Performance and Quality Improvement

2020 Annual Report

February 15, 2021

St. Mary's
HOME FOR CHILDREN
Healing Lives, Restoring Hope – Since 1877

Performance and Quality Improvement (PQI) 2020 Annual Report

A message from the Executive Director:

As you will see from this report, our PQI team has been hard at work! The great thing about gathering data is that it can validate the good work that we do. It can also highlight areas in which we need to improve.

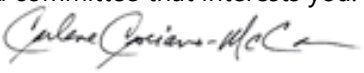
This past year provided us with multiple opportunities to use data to inform our practice and lead to meaningful change. Critical incident review, file audits and employee turnover statistics have led to new initiatives, amelioration of records and new tracking methods.

Client outcomes projects have yielded useful information that has led to great conversations about our services, hypotheses as to what the data is telling us, suggestions about new data to collect and ways in which we can improve. Until recently, we did not have the resources to connect with clients who have been discharged from our residential intervention. Now that we do, we are able to see the impact of our work post-residential. Please see page 7 to learn more. We are also tracking outcomes for a few of our community-based services and those results are on page 8.

Our PQI team has created a monthly dashboard that highlights PQI initiatives and committee work. Each month, a member of the leadership team presents progress on an initiative for which they are responsible. This enables us to celebrate our successes, re-tool when needed and hold ourselves accountable.

The agency is placing a greater emphasis on risk mitigation and is collecting data and doing a 10-year retrospective look at various areas of risk to see if there is anything to be learned for moving the agency forward. This information is being further refined for review by the Board of Directors.

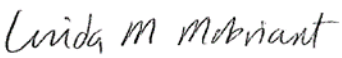
Our committees accomplish a lot throughout the year, and I'd like to thank committee members and Chairs for their commitment and encourage anyone who is interested in making change at St. Mary's to join a committee that interests you.



A message from the Director of Operations and PQI:

It was an enjoyable process for me to reflect back on the year in PQI while preparing this Annual Report. So much has been achieved, improved and enhanced as a result of the additional PQI resources introduced in late 2019, and this is just the beginning! Despite the numerous pandemic pivots in 2020, the systems we have in place helped all staff achieve an incredibly successful expedited re-accreditation while making tremendous advancements in their program and department PQI projects and activities.

It's not possible to list each and every PQI activity taking place at the agency (although I would definitely be happy to talk to anyone who is interested!). Instead, we've selected some highlights that provide a snapshot of the hard work being done by all programs and departments at the agency.



Priority Initiative

Physical Restraint Initiative: School and Residential Programs

2020 RATE OF RESTRAINT: 1.6

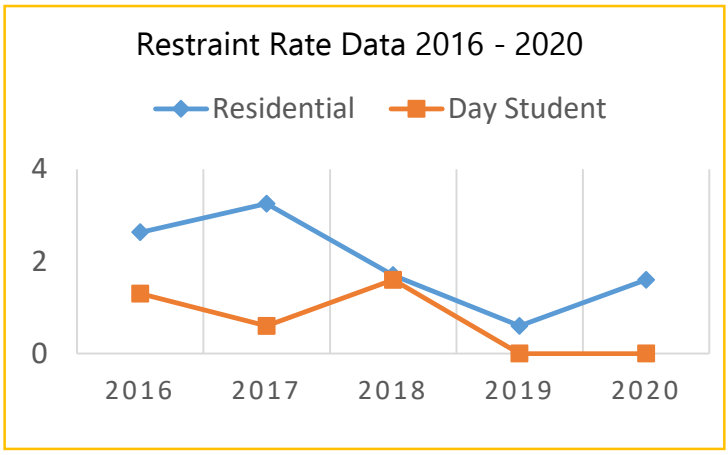
Physical interventions data is collected, analyzed and visualized by the PQI team, and then reported for monthly assessment by the Critical Incident Committee. The report is the basis for discussion and action planning at a monthly CI Data Meeting. Analysis includes but is not limited to client and staff injuries, post-restraint debriefs, a breakdown of incidents by location, date and time of day, staff involved, behaviors observed and more.

A deeper data analysis for individual youth includes review of the record including diagnosis, supports, placement history and other factors that may be helpful when trying to identify possible triggers and mitigation strategies.

In 2020, the rate of restraint increased from .6 to 1.6 which is a 166% increase. As that trend became evident, and could not be exclusively attributed to COVID restrictions, a comprehensive action plan was created. The rate of restraint is being monitored by the PQI Committee as a priority initiative.

Action Plan highlights include but are not limited to:

- 55 Trauma-Informed Care in Youth Serving Settings: Organizational Self Assessments were sent to staff across programs to help identify areas in need of improvement (e.g. training, supervision, support, etc.)
- Formal, comprehensive training of milieu Supervisors, Assistant Supervisors, Nursing staff and BBI staff in the Six Core Strategies for Restraint Reduction



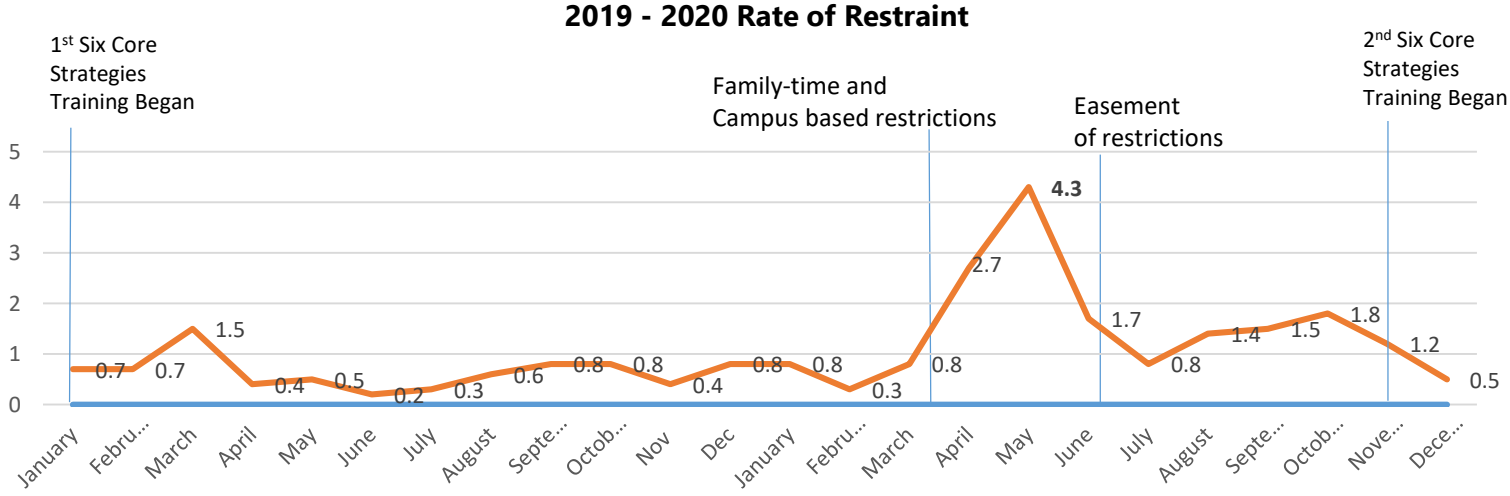
2020 COVID-19 IMPACT

We would be remiss not to consider that the COVID-19 pandemic had an impact on the initiative. Staff helped youth navigate and manage feelings including uncertainty, fear and anxiety at a time they were experiencing and managing personal responses and impacts. These were unprecedented stressors for youth, families and staff throughout the agency.

Effective March 18th a hold was placed on all in-person family time or visitation with friends. Youth were additionally restricted to stay on-campus, and on March 30th their first peer was diagnosed. Markers on the chart below show a correlation. Deep dives into data were conducted to help inform decision making during those challenging months.

Staff are commended for the tremendous amount of support they provided to youth and families.

2019 - 2020 Rate of Restraint



Priority Initiative

Clinical Records: Office, Community and Residential Programs

Client Record Reviews are conducted quarterly, and focus on Medicaid/Insurer compliance, clinical quality and best practice standards including a peer review. PQI reports results to the Executive Director, Chief Operating Officer, and respective Program Director. Reporting includes recommendations for improvement through practice or systems changes, use of technology for efficiency, and helps to identify areas that may need attention or support. Quality reviews done by the clinicians of their peer's records consistently shows a high level of clinical quality being provided to our clients. Residential program audits include 100% of clients open during the quarter under review. Office and community-based audits contain a representative sample of open and closed per COA standards.

The reader should note that record audit data below by no means tells the complete story of high quality treatment and services. Our audit system ensures that progress notes, treatment plans, assessments and other key documents are read by licensed clinicians. That peer review is where client engagement and development of client-provider relationships is evidenced, where support, advocacy and empowerment is evidenced, and where we see use of evidence informed practices to support clients in achieving their goals. We continually strive for documentation improvements, and are consistently proud of the excellent work being done by all staff involved in client services.

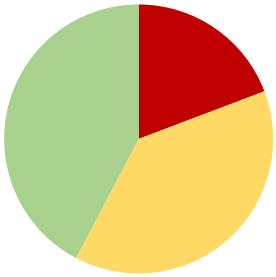
RESIDENTIAL

182 open and closed records were reviewed in 2020. As the year progressed, reporting became more detailed toward the goal of helping with efficiency and amelioration. Pandemic pivots, which occurred throughout the entire year to support clients and families, appears to have impacted results. It should be noted that presence of key clinical documents was improved, with lingering timeliness issues contributing to the ratings. Plans are in place to improve systems that in turn will help timeliness. Also in 2021, a 2x per year audit of the key medical services provided to residents will be included in the process.

OFFICE AND COMMUNITY BASED

174 records were reviewed in 2020. After an initial quarter which evidenced much to celebrate in record compliance, the swift change to Telehealth due to the pandemic appears to have impacted results thereafter. New systems with remotely working staff, with limited on-campus staff resources to support them, were created. Kinks and challenges in that regard contributed to the ratings. More staff were also observed to be working in multiple programs, and/or programs where they had not previously been working. Efforts to improve continue each quarter.

2020 Overall Residential Programs



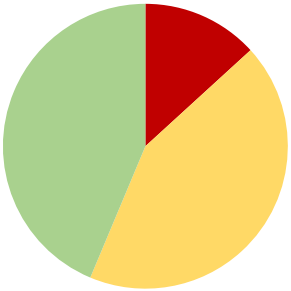
Key:

Full/substantial compliance

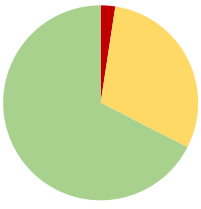
Partial Compliance

Administrative attention needed

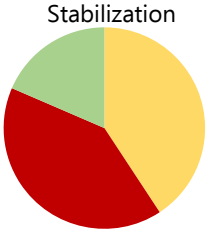
2020 Overall Office and Community Based Programs



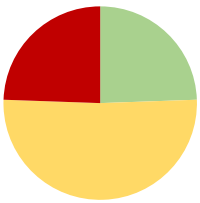
PRTF Programs



Assessment and Stabilization

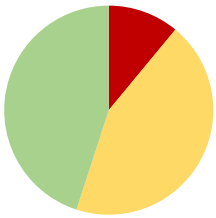


ARTS Program

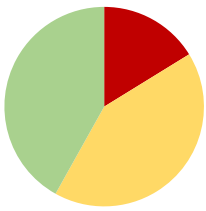


2021 Residential Programs Goal:
80% at or above target

Office Based Programs



Community Based Programs



2021 Office and Community Based Goal:
85% at or above target

Priority Initiative

Employee Turnover: Residential Programs and All Others

Employee turnover data is monitored toward the following goals:

- Provide consistent and stable staffing for client and family benefit
- Provide career opportunities and advancement
- Strengthen institutional knowledge
- Reduce financial costs associated with high turnover

Activities in 2020 included but were not limited to:

- Centralization of Recruitment, Hiring, Orientation and Onboarding
- HR/Residential recurring overtime meetings
- Salary assessments

In 2021, quarterly employee evaluation data will be analyzed to enhance the initiative

For the first time in many years, office and community based programs have experienced an increase in turnover. COVID-19, which forced an immediate change to Telehealth, is suspected to be a contributing factor. Resignations due to health concerns and personal responsibilities including distance learning were new factors as a result of the pandemic. A focus on assessing and potentially changing elements of the Exit Interview process in 2021 should help to gather data in one location for agency-wide assessment and planning.

Targets / Risk Ratings for Residential:

Stable **< 30%**

Monitor **31 – 35%**

At Risk / Act **36% +**

Risk rating on 12/31/2020:

End of FY 2021 Goal: 30% or less turnover

End of FY 2022 Goal: 25% or less turnover

Key: *Stable* *Monitor* *At Risk/Act*

Targets / Risk Ratings for all other programs:

Stable **< 10%**

Monitor **11-15%**

At Risk / Act **16% +**

Risk rating on 12/31/2020:

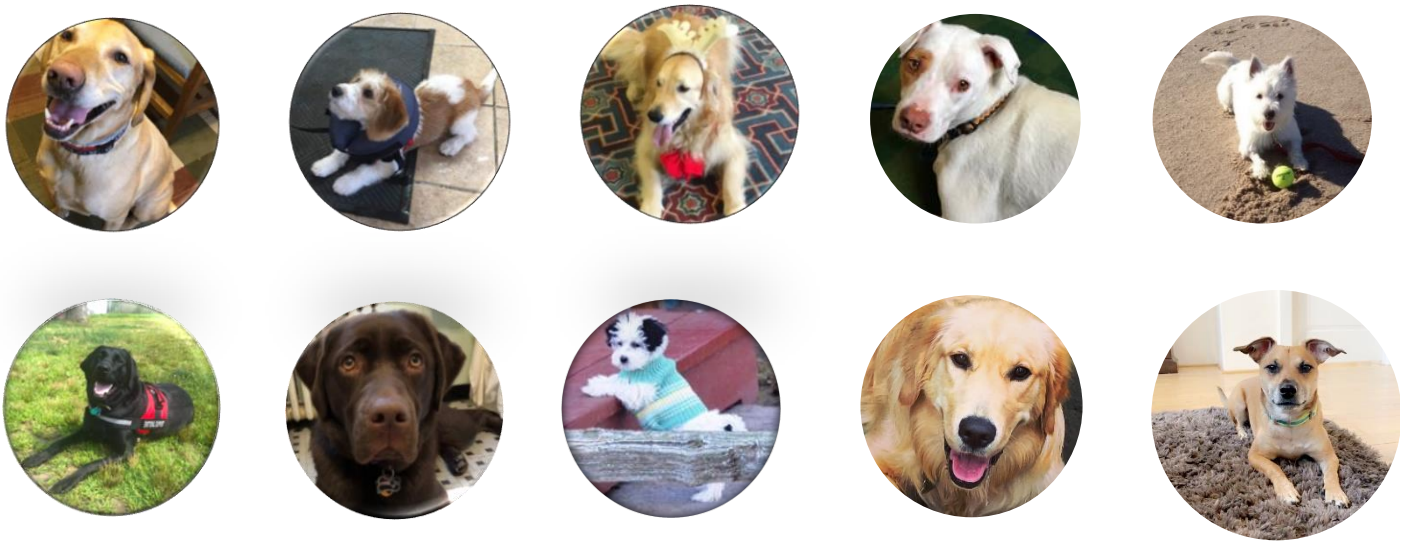
End of FY 2021 Goal: 10% or less turnover

End of FY 2022 Goal: 10% or less turnover

Master Planning

The Board Buildings & Grounds Subcommittee has been working hard since it was approved in the Fall of 2018. Reframing how we view facilities & infrastructure, and ensuring there was a full, accurate understanding about our aging property were dominant goals. It was imperative to take a more strategic approach to property investments, and to envision how the campus could better reflect our nationally-recognized, high quality programs and services. Professional master planning services were viewed as the way to achieve these goals, and by mid-2020, the Board passed a motion to accept a master planning process. They additionally committed to fund the project. A formal Expression of Interest process, followed by a Request for Proposal (RFP) process was initiated in the Fall. In late November, the Board voted to award the RFP to the SLAM Collaborative. SLAM is an architecture firm with integrated construction services, landscape architecture, structural engineering, and interior design. Master planning will continue into 2021, with a design anticipated before summer. This is the beginning of an amazing journey into our future. Be on the lookout in 2021 for much more information regarding the process and Plan.

THERAPY DOGS, A special section simply because they make us smile *The Pet Therapy program continues, and there are currently 11 therapy dogs approved by the Risk Management and Prevention Committee to work with and visit clients.*



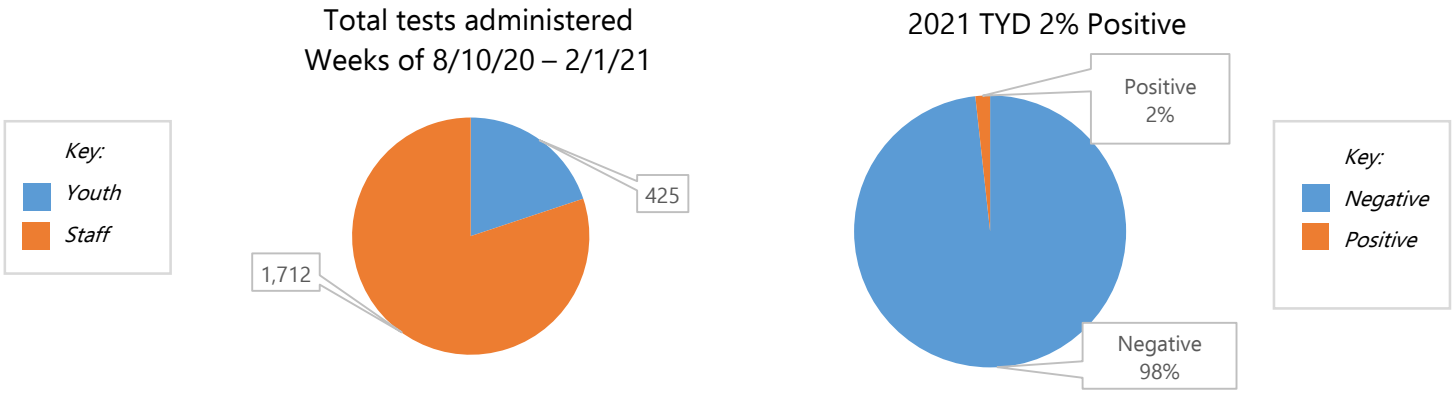
Priority Initiative

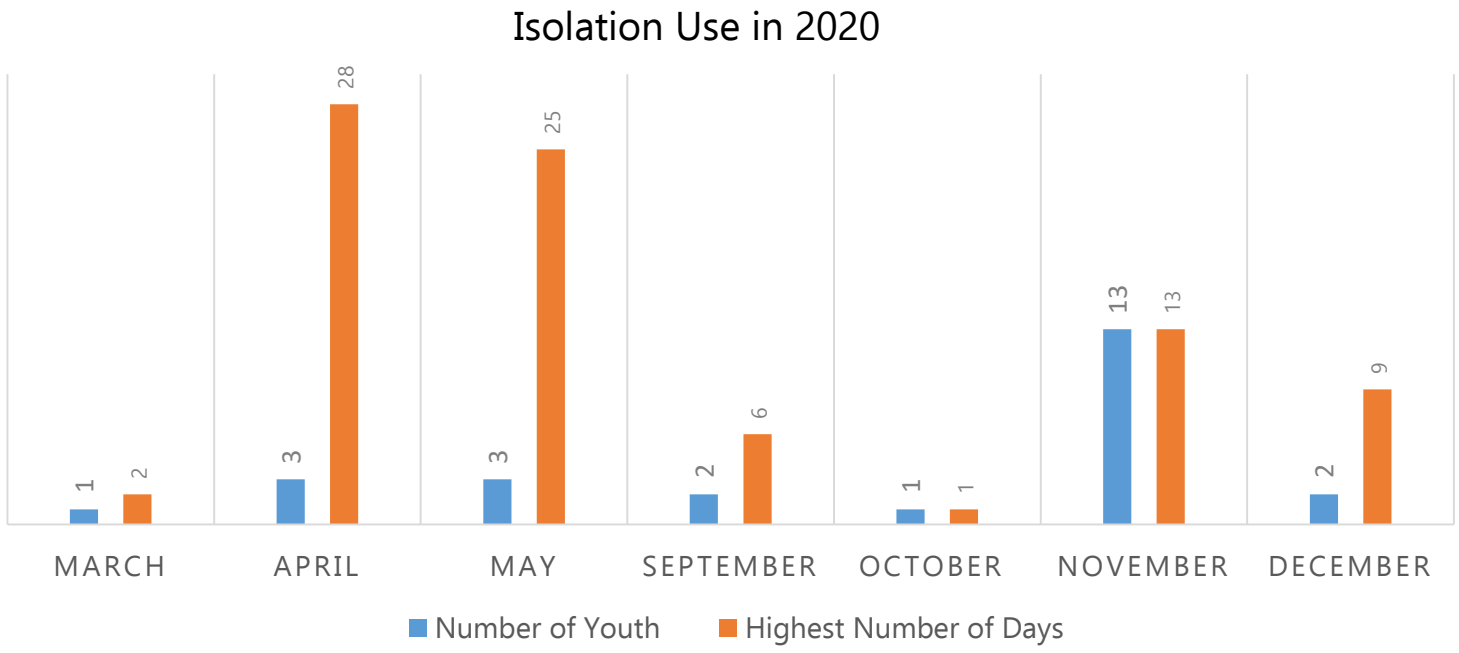
COVID-19: Surveillance Testing Percent Positivity Rate and Use of Isolation Unit

In an effort to maximize safety on campus, a COVID-19 surveillance testing program was put in place by the Nursing Director in collaboration with the Department of Health. Weekly communication of testing outcomes are distributed to staff in a manner that protects client and employee confidentiality. The third floor of the main building has been designated and is maintained as an Isolation Unit for youth who test positive or require quarantine outside their House. To the extent possible, quarantining takes place in the youth's House.

Through the week of 2/1/2021, 17 youth and 28 staff were diagnosed through the on-campus surveillance testing program. Staff in all programs and departments are allowed to access testing, and it is required of all staff who work on-site.

In November, a significant outbreak took place and space beyond the Isolation Unit was needed for client safety and care. Fortunately, a member of the RI Coalition for Children and Families in conjunction with RI DCYF provided use of a group home program in nearby Providence. Support departments prepared the home for clients in less than 36 hours, and housed 3 youth for 6 days.





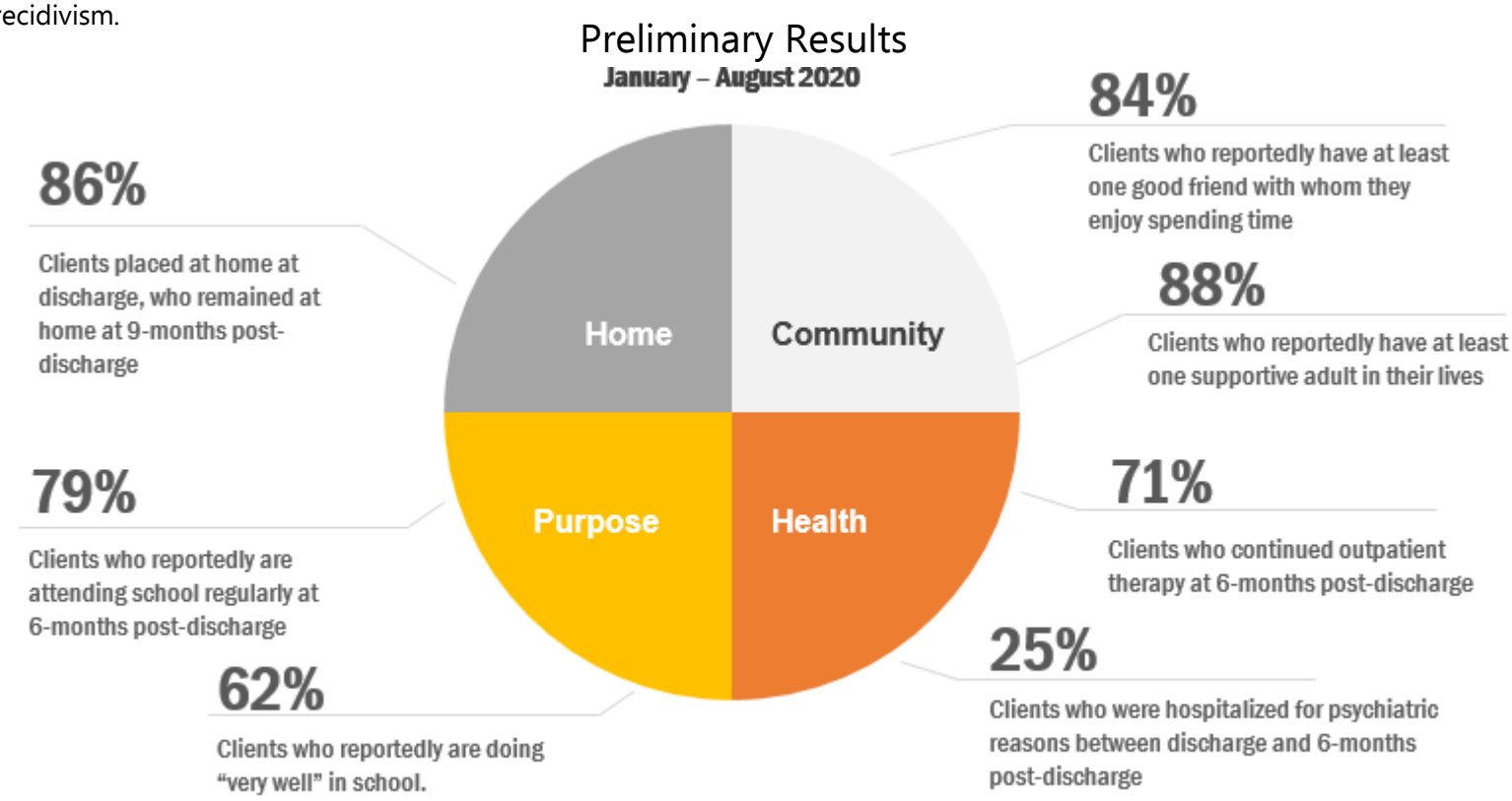
Client Outcomes

Residential: Outcomes Survey

The Board of Directors voted to approve the residential programs outcomes survey in early 2020, and it continues to be a significant project of the PQI department due to it's size and complexity. Caregivers of former residential clients are contacted at 3, 6 and 9 months post-discharge to determine current level of functioning in 4 areas:

- Home – is youth in a safe, stable, supportive living environment?
- Purpose – does youth engage in meaningful daily activities such as job, school or volunteerism that promotes independence, income and resources to participate in society
- Community – does the youth have relationships and social networks that provide support, friendship and love
- Health – has the youth sustained basic physical and behavioral health, and overcome or manage health challenges

Outcomes data will help us to increase program effectiveness, contribute to policy discussions, and prevent recidivism.



Project Questions:

Can outcome differences be explained by:

- Program; Age; Length of stay; Demographics; Gender; Reason for admission; Reason for discharge
- Frequency of physical restraints during treatment; Participation in BBI; Participation in SMHFC groups
- Diagnosis at discharge; Placement at discharge; Number of placements prior to SMHFC admission

- What are the characteristics of clients who chose not to participate or could not be contacted?
- Do outcomes change over time?
- Can we predict how our clients will function post-discharge?
- Parent involvement during treatment

Client Outcomes

Community Based Programs: Outcomes Reports

From a simple request to PQI for 2 data points – what was youth's living arrangement at the beginning, and then end, of community based program services (CBS) - came the CBS programs outcomes project. The purpose of the project was to examine client and family progress from admission to discharge as one way to determine program effectiveness. Clients who discharged over a 22 month period were included.

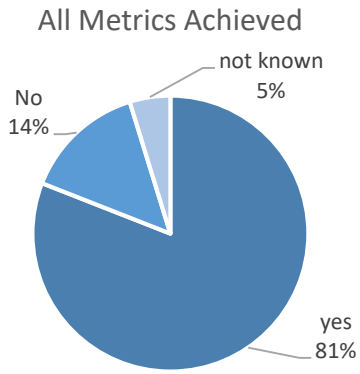
Progress was defined by 3 metrics:

- Living arrangement – is client in a living arrangement at discharge that is clinically assessed as aligning with goals?
- Did client and family achieve their treatment goals?
- Did the family participate in treatment?

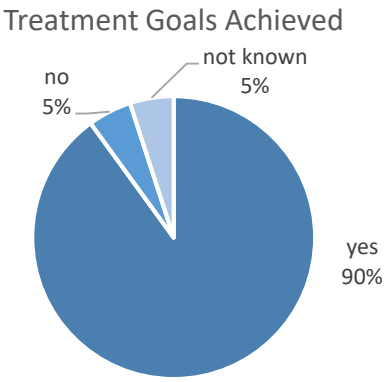
Demographic characteristics of clients, and their involvement in SMHFC clinical therapy groups or Equine Therapy, was also examined. Finally, the effect of COVID-19 on treatment was identified wherever possible.

A preliminary analysis and discussion of the results took place, with additional questions and metrics identified to enhance results. Systems to more efficiently collect data are being put in place as a result, and we anticipate a more robust report that helps inform services at the end of 2021.

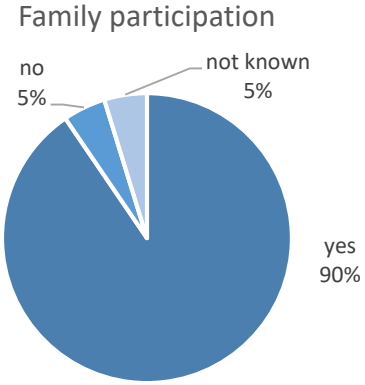
PRELIMINARY RESULTS – SAFFE Program (22 clients)

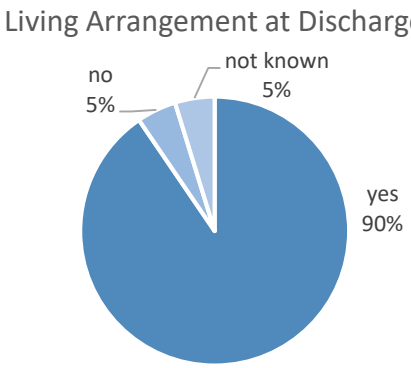


There were 2 clients who did not achieve treatment goals: 1 was discharged to a higher level of care, and 1 was discharged due to a lack of engagement during treatment. Neither of these clients participated in Equine Therapy; 1 participated in clinical therapy group.



There was 1 client with no family participation; in this case the foster parent declined the FISA curriculum and had sporadic involvement with the treatment team.





Program Monitoring

Consistent with our PQI Plan, we collect and monitor data on management and operational performance to strengthen and build capacity; measure progress toward achieving our Strategic Plan goals; evaluate operational functions that influence the capacity to deliver services; and to identify and mitigate risk.

The PQI Plan is available for anyone interested and is on the PQI page of the website www.smhfc.org. Links to the 2020 PQI Quarterly Reports, as well as our recent Annual PQI Reports , are also available on the website. Any documents references in this Report as available for review can be obtained by contacting any of the staff with PQI responsibilities (see page 13).

DATA QUALITY TEAM

We continue to monitor data quality and work to ensure consistency with the application of Best Notes agency-wide via a comprehensive team including residential and outpatient intake staff, records and administrative support staff, PQI, OB/CBS and RTX administration.

The initial formation of the team was geared at addressing observations made during the strategic planning process that programs could be better connected. While the team's primary focus is to develop, maintain and implement consistent practices with regard to data entry, data scrubbing and reporting, it also helps build broad institutional knowledge regarding system functionality; opportunities for cross-training between programs and departments; and facilitates team work.

We have seen an increase in complete data relative to race, ethnicity, religion and pronoun preferences as a result of the hard work of the team members.

PQI GUIDED SCHOOL ASSESSMENT

In mid-2020, a PQI guided school assessment was envisioned as a way to bring the school program further into agency-wide PQI practices. There are computer programs in use for individual educational plans (IEP's), classroom behavioral data through the School-Wide Information System (SWIS) which is available through the PBIS program and other systems that are used to capture data for subsequent analysis and use in continual improvement efforts. In order to best make plans, a full analysis was needed. It is anticipated that by the end of 2021, the assessment will be complete so that planning can begin.

2020 Staff Surveys

Staff, board and independent consultant surveys were completed, although delayed. Some highlights of the Employee and Intern data is summarized below (scale is to 5). Detailed results and results over time were shared with leadership team members for action planning in their programs and departments. Items in green below highlight areas in which St. Mary's survey results were higher than the average response of other COA organizations.

	2020	2019
Participation rate	**29%**	**36%**
My job responsibilities are clearly outlined in my job description.	4.2	4.17
I received an orientation within the first three months of beginning work with the organization.	4.64	4.46
I have an up-to-date copy of, or can access the personnel handbook.	4.68	4.51
I am aware of the organization's grievance procedures and know how to make a complaint.	4.17	4
I am notified when positions that I may be qualified for become available within the organization.	4.49	4.2
I can access my personnel record.	4.22	3.23
I receive annual performance evaluations.	4.42	3.93
I receive regular supervision.	4.44	4.54
At least annually, employee satisfaction is assessed by the organization.	4.31	3.53
The organization implements changes based on the feedback received from personnel.	4.08	3.28
I participate in quality improvement activities within the organization.	4.02	3.9
I receive information on program outcomes that is useful to me in working with persons served.	4	3.7
I have participated in on the job activities that enhanced my knowledge and skills.	4.41	4.41
Case records of persons that I serve are readily available or accessible to me.	4.47	3.96

2020 Client surveys were negatively impacted by COVID-19 and the lockdown that took place days before final implementation. Unfortunately, there are no client survey results for the year.

Management and Operations

SAFETY and WELLNESS

Several PQI Committees maintain active roles in safety and wellness practices. Please see PQI Quarterly Reports for summaries of their 2020 achievements, which are available at www.smhfc.org.

As always, we're appreciative for all staff who commit their time, talents, skills and resources to being members, with an extra special thank you to those who volunteer to become Chairs or Co-Chairs of the PQI Committees.

LGBTQQ+ COMMITTEE

This committee 'pandemic pivoted' for a very successful 2020 PRIDE Month, including:

- Facilitated a virtual viewing of '*Stonewall Forever: A Documentary About the Past, Present and Future of PRIDE*, and Billy Porter's "*A Brief History of Overlooked Queer Political* Action".
- Facilitated an art project to promote education and conversation between staff and clients about Black Lives Matter, Black queer and trans folx, disabled folx, undocumented folx, folx with records, women, and all Black lives along the gender spectrum.

STAFF RELATIONS AND WELLNESS COMMITTEES

These committees 'pandemic pivoted', and focused on how to connect staff in a virtual world, including:

- Designed and mailed postcards to staff to help maintain virtual-workplace connections and express appreciation;
- Hand-wrote notes and mailed holiday cards to each and every staff member;
- Hosted virtual BINGO nights, with raffle prizes (and lots of laughter); sent popcorn to staff both remote and on-site;
- Implemented a "Wellness Connect" to ensure staff have a monthly virtual forum to connect with colleagues, and to both lend and receive support.

RISK PREVENTION and MANAGEMENT

There were significant improvements to board risk reporting and monitoring in 2020. Specifically, a 10 year history of financial risks was graphed for presentation to the Board to help identify trends, and a Quarterly Report was created for use moving forward.

The process of identifying the appropriate risk areas for the Quarterly Report contributed to meaningful conversations, and they are now being widely used by the full board and several subcommittees to help inform decision-making.

In addition to the board enhancements, communication to agency leadership regarding agency-wide risks was also strengthened. As we learned in the Strategic Planning process, we need to continually strengthen agency-wide practices and processes, rather than stay too focused within our own department or program. Keeping leadership appraised of key agency-wide risk areas, such as financial risks, employee turnover risks, and high risk practices such as physical restraint helps the team maintain such awareness.

BUSINESS CONTINUITY PLAN

With so much emphasis on emergency planning in 2020 focused on the COVID-19 pandemic, it actually highlighted the need to up our practices in regard to preparedness for other emergencies. Rather than another 'talk training', the decision was made to hold modified "emergency tabletop exercises" to promote knowledge of resources, policies and practices, increase collaboration and team work, and spread institutional knowledge.

Planned in 2020, but not held until early 2021, 45 staff were invited to participate in one of three workshops. Areas for improvement that were identified through the process have been assigned to Safety and Risk Management and Prevention PQI Committees for action planning.

Commitment to conducting these 2x per was made by the leadership team, and their efforts will be needed to action plan and implement changes identified in these practices. Creating and posting visual procedures and ques to follow in emergencies is a 2021 priority goal.

Emergencies practiced:

- IT Risk - Hacked and Takeover of all system
- Death of Client on campus
- Hostages taken on campus

Management and Operations

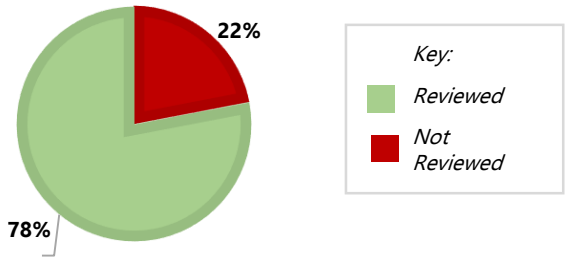
LICENSE COMPLIANCE AND EXTERNAL REVIEW

Mangers and Directors execute the work necessary to stay in compliance with regulations, while PQI centralizes licenses for agency monitoring. Site Visits, inspections and audits are often a part of these external monitoring practices.

In 2020, multiple reviewers would not come to campus due to COVID-19. After the Spring lock-down, an emphasis was placed on implementing safe practices to ensure reviewers could return to campus. In fact, the agency paid for a private kitchen inspection when the regulator would not come out to maximize safety.

Residential licenses were extended to early 2021 due to inspection impact, and we are assured the fire marshal office will resume inspections in the upcoming months. We have maintained full transparency with DCYF through these delays, and otherwise remain in full compliance with all licenses and external reviewers.

POLICY and PROCEDURE REVIEW



Our agency goal is to review, and edit as needed, all policies and procedures approximately every two years as a sound risk management practice. PQI maintains a tracking system, facilitates reminders, assists Directors and maintains access by all staff on our shared network. This provides systemic and transparent opportunity to assess if 'policy and practice match', and make corrections as needed.

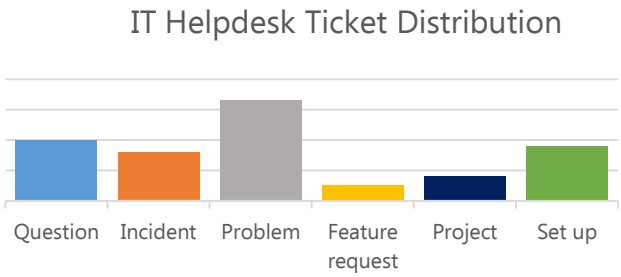
The Board is also engaged to review policies related to high risk practices such as conflict of interest and some financial and legal policies.

In 2020, 78% were reviewed and/or edited within the goal of 'no less than 2 year' reviews.

HIGHLIGHT: PQI COMMITTEE and IT DEPARTMENT PQI ACTIVITY REPORT

In mid-2020, a new format for the "Staff PQI Committee" was introduced. It was transitioned to an 18 person leadership assigned committee that captures, communicates and assesses agency-wide PQI activities. Nearly every program and department at this time is represented in the Monthly Report and discussion.

To highlight one of those activities, the IT department had implemented an email "Helpdesk" in 2020. 1,056 Helpdesk tickets were received and resolved. Data regarding tickets was collected, analyzed and used to help develop plans within the IT department to support the overall agency. The IT Helpdesk process is an excellent example of how PQI practices are solidly in place throughout the agency. The full report is available for those who wish to review.



STRATEGIC PLANNING

The Year 1 Annual Plan of Work was completed in 2020, which is a significant step toward achieving the agency's 2019 – 2022 Strategic Plan Goals. Annual Plan of Work 'plans' and 'achievements' are recorded in a power point presentation and available for those who wish to review.

The Year 2 Annual Plan of Work was also created, and accounts for a full year extension of the Plan. The decision was made to extend the Plan to allow for the necessary pandemic pivots that took place, and continue to take place into 2021. It was most important that a commitment be made to achievable Plan objectives and strategies, rather than attempt to race through tasks without meaning.

CLIENT AND EMPLOYEE GRIEVANCES

No formal grievances were filed by clients or their families in 2020.

There was 1 employee grievance filed in 2020, which followed procedures in place for resolution.

Operational Excellence

Agency-Wide Council on Accreditation Reaccreditation: Expedited

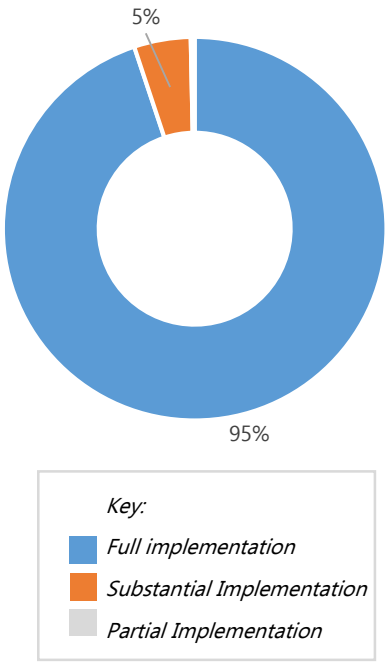
"Maintenance of accreditation" is not a catch-phrase, but a promise to clients and other stakeholders that they will receive the best we have to offer every-day. Thoughtful, coordinated implementation of well planned systems is a backbone of our PQI processes.

With that said, preparation for the reaccreditation never ends, but does intensify every four years. Staff spend approximately 9 months in a self-study phase, where they have the opportunity to ensure practice matches policy. Strengths are highlighted, and areas for improvement are improved. Pre-site evidence is gathered electronically, and sent for initial ratings.

That traditionally leads to 2 months preparing evidence for a three day site visit from two COA Peer Reviewers. During the site visit, observation and interaction with stakeholders provides further on-site evidence for final ratings.

However, in 2020's reaccreditation cycle, the pandemic began at the peak of our preparations. It was only because of the strong systems that are maintained were we able to adapt to the 'pandemic pivot' and still achieve an expedited accreditation. All staff should be proud of their work – each and every staff member contributed to this significant accomplishment.

Rated against 607 standards:



Quotes from COA Peer Reviewers:

"The organization is committed to the principles of clients' rights. The services are trauma-informed and there are opportunities for clients to provide feedback and be involved in setting goals. Staff have the opportunity to participate in a variety of trainings to meet the diverse needs of the population served..."

"(Programs are) staffed by highly qualified personnel who clearly love their jobs and are deeply dedicated to the work they do with families"

"St. Mary's has taken giant strides to put the organization on a positive trajectory towards solid financial health."

"St. Mary's is vigilant about safety training for staff and residents."

"The Hills shelter is truly a port in a storm for the girls who are placed there."

"St. Mary's clearly now has a strong and revitalized Board of Directors who are active, engaged, energetic, enthusiastic, and committed."

"The organization has polices, training and practices that assure that clients have the right of privacy and self-determination."

AFFIRMATIVE ACTION PLAN

In 2020, data regarding employee applicants was analyzed as a part of every two-year formal Affirmative Action planning. This was the first period that such data was available for analysis, and it helps inform action planning. The purpose of Affirmative Action planning is to ensure fair access to employment opportunities, and to create a workforce that is an accurate reflection of the demographics of the qualified available workforce in the relevant job market.

PQI produces a Quarterly Demographics report, which was enhanced in 2020 to be more visual/graphic, and expanded beyond client data. It now includes Board Member demographics, and a carve out of management demographics. The purpose of this report is to be ever aware of areas and opportunities for improvement.

PQI AT SMHFC

Stakeholder Input	Program and Service Delivery	Performance and Improvement	Risk Prevention and Management	Financial Viability	PQI Initiatives
Client, Employee, and Board Surveys	Data Quality Team	Client Record Audits	Critical Incident Review Committee	Board Reporting	COVID-19 Surveillance Testing
Wellness Committee	Strategic Planning	Employee Evaluations	CERT/Safety Committee	Audit and Risk Subcommittee	Use of Isolation Unit
Residential and School Improvement Committee	PBIS / Social Emotional Learning	Contract Monitoring	Risk Prevention and Management Committee	Program Census	Employee Turnover
Residential Youth and Parent Councils	Intake and Admissions Teams	PQI Committee	External Auditing and Reviews	Development Reporting	Restraint Reduction
LGBTQQ+ Committee	Client Outcomes	Standards of Excellence Training (SET)	Regulatory Inspections and Site Visits		Master Planning
Staff Relations Committee		IT Helpdesk	Client and Employee Grievances		PQI School Guided Assessment
Equity Diversity & Inclusion (EDI) Committee (2021)			Affirmative Action Plan		
Client & Staff Grievances			Business Continuity Plan		
Exit Interviews			Policy Review		

PQI Oversight Responsibility

Carlene Casciano-McCann, LMHC
Executive Director

Linda Mobriant, L.I.C.S.W.
Director of Operations and PQI

Suellen Rizzo, L.I.C.S.W.
PQI Specialist

2020 PQI Specialist Stats and Facts

Number of Ad Hoc PQI reports completed upon request	12
Number of outcomes survey phone calls made	103
Number of presentations prepared and conducted for DCYF and Board of Directors	5
Number of client records audited, data analyzed and reported	369
Number of client 'deep dive' data analysis for Critical Incident committee	12
Number of intense client data analysis of client records to inform advocacy efforts	3

Agency memberships, affiliations and certifications