, and the results of satisfaction surveys or evaluations of service. Programs should review a sample of open and closed cases. If the program has any high-risk cases, the team must review these records and discuss with program staff, as appropriate.

2. Personnel who conduct case reviews evaluate the presence or absence of required documents, and the clarity and continuity of such documents that include, but are not limited to:
   a) Assessments
   b) Service/treatment plans
   c) Appropriate consents
   d) Progress notes or case notes or summaries
   e) Evidence of regular supervision
   f) Relevant signatures
   g) Service outcomes
   h) Aftercare plans

3. Programs should establish criteria for evaluating the appropriateness and necessity and effectiveness of the services provided, as applicable.
4. Programs measure service outcomes for all persons served, including at least one of the following: a) change in clinical status, b) change in functional status, c) health, welfare, and safety, d) permanency of life situation, and e) some other quality of life indicator of the program’s choice.

5. Program use standardized evaluation tools to gather and analyze outcomes for persons served, whenever feasible.

6. External review procedures may be established via contract, or by other means, to meet particular program needs or to comply with the standards set by various stakeholders (City, County, State, Federal, COA, or others) in implementing the CQI plan.

7. Case reviews should be conducted in a manner in which all client names or other identifiers do not appear in any case review report.

8. Programs should develop measurable criteria or indicators (or use contract criteria), to rate their program standards for quality. Measurable criteria might include guidelines for admission, referral, extended service, changes in the status or level of need presented by the person served, and/ or other criteria developed by programs or third parties that require review activities for contract compliance purposes.

9. Programs should use rating scales for consumer satisfaction forms whenever possible, and for evaluating the extent of program compliance for indicators or implementation of standards, whenever possible.

10. Programs that provide any service or treatment modality involving risk or that limits freedom of choice by persons served must have appropriate standards in place for case reviewers to properly assess these activities. This includes all programs that prescribe and/or administer medications to persons served, as applicable.

11. Programs can assess how well they are participating in CQI by using the rating form in Appendix 4.
ACTION STEP #1:
Each program will identify the LEVEL OF SERVICE that it provides to the CLIENT/TARGET POPULATION it serves. Programs may provide more than one level of service to different client/target populations.

Level A  **Client(s) known by Count Only:** Basic needs/information

Characteristics: Limited data available
No file or records utilized

Examples: Presentations, information and referral

Level B  **Client(s) known from Lists/Rosters:** Brief contact services

Characteristics: Names available; minimal or no case files/records
Standard agency demographics

Examples: Catholic Youth Organization: Athletics
Community Centers: food, clothing, emergency aid, etc.

Level C  **Client(s) with Limited Case Records:** Intake Assessment/Case coordination

Characteristics: Full demographic data available
Assessment; limited or no service planning,
Limited interventions and aftercare; advocacy, if needed
Orientation; information; referral; structured activities

Examples: ADESTE (after-school program)
Central Intake Unit
Immigration/Refugee Resettlement Services

Level D  **Client(s) with Comprehensive Case Records:** Therapeutic interventions/
Ongoing services

Characteristics: Full demographic data available
Full intake assessment
Service or treatment plan
Case management/Aftercare Plans/Referrals

Examples: Shelter Programs
Catholic Counseling Services
ACTION STEP #2:
Each program will develop **OUTPUT** and **OUTCOME OBJECTIVES** based on their target population and level of service. Programs also will develop **SATISFACTION SURVEYS** or **EVALUATIONS OF SERVICE** to assess satisfaction and effectiveness of services provided.

A. Requirements:

1. Each program must define what constitutes quality and excellence for its program and for the type of services provided to its clients. Based on this definition, each program must indicate its desired service outcomes for its target population(s). At minimum, this must include one output and one outcome objective, established at the beginning of each program year in July.

2. Programs should base their output and outcomes on an established performance standard, such as a funder/contract requirement, actual program experience, a community standard, or a COA accreditation standard that impacts persons served.

B. Client and Program Outcomes

1. Programs must develop a plan to achieve their desired outcomes, based on United Way’s Outcome Measurement Framework (OMF). This approach recommends using at least one specific indicator per outcome that is measurable, developing procedures for tracking/collecting data, developing methods for aggregating and analyzing data, determining a statistic (generally the total number and percent of participants achieving program goals) that will convey the program’s overall level of achievement, and monitoring the outcome measurement process (see Appendix 11).

2. All case management programs must evaluate individual progress and achievement of service goals for persons served on an on-going basis, including at least one of the following: an improvement in: 1) clinical status; 2) functional status; 3) health, welfare, and/or safety; 4) the permanency of life situation; or 5) another quality of life indicator of choice. Programs must aggregate their outcome data to determine program effectiveness for funders and other stakeholders, as detailed in their Outcome Measurement Framework.

C. Customer Surveys

Opinions from consumers are a valuable source of information about the quality of service provided. To obtain this, each program needs to distribute satisfaction surveys or evaluations of service to determine the extent of satisfaction with the program and its services (see Appendix 3: Distributing Surveys and Reporting Data). All surveys should ensure anonymity and include basic demographic information.

D. Analyzing Data and Reporting Findings

A summary of data from client satisfaction surveys or evaluations of service should be sent to the CQI Director quarterly, as applicable, and reported in each the Annual Program Evaluation Report (see Action Step #6), along with client outcome data, as applicable.
ACTION STEP #3:

Programs that provide Level C or D services develop a CASE RECORD REVIEW process to assess implementation of accreditation standards, the appropriateness and quality of client services, including any requirements mandated by contract (state, federal, or local).

A. Defining the Content of the Case Record

1. Programs must define the standard content of their case records that reflects funder regulations, COA requirements, and professional standards for best practice. Additional items may be included depending on the type of service, funder and/or regulatory requirements.

2. The Case Record should include the following:
   a. Initial Intake Assessment
   b. Comprehensive Assessment Information (as applicable)
   c. Signed Consents, including Client Rights and Responsibilities
   d. Individualized Service Plan or Treatment Plan
   e. Progress Notes
   f. Documentation of periodic case worker and supervisory review
   g. Termination/Closing Information (specifying service outcomes)
   h. Aftercare/Follow-up Information (when possible)

B. Case Record Reviews

1. Begin by selecting a review team leader with responsibility for the review and for selecting other team members. The team leader must develop a case record review tool and scoring system that helps reviewers assess case records objectively and that tracks all required program documentation (see Appendices 7-8).

2. Programs should conduct case record reviews at least quarterly. Prior to the review, determine the number of case records to be reviewed (refer to the COA sampling guidelines in Appendix 2). Programs may choose a different sampling method as long as a rationale is provided. On-site, ensure a random selection of both open and closed cases, whenever possible.

3. All programs must use a documentation checklist that indicates the required and optional documents that should be found in each case file. The checklist will assist the CQI team members in verifying required documentation (see Appendix 10).

4. Programs should include a review of the appropriateness of service being provided to clients by analyzing the current service plan in meeting the client's needs. Document this service review in the case file, indicating the participants who performed the review and the results, including any modifications to the service plan pending client acceptance, as applicable.
**ACTION STEP #4:**
CQI Team Leaders must prepare a **CASE REVIEW REPORT** that summarizes the findings of quarterly case reviews.

**A. Reporting Requirements:**

1. The Case Review Report must address the following:
   - An analysis of any trends, issues, and/or deficiencies found
   - Review strength and weaknesses
   - Propose any corrective action or modification needed to improve the overall quality of service.
   - Discuss the results of any Action Plan the program has completed
   - Specify whether a new Action Plan is required in response to the current case review.
   - Indicate who will receive the report distributed by the CQI team leader to the program’s director for review by all staff, and, as appropriate, to all those directly involved with evaluating quality services for the organization.

**B. Reporting Format:**

1. The Case Review Report should include the following items, where applicable:
   a. Name of the program reviewed and the site
   b. Identification of the time period of the report (First Quarter, etc.)
   c. A listing of the case files reviewed (safeguarding client confidentiality)
   d. A listing of the CQI team members who conducted the review
   e. A description of any scoring system used to rate compliance and/or implementation of standards
   f. Results of any Action Plan the program recently completed
   g. Results of the Case Review, including a narrative that outlines areas of strength and weakness, areas in need of improvement, and discussion of any trends, issues, and/or deficiencies
   h. Recommendations for continuous quality improvement
   i. Indication of whether a new Action Plan of correction is required based on the results of the review
   j. A Distribution List indicating everyone that will receive the report

2. Programs may use the sample Case Review Report format (Appendix 8) or design a report following the guidelines above. Programs may add additional items to the report to meet their own needs or those of other stakeholders.
**ACTION STEP #5:**

Programs must complete an ACTION PLAN of correction in response to any Case Review Report that indicates it is required. Action Plans must the identify problem areas noted in the Case Review Report and indicate how the program will make the needed correction(s).

**A. Reporting Procedures:**

1. Program staff produces a written response within 3 weeks to the Case Review Report. The Action Plan should directly address areas identified in the report.

2. If program staff disagrees with any of the findings or recommendations of the Case Review Report, address these in writing and submit them to the CQI team leader who prepared the written report. Following this written response, the CQI team leader will meet with the program staff to resolve any issues regarding the review.

3. When completed, the Action Plan is sent to the CQI team leader for review. The CQI team leader is responsible for distributing the final Action Plan from the program to those directly involved with evaluating quality care for the program and/or for the organization as a whole. These individuals may include, as appropriate, the CQI Director, Regional Directors, Departmental Directors, and others.

4. CQI team leader reports on the success of any Action Plan completed in the next case review report.

**B. Reporting Format:**

1. The Action Plan must include the following elements:
   a. Describe the procedures you will implement to improve the areas addressed in the report.
   b. Describe the timeline for implementing changes.
   c. Indicate the individual(s) responsible for implementing changes.
   d. Describe the methods you will use to monitor progress.
   e. Describe any procedure necessary to support the change
   f. Indicate any staff response to the CQI Case Review Report

2. Programs may use the sample format provided for Action Plans (Appendix 6) or design one of their own, following the guidelines above. Programs may add additional items to the plan to meet their own needs or those of other internal or external stakeholders.
**ACTION STEP #6:**

All programs must complete an **ANNUAL PROGRAM EVALUATION REPORT**, due at the end of each September. All reports must identify the name of the individual who prepares the report and the name of the Regional/Department Director who approves it.

**A. Requirements:**

1. The program evaluation component of the CQI program is a review process designed to aid the organization in its ongoing assessment, decision-making, and development. The evaluation should address the following:
   a. Program compliance with all CQI Plan requirements
   b. Success in achieving output and outcome objectives
   c. Description of the clients served, the target population(s)
   d. Program effectiveness and program efficiency
   e. Financial information
   f. Impact of client/consumer evaluations of service and satisfaction
   g. Discussion of external reviews (audits), as applicable
   h. Summary of any research sponsored by the program, if any
   i. Discussion of any grievances, accidents, or incidents, if any
   j. Annual Short-term Plan in support of the Agency’s Strategic Plan

**B. Reporting Format**

Programs should provide a short narrative describing improvement made to the quality of client services in the past fiscal year. A format for completing the report will be distributed at the beginning of each July. The reports should address the following:

1. **Clients Served**
   a. Target population the program is designed to serve and demographic data
   b. Client referral sources to the program
   c. Description of any waiting list for program services
   d. Address clients requesting services that were not accepted (how many), and indicate reasons why clients were unable to be served (percent/reason).
   e. Address whether there are any barriers that prevent access to services provided, including physical access to program sites.

2. **Program Effectiveness/Outcomes**
   a. Identify the program goals in terms of expected client outcome (OMFs)
   b. Describe results/recommendations from any external program review process (State, County, Federal, COA, contract, licensing, audit, etc.)
   c. Provide aggregate data reflecting consumer feedback for the program. Summarize or list consumer comments, if reported.
   d. Summarize any changes you made to the program in response to client or consumer feedback.
   e. If volunteers were used for direct case management services, please describe.
   f. Summarize the results of Quarterly Case Reviews, if conducted
   g. Discuss any critical incidences, employee or client grievances, or licensing violations the program had, if any
3. **Program Efficiency**
   a. Number of new clients served during past fiscal year, and during previous fiscal year. Address any difference in clients served, if greater or less than 25 percent.
   b. Indicate the staff to client ratio by dividing the number of unduplicated clients by the number of FTE direct service staff. Is there a staff/client ratio defined by outside source (e.g., licensing, COA)? If yes, what is the ratio?
   c. Indicate staff turnover rate by dividing number of new staff hired by total program staff. If greater than 10%, explain.
   d. What is the defined unit for this service (person served, bed night, day of service, etc.)? How many total units were provided?
   e. What is the total cost per unit of service for the program? The cost per defined unit is calculated by total costs divided by number of units, or number of persons served.

4. **Personnel Planning**
   a. Does the program have a sufficient number of appropriately qualified persons available to respond to the demand for service in an efficient and effective way? If not, please address the reasons that may contribute to the lack of needed staff and what the program has been doing to supply appropriately qualified staff.
   b. Does the program formally review its personnel needs each year. If so, what procedure is used and does it help determine whether there is a need to modify personnel deployment, practices, or resources?

5. **Financial Information**
   a. What was the net gain/loss for this program at the end of the fiscal year?
   b. What percent of the program’s total expenses does this net gain or loss represent? Explain what this means for the program.
   c. How was the program funded in the past year? Indicate revenue streams.

6. **Quality Improvement and Program Stakeholders**
   a. Identify your program stakeholders and describe how they participate in the improvement process.
   b. Did you make any improvements to the program in response to client feedback, employee feedback or other program stakeholders?
   c. Do you acknowledge the contributions of stakeholders to quality improvement?
   d. Identify your quality improvement goals for the coming year, based on areas of needed improvement that were identify by the case review system or other means during the past year.

7. **Training and Supervision**
   Discuss your program’s training and supervision needs. Provide a list of training provided to staff during the year and attach a curriculum outlines for these.

8. **Short-Term Quality Improvement Plan**
   Describe a Short-Term Plan that you intend to adopt in support of CCLA’s Strategic Plan goal: to increase organizational effectiveness or efficiency by implementing COA best practice standards. Your plan may address areas of best practice you wish to promote or areas of improvement to client service that will be the focus of your efforts during the year.
Use the following format to report your short-term plan:

a. Describe the short-term goals/objectives
b. Describe these goals/objectives, including any budgetary ones, in measurable terms.
c. Describe needed resources (if applicable)
d. Describe step needed to achieve objectives
e. Indicate the method(s) you will use to assess progress, and
f. Indicate who carries the primary responsibility for the plan and any supporting personnel.

C. Distribution of Annual Program Evaluation Reports

1. All programs send an electronic copy of their Annual Report to the CQI Director.
2. The CQI reviews the reports, resolves any questions about them with the program, and submits the final reports to the CAO and the Executive Director.
3. CAO reviews all reports and recommendations by programs.
4. Executive Director reviews the reports and presents an overview of the reports to the Board of Trustees, as applicable.
STAKEHOLDER PARTICIPATION

Stakeholders, including persons served, employees, senior management, members of the governing body and advisory boards, volunteers, interns and trainees, and funders may participate in the agency-wide CQI process. Their input and participation is fundamental to the organization’s goal of providing high quality services and desired outcomes to consumers and other stakeholders. A summary of information for stakeholders can be found in Appendix 5.

Stakeholders can be involved in the organization’s CQI process in a number of ways, including opportunities to participate in:

A. Defining the organization’s mission and values
B. Identifying quality improvement goals
C. Developing service outcomes
D. Evaluating service outcomes and program changes
E. Helping to set the organization’s long-term direction
F. Reviewing the organization’s overall performance in relation to expectation

Stakeholders can be brought into the CQI process through a variety of methods or mechanisms, including the use of surveys that provide input from persons served. CQI Committee members and/or advisory board members can help assess the value of improvements and review changes to policy and procedures, and employees may benefit from a team based approach to identify, analyze and address problems, issues, and opportunities. Whatever method or methods used, the CQI process is dedicated to actively soliciting input from all stakeholder groups and to implementing procedures to ensure their meaningful participation.

LONG-TERM STRATEGIC PLANNING PROCESS

An agency-wide, long-term, strategic planning process is conducted at least every four to five years to set the overall direction for the organization. The purpose of the process is to clarify the agency’s mission, values, and mandates. The process includes establishing specific goals and objectives that flow from the agency’s mission and mandated responsibilities, assessing agency strengths and weaknesses, examining stakeholder input, and identifying specific strategies for meeting the established goals. The long-term planning process includes an assessment of community and regional needs that examines the following:

A. Services offered by other providers in the community
B. Gaps in the array of services needed by the agency’s defined target populations
C. Client/customer accessibility issues to agency programs, and
D. Need to redirect, eliminate or expand service in response to changing demographics and/or the needs and wishes of the communities served.

To enhance this internal assessment, information and findings from external need assessments, or environmental scans of significant trends, such as those conducted by United Way, universities, municipal planning boards or other organizations with a community-wide focus may be used.

As part of long-term planning, the agency creates a demographic profile of both its defined community and actual consumers that includes the following: income, gender, age, ethnicity, and primary language.
SHORT-TERM IMPROVEMENT PLANS

Each of the agency’s programs develops a short-term improvement plan each year in support of the agency’s strategic long-term plan strategic plan. Short-term improvement plans address data obtained from CQI activities, including case reviews, measurement from client outcomes, results of satisfaction surveys, audits, and data from other sources.

Short-term Improvement Plans are written into Annual Program Evaluation Reports. However, they may be written at other times, as needed (see Appendix 6). Short-term planning is staff-driven and primarily addresses goals and objectives for the program or service. It also addresses methods for assessing progress toward the goals, specific tasks to be carried out in support of these goals and objectives, associated timelines, and identification of designated personnel to carry out identified tasks.

INTERNAL QUALITY MONITORING

All programs regularly examine their internal processes that include outreach efforts, intake and assessment procedures, and service delivery processes to identify barriers and opportunities to serving any group within its defined service population. Programs also examine the need for training and supervision of staff members. Programs address their findings in the Annual Program Evaluation Report.

COMMUNICATION OF RESULTS

The results of the CQI process are shared annually with personnel, individuals and families served, and other stakeholders through an annual report or summary report. This includes aggregate data on output and outcome measures and consumer evaluations of service and customer satisfaction. The organization also provides summary results of its planning and evaluation processes to the governing body and advisory boards, as applicable.
Appendices
APPENDIX I

COMMUNITY PROFILE

Profiles of Consumer Population Compared to Defined Community
Organizational Data for CCLA (2008-09)

Organization’s Actual Consumers:  Defined Community: Los Angeles

<table>
<thead>
<tr>
<th>Annual Family Income:</th>
<th>Defined Family Income:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $13,000</td>
<td>Under $13,000</td>
</tr>
<tr>
<td>$13,001 - $20,000</td>
<td>$13,001 - $20,000</td>
</tr>
<tr>
<td>$20,001 - $30,000</td>
<td>$20,001 - $30,000</td>
</tr>
<tr>
<td>Above $30,000</td>
<td>Above $30,000</td>
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<tr>
<td>53.6%</td>
<td>14.4%</td>
</tr>
<tr>
<td>34.4%</td>
<td>8.8%</td>
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<td>6.7%</td>
<td>12.6%</td>
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<tr>
<td>5.3%</td>
<td>64.2%</td>
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<table>
<thead>
<tr>
<th>Sex:</th>
<th>Sex:</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>Male</td>
</tr>
<tr>
<td>46.9%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>53.1%</td>
<td>50.7%</td>
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<table>
<thead>
<tr>
<th>Age:</th>
<th>Age:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 12</td>
<td>Under 12</td>
</tr>
<tr>
<td>Youth 12-17</td>
<td>Youth 12-17</td>
</tr>
<tr>
<td>Young Adults 18-25</td>
<td>Young Adults 18-25</td>
</tr>
<tr>
<td>Adults 26-64</td>
<td>Adults 26-64</td>
</tr>
<tr>
<td>Adults 65 and Over</td>
<td>Adults 65 and Over</td>
</tr>
<tr>
<td>25.3%</td>
<td>19.4%</td>
</tr>
<tr>
<td>11.1%</td>
<td>8.5%</td>
</tr>
<tr>
<td>9.7%</td>
<td>12.0%</td>
</tr>
<tr>
<td>48.8%</td>
<td>50.3%</td>
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<tr>
<td>5.0%</td>
<td>9.8%</td>
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<table>
<thead>
<tr>
<th>Racial/Ethnic Composition:</th>
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</thead>
<tbody>
<tr>
<td>White</td>
<td>White</td>
</tr>
<tr>
<td>Black/African American</td>
<td>Black/African American</td>
</tr>
<tr>
<td>Indian (American)</td>
<td>Indian (American)</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>Asian or Pacific Islander</td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>Latino/Hispanic</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>11.0%</td>
<td>31.1%</td>
</tr>
<tr>
<td>14.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>5.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>3.0%</td>
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<tr>
<td>63.5%</td>
<td>44.6%</td>
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<tr>
<td>2.7%</td>
<td>2.7%</td>
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<table>
<thead>
<tr>
<th>Major Religious Groups:</th>
<th>Major Religious Groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>Catholic</td>
</tr>
<tr>
<td>Jewish</td>
<td>Jewish</td>
</tr>
<tr>
<td>Islamic</td>
<td>Islamic</td>
</tr>
<tr>
<td>Protestant</td>
<td>Protestant</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Other (please specify)</td>
</tr>
<tr>
<td>___%</td>
<td>___%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Major Language Groups:</th>
<th>Major Language Groups:</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>English</td>
</tr>
<tr>
<td>Spanish</td>
<td>Spanish</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Other (all others)</td>
</tr>
<tr>
<td>___%</td>
<td>45.9%</td>
</tr>
<tr>
<td>___%</td>
<td>37.9%</td>
</tr>
<tr>
<td>___%</td>
<td>16.2%</td>
</tr>
</tbody>
</table>

Data Sources for Defined Community: United Way of Greater Los Angeles
APPENDIX 2

DETERMINING THE NUMBER OF CLIENT RECORDS TO REVIEW

Use the information below to assist your program to demonstrate compliance with the COA’s Sampling Guidelines for Quarterly Case Record Reviews (8th Edition Standards). Programs may choose a different sampling method as long as a rationale is provided. The case review should consist of a random sample of both open and closed cases.

<table>
<thead>
<tr>
<th>Programs</th>
<th>Suggested Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Case Records/Year</td>
<td># Client Records to Review</td>
</tr>
<tr>
<td>Less than 100</td>
<td>100%</td>
</tr>
<tr>
<td>100 – 199</td>
<td>48%</td>
</tr>
<tr>
<td>200 – 299</td>
<td>47%</td>
</tr>
<tr>
<td>300 – 499</td>
<td>45%</td>
</tr>
<tr>
<td>500 – 999</td>
<td>40%</td>
</tr>
<tr>
<td>1,000 – 1,999</td>
<td>35%</td>
</tr>
<tr>
<td>2,000 – 2,999</td>
<td>30%</td>
</tr>
<tr>
<td>3,000 – 3,999</td>
<td>30%</td>
</tr>
<tr>
<td>4,000 – 4,999</td>
<td>20%</td>
</tr>
<tr>
<td>5,000 or more</td>
<td>Call COA</td>
</tr>
</tbody>
</table>
APPENDIX 3
DISTRIBUTING SATISFACTION SURVEYS AND REPORTING DATA

A. Distributing Surveys

All programs should distribute Satisfaction Surveys and/or Evaluations of Service forms on a random basis determined by the volume of clients receiving service each year.

1. Programs serving large numbers of clients (3,500 or more per year) should distribute 400 satisfaction surveys per year or approximately 34 surveys per month.

2. Programs serving moderate numbers of clients (>1,500 and <3,500) per year should distribute 200 satisfaction forms or approximately 16 per month.

3. Programs serving smaller numbers of clients (>1,000 and <1,500) per year should distribute 100 satisfaction forms based on a random sample of 100 surveys per year, or 8-9 per month.

4. All shelters and other programs with smaller numbers of clients served distribute survey forms to all of their clients, if possible, near or at the time of termination or by mail after program exit, as determined by the program.

B. Aggregating Data from Surveys

1. Programs may use the satisfaction and/or case management report forms to aggregate the data from client surveys.

2. Aggregate data must include 1) basic demographic data, and 2) the items related to whether the client was satisfied with the way they were treated by staff and with the services they received from us.

C. Analyzing and Reporting Data from Client Surveys

1. Directors review all satisfaction survey reports and/or evaluations of service from their programs and send the results to the CQI Director.

2. CQI Director aggregates satisfaction data from surveys and/or evaluations of service reports on an agency-wide basis and provides summary reports to Regional Directors and/or Departmental Directors, as applicable, and an annual report to senior management on the satisfaction of persons served.

3. CQI Director provides formats to share consumer service data with all stakeholders at least annually. Program must post this information for stakeholders to see.
APPENDIX 4

HOW TO PARTICIPATE IN CQI

Begin by rating each item below on how well CQI is being implemented by the program.
1 = Full Implementation; 2 = Substantial Implementation; 3 = Partial Implementation; 4 = No Implementation

When complete, review the scoring and develop a plan to bring all the items into Full Implementation

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>An overview of the CQI Plan is provided at new staff orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction surveys are used by the program on an ongoing basis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program managers discuss the results of satisfaction survey data with staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An annual aggregate summary of satisfaction data is posted for stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff understand how to share their ideas on how to improve quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing CQI training is provided for staff by managers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program managers keep CQI on the agenda of staff meetings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Managers share the results of quarterly CQI Case Review Reports with staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The program implements Short-term quality improvement plans/initiatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Findings based on improvement efforts are shared with all stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advisory Board members are kept informed of quality improvement activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers regularly discuss performance data with staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers discuss the program’s OMF with staff each year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers and staff work together to develop outcomes and indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome data is used to make program modifications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff understand the steps in an quality improvement cycle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programs directors recognize staff contributions to quality improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The program assesses personnel satisfaction annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All staff have access to a copy of the organization’s CQI Plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A review of incidents, accidents and grievances occurs quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients may complete a satisfaction survey at any time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results of quality improvement gains are communicated to stakeholders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continuous Quality Improvement (CQI) is an ongoing organizational process to improve the effectiveness and efficiency of service delivery that results in positive outcomes for persons served and other stakeholders, and that advances the achievement of organizational strategic and program goals.

1. Philosophy
Quality is achieved by knowing, meeting and exceeding the expectations of the persons we are called upon to serve. The tradition and purpose of this philosophy is based on the teachings and ministry of our Lord.

2. Purpose:
The purpose of CQI is to set forth quality expectations and broad goals that merit ongoing attention and to empower stakeholders at all levels of the organization to assume an active role in the improvement process to enhance the performance of the agency as a whole. Stakeholders include persons served, employees, volunteers, consultants and contractors, advisory board members, funders, and partners.

3. Core Values
The core values of CQI are based on processes that are designed to help meet and exceed the needs and expectations of persons served and to ensure their satisfaction with service rendered. These values include:

- **Promoting a culture that promotes excellence and continual improvement:** To create a culture of quality, the organization aligns itself and its processes with quality planning and desired outcomes.
- **Listening to those we serve:** By listening to and providing a means for persons served to evaluate the services they receive and to comment on their experiences, valuable information is obtained that helps to drive and focus improvement initiatives that impact service delivery processes and client outcomes.
- **Analyzing and reporting data:** The organization places an emphasis on the gathering and use of objective data to analyze processes, identify problems/barriers, and measure performance. Changes can be tested and data used to verify that changes have actually led to improvements.
- **Maximizing Stakeholder Involvement:** The organization places emphasis on obtaining the input of stakeholders that are invested in the service delivery process and in the outcomes of persons served. Stakeholder feedback is necessary to understand changes that need to be made and how the changes will be implemented. Input from surveys help to provide this important information.
- **Evaluating Systems:** The organization regularly reviews case records to assess the quality of services provided to clients, including outcomes achieved, aftercare plans and follow-up. Programs conduct annual performance reviews that address the effectiveness and efficiency of services provided to persons served.
- **Taking Corrective Action:** The organization assesses both the strengths and weaknesses of its documentation and service delivery procedures and take steps to resolve any identified problems through action plans of correction.
- **Planning for Continuous Improvement:** The organization’s CQI Plan outlines steps that explain how the quality improvement process is structured. The plan also describes the benefits of using an improvement cycle to assess the effectiveness of changes made by the organization.

4. Managing Quality
Quality is initiated and sustained by a commitment from the organization’s leadership. Practitioners report that this is the most important building block for success, as quality is not just about implementing a system or set of standards. Quality is an attitude, a way of working that improves the organization. This process includes:

- Developing a formal Strategic Plan and implementing accreditation standards of best practice
- Using short-term improvement planning to address quality improvement issues
- Measuring client outcomes that result in improvements in clinical status, health, welfare, and safety, permanency of life situation, functional status, or in some other quality of life indicator
- Building knowledge of how to improve the effectiveness and efficiency of service delivery and implementing change
APPENDIX 6
SHORT-TERM QUALITY IMPROVEMENT PLAN
REPORTING FORMAT

1. The program’s annual quality improvement plan was identified from the following source(s):

☐ 1. CQI Case Review data  ☐ 8. Service delivery data
☐ 2. Client Outcome data  ☐ 9. Financial information
☐ 3. Consumer Survey data  ☐ 10. Consumer complaint/grievance information
☐ 4. Staff Survey data  ☐ 11. Consumer advisory group input
☐ 5. COA Standards  ☐ 12. Feedback from Stakeholders
☐ 6. CQI Annual Report  ☐ 13. Program performance information

2. The goal/objective of the quality improvement plan was:

3. The following work groups or individuals in our organization will be involved with implementing the plan (list job titles of individual(s) or names of work groups):

4. If the program plans to involve consumers or external stakeholders with the improvement plan, please describe briefly.

5. The program obtained the following results/outcomes:

6. Our evaluation of the results/outcomes is (describe briefly):

7. We communicated the results of our improvement plan initiative by (describe briefly):

8. Our results were communicated to the following stakeholders (check all that apply):
   ☐ Governance
   ☐ Persons Served
   ☐ Staff
   ☐ Community
   ☐ Other Stakeholders (Specify):
### APPENDIX 7

#### CASE RECORD REVIEW FORM

#### SAMPLE

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the client intake assessment complete and present in the case file?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full Compliance</td>
<td>Substantial Compliance</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recommendations / Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Do client needs as assessed meet the exiting standards for program eligibility and admission?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full Compliance</td>
<td>Substantial Compliance</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recommendations / Comments:</td>
<td></td>
<td></td>
</tr>
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</table>

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Is there an appropriate and current client service plan based on client’s documented goals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full Compliance</td>
<td>Substantial Compliance</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Recommendations / Comments:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 8

CASE RECORD REVIEW REPORT

SAMPLE

1. Describe the types and number of files reviewed (open vs. closed case files, etc)

2. List the CQI Team Reviewers

3. Indicate Areas to be Evaluated
   (Case files should be evaluated by standards established by the program, by COA Standards, and/or other quality standards developed by/required by internal or external stakeholders)

4. Describe the Scoring System used for the Case Reviews
   Each item/standard should be evaluated by using a 4-point rating scale from full compliance to no compliance. If a document should be in the case record, but is not, it is rated as “not present.” If the question did not apply to the case record under review, the item was rated N/A.

   The following rating scale should be used for items under review:
   - Full Implementation/Compliance, indicating the documentation was appropriate;
   - Substantial Implementation/Compliance, indicating there were some areas of concern, but that the file/chart was otherwise adequate in most respects;
   - Partial Implementation/Compliance, meaning the reviewers felt that there were some significant problems, that there were inconsistencies, that issues were not sufficiently addressed, or that the reviewer could not assess the question sufficiently; or
   - No Implementation/Compliance, indicating that no or poor documentation was found, that there were serious omissions, or that there were other major problems noted.

5. Discuss the results of the Previous Action Plan (if any)

6. State the results of the quarterly case review, indicating areas of strength and weakness

7. List all recommendations for continuous improvement

8. Indicate if there is a need for a new Action Plan of correction based on the review

9. Indicate that the staff can request a debriefing of the results

10. Distribution List: indicate who received the case review report from the team leader
Overview:
(The program is responsible for producing a corrective Action Plan in response to the Case Review Report within 3 weeks if the review team indicates immediate action is needed. If the program staff disagree with any of the findings or recommendations of the review, these should be addressed in writing and submitted to the CQI team leader)

A. Describe procedures you will implement to improve the areas addressed in the report.

B. Describe your timeline for implementing changes.

C. Indicate the individuals responsible for implementing changes.

D. Describe the methods you will use to monitor progress.

E. Explain any procedure necessary to support change (i.e., revised training, policy changes).

F. Address any staff response to the review(s).

Submitted by:

__________________________________________ Date

Reviewed by:

__________________________________________ Date
# APPENDIX 10

## NAME OF PROGRAM

### Case File Documentation Checklist

<table>
<thead>
<tr>
<th>Section 1 - Client Information</th>
<th>Required or Not?</th>
<th>Is Document Present</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation Checklist</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral Application</td>
<td>If Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certification / Verification of Homelessness</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Eligibility Worksheet</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welcome Form / House Rules</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement of Confidentiality</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCLA Client Rights and Responsibilities</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCLA Client Grievance Procedure</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acknowledgement of Rights/Grievances</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization to Disclose Information</td>
<td>If Applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID (Drivers License, CA ID, SS Card)</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral form (Other Agencies)</td>
<td>If Applicable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Section 2 – Medical Reports     |                     |          |          |
| TB Test Results                 | Yes                |                     |          |
| Drug/Alcohol Test Results       | If Applicable      |                     |          |
| Physical Report / Notes (from Hospitals) | If Applicable |                     |          |
| Radiology Report                | If Applicable      |                     |          |
| Lab Reports / Medical           | If Applicable      |                     |          |

| Section 3 - Assessment Information |                     |          |          |
| Client Self Assessment Form      | Yes                |                     |          |
| Initial Intake Assessment Form   | Yes                |                     |          |
| Social Work Summary and Impressions | Yes |                     |          |
| Other Comprehensive Assessment (Psychiatric, etc) | If Applicable |                     |          |

| Section 4 - Service Planning    |                     |          |          |
| Individualized Service Plan (Part 1) | Yes |                     |          |
| Individualized Service Plan (Part 2) | Yes |                     |          |
| Initial Aftercare Planning form | Yes                |                     |          |
| Resident Resume                 | If Applicable      |                     |          |

| Section 5 – Progress / Exit Planning |                     |          |          |
| Progress Notes                   | Yes                |                     |          |
| Referrals (sheet)                | If Applicable      |                     |          |
| Referrals (to other agencies)    | Yes                |                     |          |
| Benefits (SS, SDE, GR, others)   | If Applicable      |                     |          |
| Exit Summary                     | Yes                |                     |          |
| Aftercare Plan                   | Yes                |                     |          |
| Aftercare Contact Sheet          | Yes                |                     |          |
| Aftercare Referrals              | If Applicable      |                     |          |
| Follow-Up Information            | Yes                |                     |          |
APPENDIX 11

MEASURING PROGRAM OUTCOMES
This material is based on Measuring Program Outcomes: A Practical Approach (1996) and A Training Kit for Measuring Program Outcomes. Both are publications of United Way of America.

**Passionate about outcomes!**

We’ve all heard about how the agencies that fund our programs and accredit our Agency are now demanding outcomes. It hardly needs to be said that such demands do not generate much enthusiasm for outcome measurement among our staff. However, I believe we should be passionate because outcomes flow from our core values.

In a sense, outcomes are simply the things we want for our clients. We work at Catholic Charities because we want to help people fulfill their potential. Outcomes are the milestones on our clients’ journeys toward that potential and the services we provide are the stepping-stones that keep them moving in the right direction. Each service we provide is but one stepping-stone in a very long journey, but that doesn’t mean we shouldn’t keep a vision of the whole journey in our minds.

When creating outcomes measures for our programs, we should at first forget about what is practical or feasible and think about what we truly want for our clients. In other words, we should envision the entire journey; then, and only then, should we focus on what our programs can realistically contribute to the successful completion of this journey. I believe we need to keep the whole journey in mind because it is this vision that motivates us in our work. It is what makes us eager to come to work each day.

Outcomes, then, should not be viewed simply as a dull technical process for producing reports, but as a method for discovering whether or not our clients are making progress toward realizing their potential.
8 Steps to Measuring Your Program’s Outcomes

1. Get ready
2. Choose outcomes to measure
3. Specify indicators for your outcomes
4. Prepare to collect data on your indicators
5. Try out your outcome measurement system
6. Analyze data and report findings
7. Improve your outcome monitoring system
8. Use your findings
Step 1: Get Ready

Task 1: Assemble and orient an outcomes measurement work group

- Involve stakeholders in outcomes measurement
- Stakeholders are persons or organizations that have an investment in what will be learned from an evaluation and what will be done with the knowledge.
- There are three principle groups of stakeholders:
  a. Those involved in program operations (workforce members, etc)
  b. Those served by the program (clients, family members, agencies)
  c. Primary uses of the evaluation: persons in a position to do or decide something with regard to the program.

- Make a list of stakeholders you will include in your outcome measurement work group:
  1. 
  2. 
  3. 
  4. 
  5. 
  6. 

Task 2: Develop a timeline for implementing each major step.

Task 3: Distribute the game plan to key players in outcomes measurement.
Step 2: Choose Outcomes to Measure

Task 1: Gather ideas for your program’s outcomes from:

- Program documents, including mission statements, statements of program goals and objectives, annual reports, etc.
- Funding agency requirements
- Accrediting agency requirements
- Program staff and volunteers who work directly with clients
- Participants
- Representatives of agencies that are the “next step” for former clients
- Documents from similar programs
- Records of complaints that suggest outcomes clients expected to achieve but did not

Task 2: Construct a logic model for your program (see next page)

- A logic model displays the major components of your program, including its:
  - **Inputs**: the resources your program used to deliver its services
  - **Activities**: the services your program delivers to clients
  - **Outputs**: the amount of “product” of the program’s activities
  - **Outcomes**: the benefits clients achieve as a result of participating in the program
- It is called a “logic” model because it presents the logical relationships between a program’s components. A logic model can be “read” from left to right:

  Input A enables >>> activity B >>> leading to output C >>> producing outcome D

- By placing outcomes to the right of other program components, it discourages the development of inappropriate outcomes.
- Immediate, intermediate and long-term outcomes represent the sequencing of outcomes over time.
- Immediate outcomes should be the direct product of program outputs.
A PROGRAM LOGIC MODEL

<table>
<thead>
<tr>
<th>Program Inputs</th>
<th>Program Activities</th>
<th>Program Outputs</th>
<th>Initial Outcomes</th>
<th>Intermediate Outcomes</th>
<th>Long Term Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources used by program</td>
<td>What the program does with its inputs to achieve its objectives</td>
<td>The direct product of program activities</td>
<td>First benefits for clients of participating in program activities</td>
<td>Intermediate benefits for clients of participating in program activities</td>
<td>Increased ability of clients to meet their own needs</td>
</tr>
<tr>
<td>Staff</td>
<td>Provides food</td>
<td># Bags of food</td>
<td>Client has food in sufficient quantity to meet immediate need</td>
<td>Job interviews</td>
<td>Improved stability in financial condition</td>
</tr>
<tr>
<td>Money</td>
<td>Provides job training</td>
<td># Job training classes conducted</td>
<td>Increased skill</td>
<td>Change in behavior</td>
<td>Stable housing situation</td>
</tr>
<tr>
<td>Supplies</td>
<td>Provides housing assistance</td>
<td># Bed nights of shelter</td>
<td>New knowledge</td>
<td>Increased educational achievements</td>
<td>Permanent job</td>
</tr>
<tr>
<td>Equipment</td>
<td>Provides shelter</td>
<td># Counseling sessions</td>
<td>Improved condition</td>
<td>New resources/options become available</td>
<td>No gang affiliation</td>
</tr>
<tr>
<td>Facilities</td>
<td>Provides prepared meals to seniors</td>
<td># Case management hours provided</td>
<td>Increased stability</td>
<td>Implementation of new knowledge</td>
<td>Children safe and doing well at school</td>
</tr>
<tr>
<td>Volunteers</td>
<td></td>
<td></td>
<td>Increased safety</td>
<td>Better financial management</td>
<td>Satisfactory adjustment to family living</td>
</tr>
</tbody>
</table>

Task 3: Select outcomes that are important for clients and/or your program.

Evaluate each of your program’s outcomes by the following criteria:

- Will your program have a significant impact on the outcome?
- Will measuring this outcome help identify program successes and failures?
- Will the program’s stakeholders accept this as a valid outcome of the program?

For the outcomes you have selected for measurement:

- Do program inputs, activities and outputs relate logically to the initial, intermediate and long-term outcomes?
- Do the long-term outcomes represent meaningful benefits to clients?

ENTER THE OUTCOMES THAT HAVE MADE “THE CUT” INTO THE FOURTH COLUMN OF THE GRID ON THE NEXT PAGE
# AN OUTCOME MEASUREMENT FRAMEWORK

<table>
<thead>
<tr>
<th>Program Goals</th>
<th>Program Objectives</th>
<th>Intervention/Activities</th>
<th>Outcomes Expected</th>
<th>Outcome Indicators</th>
<th>Data Sources</th>
<th>Data Collection Methods/Instruments</th>
</tr>
</thead>
</table>
Step 3: Specify Indicators for Your Outcomes

Task 1: Specify one or more indicators for each outcome.

- The concept of indicator is more easily explained by example than definition:

Imagine for a moment that you are looking for a new home. You tell the realtor it has to be the “house of your dreams.” The realtor says, “That’s a little vague. How would I know the house of your dreams if I saw it?”

- Take a few minutes and write down 5 features of your “dream house.”
  1. ________________________________
  2. ________________________________
  3. ________________________________

- What you have written down are indicators of your “dream house.”

An indicator is simply an item of information that lets you know whether or not an outcome has been achieved. It has the following characteristics:

- It identifies the change in behavior or condition that signals that an outcome has been achieved.

- It is observable and measurable.

- It is expressed as the NUMBER and PERCENT of clients that achieved the desired outcome.
## SAMPLE OUTCOME INDICATORS

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Outcome</th>
<th>Indicator(s)</th>
</tr>
</thead>
</table>
| Shelter and counseling for at-risk runaway youth | Youth will obtain a safe residence upon program exit via reunification, or other stable long-term housing. | >Number and percent of youth who return home  
>Number and percent of youth placed in alternative living arrangements 6 months post discharge. |
| Teen Mother Parenting Education              | Teens are knowledgeable of prenatal nutrition and health guidelines        | >Number and percent of program participants who are able to identify food items that are good sources of major dietary requirements |
| Youth Development                            | Youth expand skills in areas of interest to them                          | >Number and percent of program participants that identify and demonstrate two or more skills they have learned |

**FILL IN THE FIFTH COLUMN OF THE OUTCOME MEASUREMENT FRAMEWORK (PAGE 7) WITH ONE OR MORE INDICATORS FOR EACH OUTCOME.**
Step 4: Prepare to Collect Data on Your Indicators

Task 1: Identify data sources for your indicators:

- Records, either from your program or other agencies
- People, such as clients or people in direct contact with clients
- General public, for programs directed at community-level changes
- Trained observers, for rating behavior, facilities, or environments
- Clinical tests and measurements, e.g., for evaluating pre-post changes in a client’s level of depression, anxiety, attitude, quality of life, etc.
- Client Evaluations

FILL IN THE SIXTH COLUMN OF THE OUTCOME MEASUREMENT FRAMEWORK (PAGE 7) WITH A DATA SOURCE FROM EACH INDICATOR

Task 2: Design data collection methods:

A. Decide how to obtain needed data from each source

- Extract data from written records
- Survey individuals or households
- Self-administered questionnaires
- Interviewer-administered questionnaires
- Modes of survey administration (mail, phone, in person, others/combinations)
- Trained observers rate behavior independently
- Take physical measurements

FILL IN THE SEVENTH COLUMN OF THE OUTCOME MEASUREMENT FRAMEWORK (PAGE 7) WITH THE DATA COLLECTION METHOD FOR EACH INDICATOR.
B. Prepare data collection instruments

Developing sound questionnaires, interview guides, tests, rating scales and other data collection instruments may be a time-consuming task. Try to locate instruments that others have developed and tested to see what you can use or adapt. Many pre-tested instruments provide scales for measuring a variety of human conditions and attitudes, such as self-esteem, family health, parenting skills, and mental outlook.

C. Develop data collection procedures

- When will data be collected
  1. When entering program
  2. When completing or exiting program
  3. Fixed interval after entering
  4. Fixed interval after completing
  5. Combination of the above

- Who is considered a participant?

- Include all participants, a sample, or just those who complete the program?

- Who will collect that data?

- How will confidentiality be protected?

Task 3: Pretest your data collection instruments and procedures.
**Step 5: Try Out Your Outcome Measurement System**

A pretest, as mentioned in Step 4, checks individual instruments and procedures.

A pilot test checks the functioning of the entire outcome measurement system.

Problems that can be uncovered in a pilot test include:

- **Measurement problems**
  1. Overlooked outcomes
  2. Badly defined indicators
  3. Inadequate data collector training
  4. Conflicting instructions for related instruments

- **Administration problems**
  1. Agency records that are not current
  2. Data collectors loose interest
  3. No return address on questionnaire
  4. Problem with locating clients for follow-up interviews
  5. Respondents refuse consent, don’t keep appointments, can’t remember, or don’t respond

**Task 1: Develop a Trial Strategy**

The pilot test does not have to involve the entire program, but it should

- Include all aspects of the outcome measurement system
- Involve a representative sample of clients
- Last long enough to cover key data collection points

**Task 2: Prepare the Data Collectors**

In most cases, direct service staff will serve as the data collectors. When direct service staff function as data collectors, they need to be aware that, for certain data collection methods, they will need to interact with their clients in a style to which they may be unaccustomed.
Task 3: Track and Collect Outcome Data

- Assign an individual to monitor and track the data collection process
- If necessary, develop forms to track the flow of data from their sources to the person(s) assigned to data entry.

Task 4: Monitor the Outcome Measurement Process

- Outcome Measurement System Features of Monitor
  1. Time spent on data collection and data entry
  2. Data missing from records
  3. Planned observations not completed
  4. Data collection errors
  5. Costs beyond staff time
  6. Former participants not located
  7. Response rates
  8. Refusal rates
  9. Missing data

If necessary, devise forms to capture the preceding information.
Step 6: Analyze Data and Report Findings

Task 1: Enter the data and Check for Errors

Processing the data means transferring the information recorded on questionnaires, observer rating forms, and other documents to either a computer or a new form, such as a spreadsheet, that helps you summarized the data. Whatever means you use for data entry and analysis, it is important to check for errors.

Task 2: Tabulate the Data

The data obtained on each participant (or class of participants, such as those that complete treatment, those that drop out prematurely, etc.) for each outcome indicator need to be added together to provide the overall value for that indicator for the reporting period. Most outcome indicators are expressed as the number and the percent of something, such as the number and percent of participants that achieved improvement.

To calculate the basic data:

- Count the total number of participants for whom you have data
- Count the number achieving each outcome status
- Calculate the percentage of participants achieving each outcome status
- Calculate other needed statistics, such as the “average” number of counseling sessions attended by clients who completed treatment and the “distribution” of sessions attended.

Task 3: Analyze the Data Broken Out by Key Characteristics

Identifying factors such as participant and/or program characteristics may influence your outcomes. If you think they may, plan to breakout the data by the appropriate factor.

Task 4: Provide Explanatory Information Related to your Findings

It is not enough simply to present outcome data (or any data) without a discussion and explanation of your findings to help readers understand what the numbers may mean. Some programs, for example, are designed specifically to serve participants that present difficult problems. Discussions of outcome findings should make this clear, especially
when directed toward funders. When you present data, include information that tells users the probable reasons why the outcomes look unusually high or low.

Task 5: Present Your Data in Clear and Understandable Form

Visual presentation in tables and charts will make the data more understandable to your readers, and once you have formats in place, you will be able to report changes over time.

Be sure to include narrative discussion of the findings they portray, although each table or chart should be as self-explanatory as possible.
Step 7: Improve Your Outcome Monitoring System

Task 1: Review your pilot test experience, make necessary adjustments, and start full-scale implementation.

After the pilot test, and periodically after this, the outcome measurement work group should review the adequacy of the following:

- Data collection instruments
- Training of data collectors
- Data collection procedures
- Data entry procedures
- Time and cost of collecting and analyzing the data
- Monitoring procedures used during the trial run

Step 8: Use Your Findings

You have designed and implemented a system for measuring your program outcomes and have analyzed the resulting data. Now, it is time to make maximum use of your findings to improve and promote your program.

Some uses of outcome data are internal to your organization. The findings represent feedback on how well the program is doing – feedback that can, for example, help:

- Provide direction for staff
- Identify needs for staff and volunteer training
- Point out program improvement needs and effective strategies
- Support annual and long range planning
- Guide budgets and justify resource allocations
- Suggest outcome targets
- Focus board members’ attention on program issues

Most importantly, outcome data are related to enhancing a program’s external image and interaction with its various funders and public partners. Outcome findings can help programs demonstrate that they are in fact making a difference for individual and families, and can strengthen the case of programs seeking funding for new services.
APPENDIX 12
DEFINITION OF TERMS

**Accidents**: Events that have occurred that have caused harm. (Cp. incidents)

**Benchmark**: An industrial term that indicates an absolute standard against which performance is measured. The human service field is in the very early stages of developing measures that could be considered true benchmarks. When the term benchmark is used in this document it refers to a comparative assessment or performance standard.

**Client/Consumer Satisfaction**: Feedback provided by clients about their experience with a program's services; often obtained by surveys of clients.

**Difference from Standard**: The extent to which the actual results of performing a service differ from the expected results; the Performance Standard minus the measurement equals the Difference from the Standard.

**Efficiency**: The volume of output compared to the resources needed to achieve the output. Resources may be financial, human or time.

**Incidents**: Unusual events that put either clients or staff at risk of harm (emotional or physical).

**Limited Intervention**: Level C client services that are limited by the intensity of the service but are not necessarily time limited.

**Measurement**: A determination of the results of providing a particular service. Measurements should not be confused with measurement tools or instruments. Pre and post-tests are tools used to measure a change in knowledge or ability. The size of change is the measurement.

**Outcome Objective**: A report on the impact of a program's service on its target population. The outcome objective must be measured (benchmarked) against a contract requirement, an internal or external program, or a community standard. Outcomes are benefits for participants during or after their involvement with a program. Outcomes may relate to knowledge, skills, attitudes, values, behavior, condition, or status. Examples of outcomes include greater knowledge of nutritional needs, getting a job, or having a place to live. These objectives must specify the following: 1) the target population, 2) the impact expected (i.e., describe changes in behavior, competencies or milestones that clients are expected to achieve), and 3) how is the impact being measured?

**Output Objective**: A report on the quantity of services provided. The output objective must be measured (benchmarked) against a contract requirement, an internal or external program, or a community standard. Outputs are products of a program's activities, such as number classes taught or participants served. Another term for "outputs" is "units of service." A program's outputs should produce desired outcomes for the program's participants.

**Performance Standard**: The level of performance expected in a program's service. This may be based on a contract requirement, actual experience, or a community standard.