PERFORMANCE AND QUALITY IMPROVEMENT PLAN

Promoting excellence and continuous improvement for St. Mary's Home for Children's staff and children.

A: ORGANIZATIONAL PHILOSOPHY OF PQI

The Performance and Quality Improvement ("PQI") program of St. Mary's Home for Children ("SMHFC") promotes excellence and continuous improvement in all functions of client care and support services provided. Leadership endorses the collection and constructive use of data to promote high learning/high performance results. Performance and outcome expectations are communicated in a supportive manner and ensure protection for employees who identify areas of needed improvement. SMHFC provides for "whistle blower" protections.

The PQI plan is broad-based and includes all employees, Board of Directors, clients/consumers and external stakeholders. With input from stakeholders, the Board of Directors and staff establish strategic priorities and goals. Key performance objectives are delineated for all services and performance and client outcomes are measured in each program area. These key objectives include those that have the greatest impact on the quality of care/service the client ultimately receives. Priority will be given to functions which are performed frequently, which can be high risk or problematic, or for which there is a unique interest in the data to be collected.

B: RESPONSIBILITY FOR OVERSIGHT OF PQI/PQI STRUCTURE

The PQI Coordinator is responsible for overseeing the process and organizing and coordinating all PQI activities. These activities include the review of management outcomes, client outcomes, program/service delivery effectiveness and risk prevention activities. The PQI Committee consists of the PQI Coordinator, Executive Director, Program Directors, a Training Department representative, and support/direct-care staff representatives. The PQI Committee will meet during the third week of the month. The PQI Committee will review reports at least quarterly from all Performance and Quality Improvement areas, listed below. All Quarterly Reports will include action plans, metrics, and PQI initiative updates. The Committee will review and interpret the data and approve or revise proposed initiatives and coordinate implementation. Benchmarks will be reviewed and updated as necessary. Oversight of the execution of PQI initiatives, PQI recordkeeping, and follow through will be the responsibility of the PQI Coordinator.

The PQI Coordinator will distribute a PQI Quarterly Report to all staff, volunteers, and Board members and will have it posted on the Agency website. An annual summary report of gains made against goals will be presented at the year-end PQI Committee meeting and the annual Board retreat. It will also be distributed to SMHFC staff and stakeholders.

To support PQI processes, the organization will analyze Agency data in relation to:

- Consumers (Client Outcomes, Demographics);
- Program/services (Program Outcomes, Service Delivery);
- Performance (Client and Employee Satisfaction,);
- Risk management; and
- Financial viability.

Reports that will be reviewed include:

- Case Record Review
- Safety Review
- Risk Prevention
- Critical Incident
- Grievance
- Staff Relations
- Improvement
- Kids' Council

C: STAKEHOLDERS

Stakeholder involvement is a significant component of St. Mary's PQI process. Stakeholders include: service recipients, families of recipients, employees, volunteers, governmental entities, funders, community partners, and members of the Board of Directors. Annually, St. Mary's distributes surveys via **surveymonkey.com** to the following stakeholders: employees, volunteers, funding sources, community partners and the Board of Directors. Service recipients receive a client satisfaction and outcome survey at discharge.

Employee Satisfaction Survey: Annually, an Employee Satisfaction Survey is distributed to all staff to identify areas of satisfaction and areas in need of improvement. Components of the survey include: work environment, supervisory relations, team interactions, job satisfaction, commitment, and knowledge of policies and committees.
Data Review & Analysis:
This data is collected and aggregated using surveymonkey.com. The PQI team, in concert with the Improvement and Staff Relations Committees, determines areas of improvement/focus from the results of the survey and develops a response.
Communicating Results and Action Plan:
The results are shared with all members of the SMHFC staff and Board of Directors. Program Directors address areas of needed improvement with individual programs and develop an action plan. The action plan is disseminated to all Agency employees and the Board of Directors.

Service Partner Survey: An Annual Service Partner Survey is distributed in October of each year to solicit input from the broader community on the overall quality of the Agency and how to improve. Service Partners are defined as advocates, volunteers, funding sources, referring agents and community supporters. Components of the survey include: knowledge of the organization's mission; community need; agency status through distribution of corporate materials; and review of the organization's overall performance in relation to established expectations.
Data Review & Analysis:
The data is collected and aggregated using surveymonkey.com. Utilizing the results of the survey, the PQI team, along with the Board CQI Committee, determines areas of improvement/focus and develops a response.
Communicating results and action plan:
The PQI Coordinator shares the results with the Board CQI Committee. Recommendations are made for quality improvement of organizational performance based on the results of the data and included in the Annual PQI Report. The results and Agency action plan in response to issues raised are distributed to service partners, Agency staff members and the Board of Directors via e-mail.

Client Satisfaction & Outcome Survey: At each discharge in both the Outpatient and Residential Programs, the parent/guardian and child are given a survey to complete anonymously and place in an envelope to be delivered to the PQI Coordinator. The survey addresses satisfaction with services, respectful treatment, client's perceptions of issues, reduction of symptoms/problematic behaviors, unmet needs and recommendations for improvement.

Data Review & Analysis:

The Outpatient survey results are compiled and analyzed and a report is written by the Director of Outpatient Services. The Clinical Director, Residential Services compiles data from the client outcome questionnaire in the Residential Program and writes a summary report. Quarterly data is compiled and included in the report to the PQI Committee. Areas for improvement are identified and an action plan is developed.

***Communicating Results & Action Plan*:**

The results and action plan are disseminated to Agency staff members and the Board of Directors.

Volunteer Survey

The survey addresses satisfaction with the volunteer experience; motivation for volunteering, meaning derived from the experience and feelings of appreciation by the organization.

***Data Review & Analysis*:**

The results are reviewed with the PQI team and volunteer coordinator and a response is written by the Volunteer Coordinator for review by the PQI Committee. The PQI Committee reviews the results and written report and makes recommendations for improvement.

Communicating Results & Action Plan:

The results and action plan are disseminated to volunteers, departmental Directors and the Board of Directors.

Board of Directors Self-Assessment

Annually, the Board of Directors completes a self-assessment that is distributed via surveymonkey.com. The Board Self Assessment tool measures the members' understanding of Board role and responsibilities and the mission of SMHFC, Board effectiveness in monitoring progress toward strategic goals, and Board's efforts in setting fundraising goals, and it elicits the Board's opinion of time spent on issues over the past year, areas of focus for the next year, successes, and observed shortcomings.

Data Review & Analysis

The President of the Board of Directors and Executive Director review the results of the Board Self Assessment and determine areas for improvement/clarification/focus for the year and present these findings to the Board Retreat facilitator who uses these findings during her presentation to the Board.

Communicating Results

Results of the Board Self-Assessment are reported to the Full Board and used to develop Board goals during the Annual Board retreat in October.

D. LONG-TERM STRATEGIC GOALS AND OBJECTIVES

An organization-wide, long-term strategic planning process is conducted every four years. An annual review of the Strategic Plan takes place at the October retreat of the SMHFC Board of Directors. The review:

• clarifies the organization's mission, vision, and beliefs and values;
• establishes long term goals that flow from its mission, financial situation, and mandated responsibilities;
• assesses its strength, weaknesses, threats, and opportunities;
• assesses human resource needs; and
• identifies and formulates strategies for meeting identified goals.

The long-term strategic planning review includes an examination of community needs that assesses:
• services offered by other providers in the community;
• partnership opportunities with other child and family serving agencies;
• trends in needs and expectations in referral sources;
• gaps in the array of services needed by the organization's defined service population;
• accessibility issues;
• the need to redirect, eliminate and/or expand services in response to changing demographics and the needs and wishes of the community; and
• any other operational concerns affecting the services and financial health of the Agency.

Based on the long-range goals, the Board and staff develop an annual plan of work. Results from the annual staff and stakeholders surveys as well as results from PQI data, permits a flexible response to changing conditions and needs. This plan outlines in concrete terms the action that will be taken during the fiscal year to move the Agency towards achieving its four-year goals. The Executive Committee oversees the strategic process and charges Board subcommittees to establish and implement strategic initiatives.

Organizational goals from the 2010 Strategic Plan include:

- Redefining the program portfolio to better meet local and field trends in child welfare and children's behavioral health;
- Creating a network of supportive relationships to enhance mission accomplishment;
- Adjusting organizational infrastructure to better support strategic goals; and
- Re-focusing emphasis on quality assurance and organizational learning.

E. MANAGEMENT/OPERATIONAL PERFORMANCE

Financial Stability, Workforce Stability, and Risk Prevention are areas of organizational focus.

Financial Stability

Organizational leadership and the Board of Directors have committed to diversification of St. Mary's program portfolio and funding streams while staying true to its mission. Trends in the field are considered and opportunities for development of new programs and/or services are continuously examined. In addition, the agency is committed to the continuous monitoring of revenue and expenses so that adjustments/corrections can be made quickly and decisively to prevent significant loss and financial instability.

Data Review & Analysis:

The following reports are reviewed by the Finance Director and Executive Director on a weekly basis: Outpatient productivity reports, overtime expenditures, payroll analysis. Billing procedures and collections are regularly analyzed as are payables/receivables reports. Monthly and year-to-date financial summaries and five year comparison reports are presented to the Board Finance Committee.

Communicating Results & Action Plan:

Every other month the financial summary report is presented to the full Board. Adjustments are made, initiatives identified as trends are recognized.

Workforce Stability

The Director of Administration conducts a workforce analysis annually in preparation for budget development meetings. The information reviewed is a combination of internal workforce trends and projections for growth/decrease in service need in accordance with the Agency's long-term

goals and short-term annual objectives. Additionally, HR analyzes workforce needs and patterns for reports at quarterly Personnel Committee meetings.

Data Review & Analysis:

Employee surveys, exit interview information, payroll reports, including overtime reports, employee turnover data, hiring data, benefits data, Department of Labor & Training statements, Workers' Compensation data are generated and reviewed.

Communicating Results & Action Plan:

Identified trends, concerns, and opportunities are reported to Personnel Committee. Initiatives are reported to PQI Committee.

Risk Prevention

Administrative review is conducted quarterly to assess areas that pertain to administration/operations of SMHFC. The review committee consists of the Executive Director, Director of Operations, Director of Administration and Human Resources Assistant. Areas that are assessed include: compliance with legal and licensing requirements, insurance and liability, human resources practices, contracting practices and compliance, client rights and confidentiality issues, ability to pursue strategic goals, financial risk and conflicts of interest. This committee is responsible for reviewing essential management and operational compliance and processes, documenting trends, developing performance improvement indicators and recommending a course of action to the Board of Directors. Each member of the Board is required to complete a conflict of interest document, identifying any known or potential conflicts on an annual basis. Other areas of potential risk are reviewed in the Critical Incident Review and Safety Committees, who report to the agency PQI Committee and submit quarterly reports.

***Data Review & Analysis*:**

The above-stated areas of potential risk to the organization are presented to the Board of Directors on an annual basis. The Board reviews the information provided and makes recommendations to mitigate risk to the organization. Additionally, an annual Financial Audit is conducted by an accredited independent certified public accounting firm. The responsibility of the independent auditor is to conduct the audit using professional standards to provide an opinion that the financial statements are fairly presented in all material respects in conformity with generally accepted accounting principles. As part of the audit, the auditors will review the internal controls of SMHFC. This information is brought to the Audit Committee of the Board of Directors. The Executive Director and Director of Administration are responsible for ensuring that Board recommendations are carried out and for making the appropriate adjustments/corrections as noted in the management letter of the audit.

Communicating Results & Action Plan:

Based on the Board's recommendations, the Executive Director and Director of Administration report the actions taken and results to the Board of Directors. Risk Prevention reports are written quarterly and an annual report is written at the end of the fiscal year and presented to the Board of Directors for review. The Safety and Critical Incident Review Committees also submit quarterly reports that are included in the PQI quarterly, which is distributed to all members of the Board of Directors.

Safety Review:

The Safety Committee meets monthly to conduct a review of all issues regarding employee and client safety by focusing on facilities and risk management. The Safety Review Committee utilizes representatives from human resources, performance quality improvement, administrative support, direct care and other program staff. Committee members meet to discuss safety issues, incidents, and reports as related to safety and risk management. Data and reports are gathered by the responsible committee members and brought to the meeting for review. These reports assist in

making a determination of areas that are in need of improvement. Reports gathered for assessment include:

• Health, OSHA, Building and Fire inspections: The Director of Operations presents building, safety and health inspections as well as the Fire Inspection to the committee meeting. A review of the current inspections is examined for areas that need attention.

.• Incident reports regarding staff and child accidents and injuries. Accident and injury reports are analyzed at monthly meetings for safety issues and a quarterly review of all injuries is done to identify patterns.

• Environmental, Health and Safety/Physical Plant Audit: The environmental/physical plant audit is conducted by the Director of Operations, Program Directors, PQI Coordinator and direct care staff representative. The data is compiled and used to determine where improvements are needed.

• Review of medication storage and record keeping are examined and any issues discovered are discussed and recommendations are made in areas in need of improvement.

• Facility concerns and any reported property destruction will be reviewed to determine areas of needed improvement and recommendations will be made and presented.

Data Review & Analysis

Reports brought to the committees as well as data supplied by the HR department regarding accidents and injuries are analyzed for potential improvement opportunities. Recommendations regarding recently submitted information and previous initiatives and action plans are reviewed to insure compliance and follow-through. On occasion, a safety concern will necessitate immediate action. In such an instance, the Director of Operations, Director of Administration and Executive Director will determine a course of action and ensure its implementation. This action/decision will be presented at the next scheduled Safety Committee meeting for review.

Communicating Results & Action Plan

Due to the importance of safety to all clients, visitors and staff, any safety issues presented to the safety committee will necessitate the immediate formulation of an action plan and will be reported as part of an improvement initiative to the PQI Committee. Any actions taken will be publicized to the St. Mary’s campus community by posted notices.

F. PROGRAM RESULTS AND SERVICE DELIVERY QUALITY

Case Record Review:

The Case Record Review is conducted monthly to analyze and evaluate clarity, content and continuity of open/closed records and to determine if children’s needs and strengths are being assessed appropriately. In addition, peer auditors are making determinations about the completeness of each file using the file audit form. The Director of Operations produces a list of children from each program area selected at random. This list will represent 25% of children each quarter in each of the program areas. Assignments are given to each peer reviewer and files are distributed for review and will uphold the standard of reviewing only those cases in which they have not been directly involved or for which there is no conflict of interest. All records reviewed are subject to the Agency’s Confidentiality Policy. On an annual basis the Rhode Island DCYF conducts an audit of each program, reviewing risks, challenges and improvement in programs and client care. They also conduct a quarterly review of the records for children in contracted programs. Health insurers conduct random audits of both the outpatient and ARTS programs.

Data Review & Analysis:

The Director of Operations collects the audit forms and completes a monthly report. At the end of each quarter, Program Directors/Coordinators write a quarterly report. After the quarterly report is completed, the Peer Case Record Review committee meets to discuss patterns and/or trends in the case records. Concerns and recommendations are discussed at the meeting and improvement initiatives and implementation status are reported to the PQI Committee.

***Communicating Results & Action Plan*:**

The Clinical Directors and Director of Operations use the team's recommendations to develop an action plan. The results are communicated to both the residential and outpatient clinical teams.

Client Grievance Review
The Grievance Committee is an ad hoc committee that meets as a grievance is brought forth. When a grievance reaches the Executive Director level pursuant to the Client Greivance Policy, the Executive Director will inform the PQI Coordinator of the grievance. The PQI Coordinator will notify the Grievance Committee chairperson and a grievance committee meeting will be scheduled. The committee will review the grievance and make recommendations for change based upon information obtained. The committee will put these recommendations for improvement in writing in minute format and after consultation with the Executive Director may respond in writing to the person filing the complaint.
Data Review & Analysis:
All written grievances, responses, and other documents or evidence provided by the grievant or Agency personnel that pertains to the issue will be reviewed by the Committee.
***Communicating Results & Action Plan*:**
The Executive Director will inform The Board of Directors of any formal grievance initiated by a client, resident, student or parent and will inform the Board of the resolution. The Grievance Committee will provide its report to the PQI Committee.

Critical Incident Review
The critical incident review committee meets weekly to conduct a review of all incidents of physical restraint, magnetic door room usage, AWOLs, medication errors and other incidents of a critical nature. The committee includes the Executive Director, Residential Director, a Unit Supervisor, Staff Development Coordinator, Nurse, Behavior Support Specialist and Secretary. Agency Incident Forms, completed by a unit staff member, and reviewed and signed by the supervisor on duty are reviewed in the weekly meeting. The Committee assesses the consistency between actual practice and the espoused model of care at SMHFC. From this, the need for additional training/supervision or other interventions is determined.
***Data Review & Analysis*:**
During the review, a summary of each incident is written. If a particular incident requires follow-up, it is noted and the individual responsible reports back to the committee the following week. Feedback is given to staff members that were involved in the incidents to inform practice and to adhere to best practice philosophy, patterns are identified and action taken to intervene. Positive and corrective feedback are given to involved staff members.
Communicating Results & Action Plan:
A quarterly report is written by the Committee Chair and presented to the Board CQI and PQI Committee. This report outlines the type and number of incidents, identifies patterns and recommends interventions and an action plan. The report is disseminated to unit supervisors and assistant supervisors and shared with residential staff.

Intake/Admissions
The Residential Admissions Committee meets weekly to discuss cases referred for residential treatment. Members of the committee include the: Intake Coordinator, Clinical Director, Residential Services, Nursing Director and Director of Education. During the case review, the group makes a determination of the Agency's ability to meet the child's needs. The intake coordinator tracks the following information: number of clients referred to each program, number admitted and accepted, reason for admission being denied, length of time between initial contact and admission.
Data Review & Analysis

We conduct and analysis of the following: types of referrals, ability to serve children denied admission, length of time between initial contact and admission, reasons for delays, and processes that could be put into place to hasten the intake process and/or increase referrals.

Communication Results & Action Plan

Quarterly intake report written by the intake coordinator for the outpatient program and the residential intake coordinator writes it for the residential program. Results are shared with the PQI committee.

G. CLIENT AND PROGRAM OUTCOMES

Client Outcomes:

Children will be free of abuse and neglect while in care: Incident Reports regarding abuse/neglect are retrieved by the Director of Operations. Any reported incident of abuse and/or neglect while the child is in care is reported to the Child Abuse and Neglect Tracking System. The incident reports are examined and improvements are recommended by the members of the Critical Incident Review team. Implementation of corrective action or termination of employment in indicated cases is enforced by the program director and unit supervisors and overseen by the Executive Director. This process is included in the Critical Incident Review report to the PQI Committee.

Children will exhibit improved daily functioning and emotional health and: The CAFAS is administered to residents upon admission and at each three month interval, coinciding with treatment plan reviews. In both the Outpatient and Residential Programs, ratings on the GAF from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) will be tracked on a quarterly basis throughout the child’s treatment. Service goals are established upon initial assessment and reviewed quarterly for each child. This data is included in a report to the PQI Committee. Data will be tracked in the Agency’s database and reviewed quarterly. Improvement in GAF scores is expected. Adjustments are made and programming is individualized and tailored to meet each client’s unique clinical needs.

Family relationships are improved and strengthened: At placement a service plan is developed and family relationships are established. The goals are entered into the child’s treatment plan. Progress is reviewed on a quarterly basis. Family engagement is a key component of effective treatment. In this context, family engagement is measured by family therapy appointments scheduled and attended, frequency of visitation, and family attendance at family nights. This information is collected by Placement Solutions, tabulated and returned back to the Residential Director on a monthly basis.

ASSESSMENT OF THE EFFECTIVENESS OF THE PQI PROCESS

The PQI process is reviewed on an annual basis within the PQI Annual Report. This Report also includes provision for an annual assessment of the PQI program’s utility, including any barriers to and supports for implementation. The PQI Annual Report is presented to the Board of Directors and all staff.