

Performance and Quality Improvement

2021 Annual Report

Person-centered

Integrity

Excellence

Equity

Respect



Collaborative

Innovative

February 22, 2022



Table of Contents

Message from the Executive Director and Director of PQI and Operations *p. 3*

2021 PQI Priority Initiatives *p. 4-8*

- Restraint Reduction *4*
- Record Audits *5*
- Staff Retention *6*
- COVID-19 Vaccination *6*
- COVID-19 Surveillance Testing and Use of Isolation Unit *7*
- Master Planning *8*

Department Projects and Activities *p. 9*

- IT
- Human Resources
- Development
- Outpatient
- PQI
- Training

Stakeholder Input *p. 10*

- Surveys
- Staff and Client Grievances
- PQI Committees
- Exit Interviews and Termination Report

Strategic Practice and Process *p. 11*

- Policies and Procedures
- Affirmative Action Plan Progress
- Strategic Planning

Risk Prevention and Management *p. 12*

- Committee Activities
- BCP Tabletop Activities
- Program Census
- License compliance and external reviews

Client Outcomes *p. 13*

PQI Department Projects *p. 14*

- Program evaluation
- Employee onboarding

The Year Ahead *p. 15*

PQI at SMHFC *p. 16*

Our values

All of the PQI activities at St. Mary's reflect the agency's commitment to our **core values** while providing outstanding services to our clients:

Innovative — We create new knowledge in our field, use creative solutions to solve problems and meet the needs of those we serve.

Equity — We meet each youth, adult, and family where they are to meet their unique needs through care that is both culturally and linguistically aware.

Person-Centered — We partner with those we serve and individualize our services to ensure that they have voice and choice in determining their desired outcomes.

Respect — We treat everyone with dignity, compassion, and an appreciation for their unique strengths.

Integrity — We are ethical, honest, and trustworthy; we are transparent in all of our interactions, and responsible stewards of our resources.

Excellence — We are committed to the use of evidence-informed practices in all that we do, and ensuring that our staff are well trained and supported to deliver the highest quality services.

Collaborative — We seek to partner with others to build relationships and networks of support for those we serve.

Throughout this report, we have connected each activity to one or more of our core values to highlight how each activity fits in with our values and mission. When you see one of these words in the report, take a moment to read how the activity strengthens our commitment to these core values.

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Performance and Quality Improvement (PQI) 2021 Annual Report



A message from the Executive Director :

In this report you will read about initiatives that improve our practices for the betterment of our clients, ensure compliance for regulating agencies, aspire to make improvements for our employees, mitigate risk to our staff and clients, plan for the future of St. Mary's, create efficiencies for many different agency processes, ensure equitable practices and provide opportunities for us to learn from our clients and improve our service delivery.

I have been impressed with the consistent focus of our teams, through the pandemic, on quality improvement. These initiatives are aligned with our agency values and our mission. I am grateful for all of our team members who work so hard each and every day to fulfill our mission and for our PQI team for guiding our efforts and providing us the structure and roadmaps for continuous quality improvement at St. Mary's.

A handwritten signature in cursive script, reading "Colene Gaudin-McCauley".

A message from the Director of PQI and Operations:

Compiling this Annual Report, as required by the Council of Accreditation, is a great reflection back on all of the outstanding work taking place at the agency. There is much to celebrate in all programs and departments. I encourage everyone to take the time in an upcoming team meeting to recognize the successes and celebrate. Request a platter of sweets and snacks from the Café, grab some sensory items from the Development team – do something special to celebrate the outstanding year among your team!

In the PQI department this year, we were really fortunate to expand the team by onboarding a PQI Documentation Specialist. This opportunity was presented after nearly a year of assessing of the agency's changed record keeping needs following the complete implementation of Best Notes. The Documentation Specialist brings extensive classification and IT experience to the role which fits perfectly with the PQI goal of supporting all departments and programs to do the hard work that you do.

I hope you enjoy this reflection, and appreciate that there are so many employee contributions to the betterment of the agency. That in turn positively impacts employees, clients and families. I appreciate all that you do.

A handwritten signature in cursive script, reading "Linda M. Morvant".

2021 Priority Initiative

Restraint Reduction

Celebrate the work of the restraint reduction initiative!

Highlights include but are not limited to:

- Completion of 15 full hours of formal Six Core Strategies training;
- Held mock debriefing meetings, including youth involvement, as a teaching tool;
- Implemented the requirement of a Nursing Order for physical transports;
- 5 additional Residential Supervisors certified as TCI trainers;
- Formed a PRTF Unification work-group and Residential Re-Set work-group, including youth, who created a 2022 Action Plan.
- Ended the year with zero physical restraints in Quarter 4.

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Youth should not be re-traumatized which happens in every physical restraint. Youth should not be injured in care and staff should not be injured while at work, which are real risks during every physical restraint

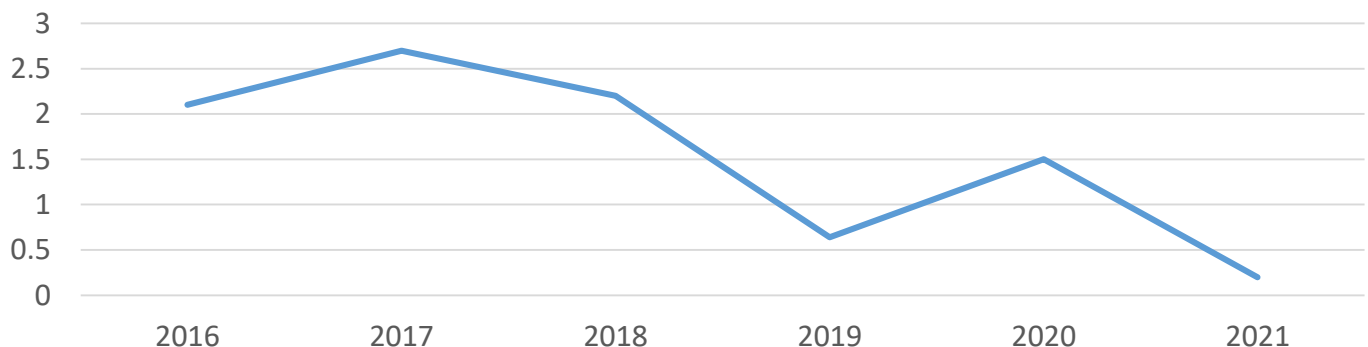
85% Restraint decrease from 2020

.2 2021 Rate of Restraint

2021 Ongoing COVID-19 IMPACT:

While there were no lockdown periods in 2021, there were periods of youth needing to quarantine due to exposures. Data, research, and our experiences in 2020 showed that restraints may increase during periods of quarantine. In 2021, a policy to allow contact during quarantine on campus with full consent of the visitor led to a decrease in restraints during quarantines.

2016 - 2021 Rate of Restraint

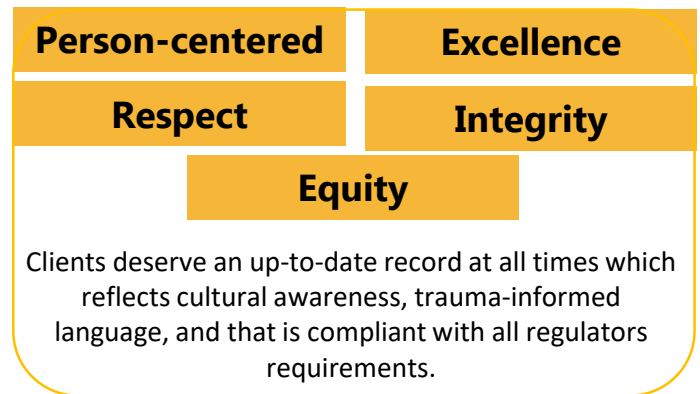


Rate of restraint was introduced in 2016 as a way to view the restraint data without having to account for changes in census over time. This was introduced at the same time a conscious move toward restraint reduction was taking place. Research, preparedness assessment and planning took place through mid-2018, at which point a comprehensive Six Core Strategies Restraint Reduction Action Plan was created for January 1, 2019 implementation. After seeing great success in 2019, monthly monitoring in 2020 indicated a problem that need to be re-assessed and corrected in 2021.

2021 Priority Initiative

Record Audits

Client Record Reviews are conducted quarterly, and focus on Medicaid/Insurer compliance, clinical quality and best practice standards. Audits review compliance with documentation standards as well as a peer review of client engagement, effective client-provider relationships, support, advocacy and 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.



"There is no shortage of services and treatment that this team has provided . . the team has painted a picture of a resilient, smart, cheerful child who consistently works toward an improved quality of life. I am impressed by how much progress has been made in a short amount of time."

Outpatient peer reviewer commenting on a client record during 2021

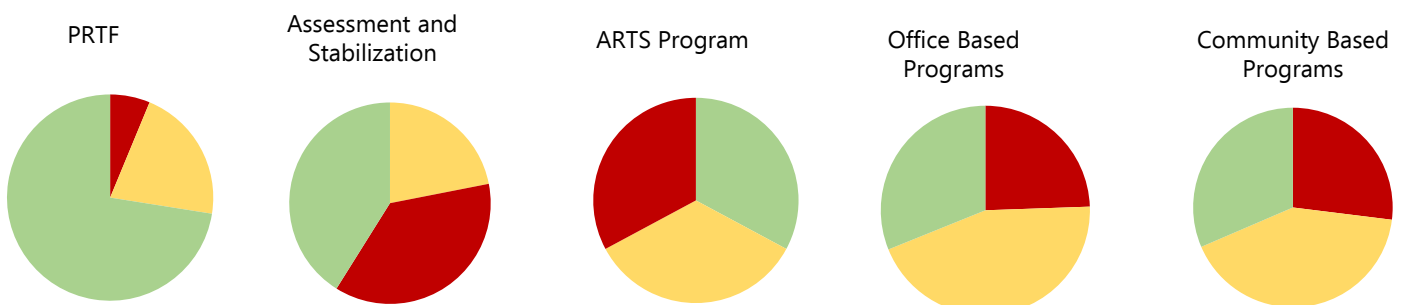
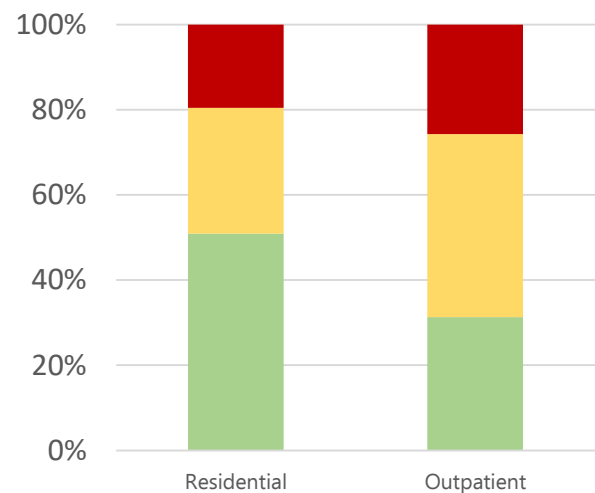
Attention to **Timeliness of Progress Notes** was initiated as a part of the Medicaid Compliance Plan. A comprehensive analysis was conducted using 3 months of data for both the Residential Programs and the Outpatient Programs. This baseline data helped create improvement targets for 2022, and is being monitored as part of the 2022 Medicaid Compliance Agency Initiative.

A **Medical Record Audit** consisting of a twice-yearly review of residential records was implemented in 2021 with results made available on April 26 and November 3. The Director of Nursing used these results to identify training and work-flow improvements. Thanks to the Nursing staff for their hard work providing top-quality nursing and medical care to residents and day students.

Key to Record Audit Results:

- Full/substantial compliance
- Partial Compliance
- Needs Attention

2021 Documentation Audit Results



2021 Priority Initiative Staff Retention

Activities to improve staff retention included:

- Formed a Staff Retention Committee, charged with exploring underlying turnover problems and creating an action plan to address problems;
- Created a comprehensive 2022 Action Plan to enhance initiative in the year ahead;
- Implemented changes to the Exit Interview process which increased participation (a **383%** increase from the year prior);

- Expanded initiative to include data regarding employee performance evaluations.

This Initiative will carry over into 2022.

2021 Turnover Goals:

Turnover rates (% of employees who leave the agency) are tracked for 2 groups: Residential, and Everyone Else (Outpatient, School, and Administration). Employee turnover is tracked quarterly.

- The Residential turnover goal is that no more than 30% of staff will leave during the calendar year. The actual rate in 2021 was **23.5%**, meaning the turnover rate in Residential is stable.
- The turnover goal for Outpatient, School, and Administrative staff is that no more than 10% of staff will leave during the calendar year. The actual rate in 2021 was **11.25%**, meaning that turnover among non-residential staff was slightly higher than the calendar year goal.

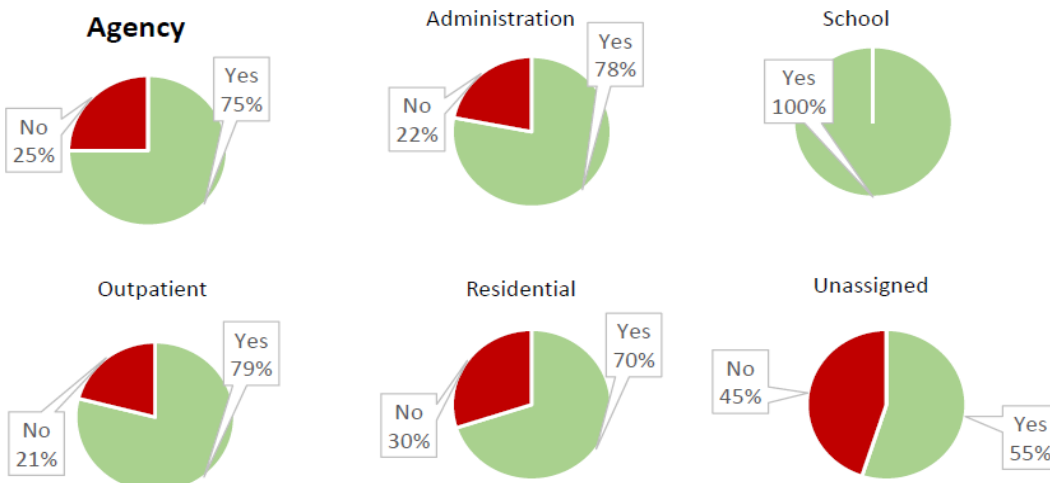
Innovative	Integrity
Equity	
<p>Clients deserve a consistent and stable work-force to build positive helping relationships. Employees deserve career opportunities & advancement. Financial costs of high turnover are a wasteful use of valuable resources.</p>	

2021 Priority Initiative COVID-19 Vaccination

Many efforts were carried out to encourage employees to become vaccinated against COVID-19. Employee testimonials, newsletters, Q&A Nursing groups, 1:1 meetings, and four on-site vaccination clinics were held. Employees who had medical reactions to the vaccine were not required to use PTO during day(s) needed to fully recover, and time was provided within schedules to be vaccinated off

site if that was preferred. Following implementation of the federal CMS mandate, vaccine rates increased significantly. All employees must be vaccinated, or have an HR and legally reviewed exemption, effective 2/25/2022. At that time, we will be among the safest organizations in the state serving clients relative to COVID-19 and it's potentially deadly effects on vulnerable individuals.

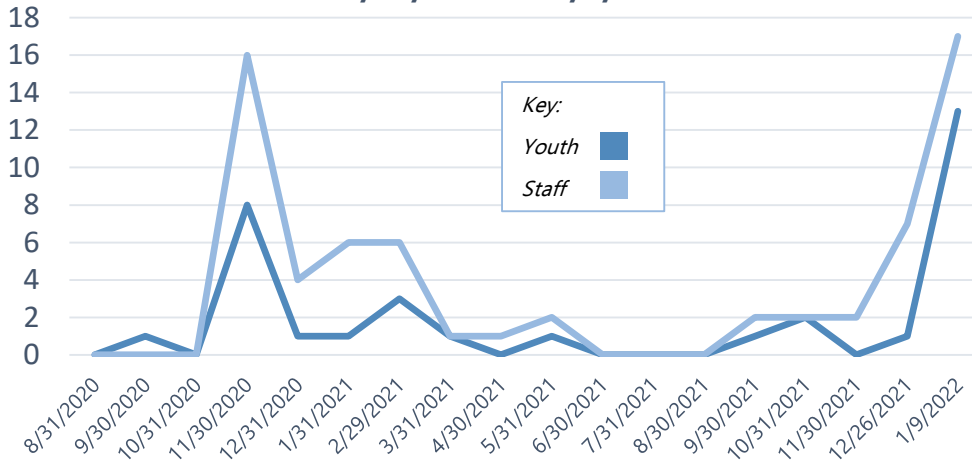
Agency Vaccination Rate as of January 5, 2022



Respect
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<p>Clients deserve to be served in an environment that understands the impact our choices have on one another.</p>

2021 Priority Initiative Surveillance Testing and Isolation Unit Use

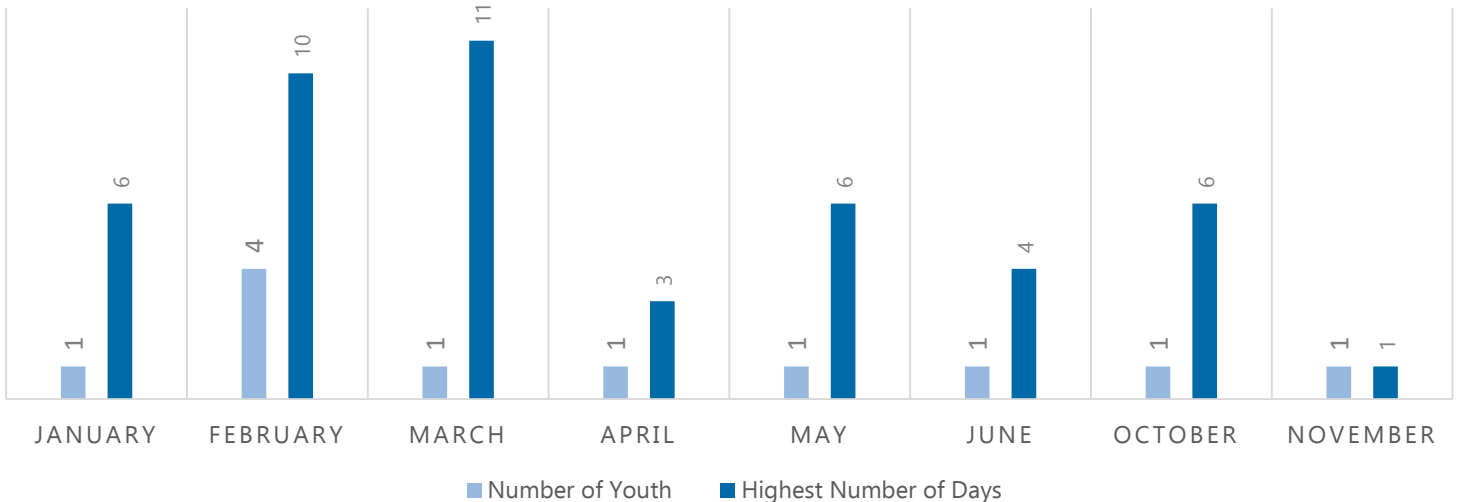
**Positive Surveillance Test Results
8/10/2020 – 12/5/2021**



.8
Positivity Rate
Between 8/8/10 – 1/9/22

12/19/21 - 1/9/22, there were an additional 11 employees who reported a positive test that had been conducted outside the agency. Had they been tested on-site, positivity rate would have been .95.

Isolation Use



These numbers do not include the spike in COVID-19 diagnosis among residents, day students, and staff which occurred in December 2021 – January 2022.

2021 Priority Initiative

Master Planning

Understanding the aging property is critical to developing a strategic approach to property investments, and to envisioning the future of the agency. The SLAM Collaborative, an architecture/design firm, guided the Master Plan Committee through that process, funded by the Board of Directors.

Activities included:

- Employee, client, family and board interviews
- Virtual and on-site interactive workshops including employees and clients
- Analysis of building blueprints, current conditions, surrounding community, potential restrictions
- Analysis of existing problems, Strategic Plan goals, objectives and vision
- Conceptual planning, campus re-organization, identification of 9 potential priority projects

The resulting Master Plan is a living document that will change over time. It is a vision to guide and inform property investments, projects and improvements. We don't know exactly what St. Mary's will look like 25 years from now, but we know it will be better suited to meet the needs of clients and better support our excellent programs and services.

Principles of the Master Plan:

1. **Organized:** Programs and departments are connected by outdoor pathways, but maintain autonomous spaces for client care and team building
2. **Safe:** Parking is moved to the perimeter, increasing outdoor spaces to be used for client care, learning, playing and reflecting
3. **Mindful:** Playground spaces for older and younger youth are accounted for; indoor and outdoor sensory spaces are integral to plans in all programs; supervision is considered in all indoor renovations; vendor deliveries have been considered
4. **Growth:** Supports envisioned growth of programs, and accounts for new opportunities to expand



Innovative	Equity
Person-centered	Integrity
Excellence	Collaborative
<p>The physical environment has an impact on client well-being and healing. Clients and employees deserve to receive and provide exemplary services in exemplary environments. It is our responsibility to plan and build for the future now.</p>	

2021 Department Projects and Activities

All departments and programs operate under the guiding principles and values of performance, quality and improvement. Continuous quality improvement is a foundational component of accreditation with the Council on Accreditation (COA), and has been a long-standing value at the agency. These two pages highlight a *small sample* of the excellent work being done under those guiding principles within these departments, and throughout the entire agency

IT: IT Help Desk

The Director of Technology conducted an analysis of the IT Helpdesk tickets received for improvement purposes both within and outside the IT department.

Improvements were made after the 2020 analysis and included 'tagging' tickets to help identify trends, and classify tickets in multiple categories.

Key performance indicators:

- First contact resolution occurred in 35% of tickets;
- Resolution occurred within 5 hours of receipt in 49% of tickets.
- Published clearer VPN instructions, and explored cell phone upgrade changes for the future year.

PQI: School Assessment

This participatory assessment ran from Fall of '20–Fall of '21 as a joint school-PQI project to identify existing data sources for GNHCS students, and to help school staff and administrators use that data more effectively.

Significant changes were implemented throughout the project (for example, securing technology for all TA's to perform live-time data entry into the SWIS system). The School Administrator has already prioritized continued improvement efforts with regard to SWIS including staff log-in abilities, training and has solicited SWIS experts to assist with the system reporting abilities.

Development: Fund Development

For each quarter of 2021, the Development Officer reported a summary of fundraising activities to agency leadership in the PQI Committee. An example of the team's hard work and effort is evidenced with the Annual Children's Friendship Award Event (held virtually due to COVID-19).

The 2021 Event exceeded the targeted fundraising goal by over 52,000; and raised 92% over 2020 net!

Human Resources: Compensation

Initiated a professionally-led analysis of the compensation structures against market and turnover indicators.

Goals included:

- Develop compensation philosophy and policies;
- Determine compensation and benefits strategy alternatives (other than incremental cash options);
- Establish a system with projected career ladder and compensation increase steps.

Some goals have been accomplished, and the project continues into 2022.

Outpatient: Improve records audits

- Creation of Best Notes Clinical Documentation Group Consultation to support providers in need;
- Changed the fee-for-service payment process;
- Implemented use of the Best Notes "task" feature.

Outpatient: Enable increased productivity

- Focus group created to address the challenges;
- Change the Best Notes appointments system to support productivity efforts;
- Increases in billable hours have already been observed since the changes were put in place.

Training: Improvements and Enhancements

- Implemented a cohesive weekly Orientation for any new employees;
- Implemented several risk management trainings at the weekly orientation, as well as human resources paperwork, IT set up and policy reviews;
- Standardized welcoming for residential staff via a 'Tea Time' with the Executive Director;
- Enhanced full day Orientation that ensures new employees meet agency leadership and participate in important Standards of Excellence trainings;
- Actively participating on the Retention Committee and assuming role of the Lead for many action plan items related to employee evaluations and supervisor staff training.

2021 Stakeholder Input

Client, Staff, and Board Surveys

Annual surveys were emailed to adult clients, young adult/teens and parents of minor clients for whom an email address was available. Other client surveys were facilitated via tablet use in residential Houses and school classrooms.

Surveys were also distributed to employees and interns, supervisors and managers, independent consultants, and the SMHFC Board of Directors. Survey results are analyzed and aggregated by PQI, and distributed to the agency. Results were overall positive, and provided a sixth year of results useful for detecting positive or negative trends to help guide for improvement actions. Results for three survey questions appear on the right.

Client and Employee Grievances

There were no client or employee grievances filed in the year 2021. That is not to say there haven't been concerns brought forth, instead it is a reflection on the strength of the grievance processes.

PQI Committees

There are eleven active standing PQI Committees, including a Residential / School Parent Council, and a Youth Council.

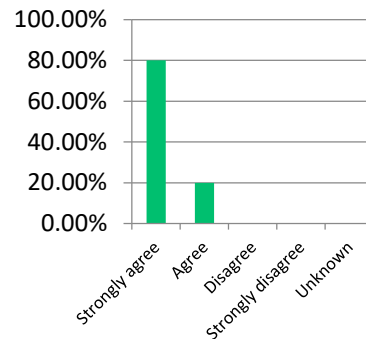
Special thanks to the Chairs and Co-Chairs of the PQI Committees, who work quietly and with less recognition than deserved.

Each individual who participates on a PQI Committee is contributing to positive change at the agency.

Exit interviews and Termination 2021 Report

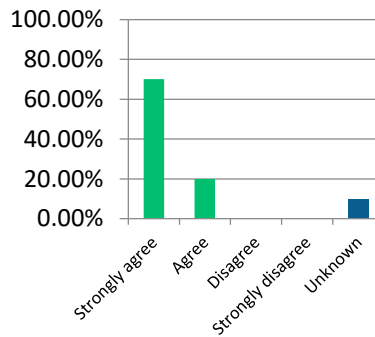
- There were 108 total terminations in 2021; 63% of these were resignations, 5% layoffs/not needed, 11% policy violations or performance, 7% abandoned jobs, and 5% retirement;
- Of the 68 resignations, 55% were in residential programs.
- 54% of 68 terminations were for employees who had been at SMHFC for less than 1 year;
- As in 2020, there were some race disparities among terminated employees.
- Actions will be taken to further explore, correct and improve undesirable results. Specifically, the racial disparity evidenced in both '20 and '21 will be an area of focus, aligning with Priority Initiatives for 2022.

CLIENT: If I needed help or services again I would come back to the organization.



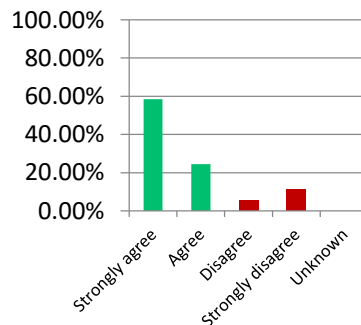
"Thank you so much for helping my family. It's very much appreciated. They do a wonderful job."
-Respondent, Client Survey

BOARD: At least annually, as members of the Governing Body we assess areas of risk to the organization.



The board is active in assessing the organization's risk.

STAFF: I receive regular supervision.



Results like this helped drive the decision to form the Retention Committee, and help inform their action plan for improvement.

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It's imperative to understand the views, beliefs and desires of all stakeholders in order to continually improve. Stakeholders should be actively engaged in a variety of ways to help identify problems AND solutions.

Strategic Practices and Process

Policies and Procedures

The system of centralizing and reviewing policies every two years continues to be an effective risk management practice.

Compliance targets are: <15% Stable; 15-20 Monitor; 21+ Risk

The year started in the 'red' risk range, but quickly went to stable and stayed there for the remainder of the year.

Additionally, the Employee Guidebook was reviewed and accepted formally by the Board of Directors in 2021 per best practice and accreditation standards.

Thanks to the Directors, Managers and members of the Board of Directors and all who contribute to this important process.

Affirmative Action Plan

Every two years, applicant and employee data is analyzed as a commitment to taking affirmative action to employ, and to advance in employment, all persons regardless of their status, and to base all employment decisions only on valid job requirements.

2021– 2023 Affirmative Action Plans (Minority and Veteran) are available on the public drive and in the HR department.

Some achievements in 2021:

- Redesigned the Exit Interview process, and saw an increase in participation of over 300% from '20 – '21!
- Conducted an analyses of job descriptions to ensure they accurately reflect job functions.
- Started to diversify recruitment efforts and now engaging the Manager of Marketing and Communications to promote openings in more diverse publications.

Strategic Planning

The current Strategic Plan was extended to run through 2023 due to significant pivots in 2020 that were critical to navigate the COVID-19 pandemic. Annual Plans of Work are created to help guide agency leadership toward their goals. A Presentation was held on 8/18/21 where Program Directors highlighted one successful element of their plan.

Goal 1: Align our programs to maximize the impact of our work for youth, adults, families, and communities.

Goal 2: Strengthen our relationships with community partners, community leaders, and funders to advance our mission and increase our sustainability.

Goal 3: Improve human resources related systems and professional development to support organizational growth.

Goal 4: Invest in our internal capacity to support the evolution of our organization.

Goal 5: Continually develop our board of directors to further drive impact and support our vision.



Risk Prevention and Management

Risk Prevention and Management Committee Activities

There are multiple risk management processes in place at the employee and Board level. Changes were made in 2021 to ensure timely monitoring and reporting of identified risks. A set agenda is followed by the Committee, actions are identified, and outcomes are reported each month. The Committee assesses risk in of each of these categories:

- Physical safety
- Property Safety
- Reputation
- Client rights and confidentiality
- Human resources
- Information Technology
- Financial
- Insurance and Liability
- Legal requirements
- Contracting
- Conflict of Interest
- COVID-19

In addition to updating a ten+ year financially driven risk report every year, a more comprehensive and action-driven Risk Report was created in 2021. Every two months progress toward mitigating risks, and identifying new risks, is documented in writing and reported to the Board.

BCP Emergency Tabletop Activities

Six discussion-based workshops (called tabletop activities) where team members discuss their roles and responses during emergencies were held. Summary results are analyzed by the Risk Management and Prevention (RPM) Committee, who also monitor the subsequent actions.

Actions taken as a result included:

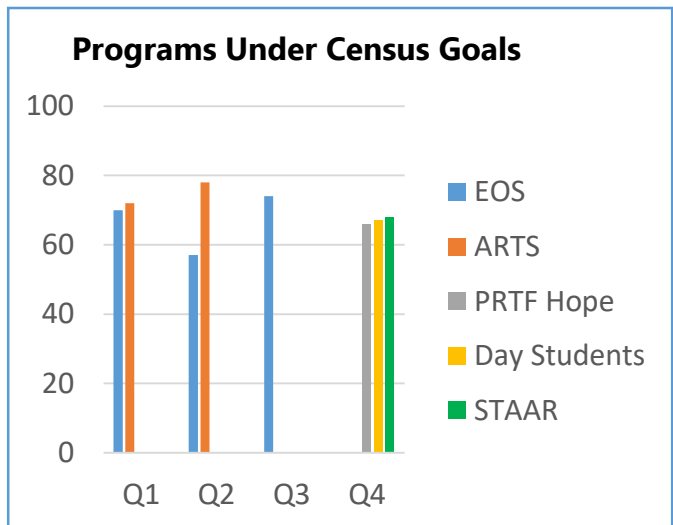
- Posted visual instructions for selected emergencies;
- Enhanced media response preparedness;
- Identified an external professional who could debrief employees following death or significant disasters;
- Expanded access to the emergency alert system ("One Call") to all residential supervisors;
- Created a folder on the agency Google Drive and populated it with emergency resources.

The IT department also conducted comprehensive disaster recovery practice drills, with great success - systems were fully recovered. Analysis of drills is utilized for additional performance and improvement practices.

Program Census

Program census can pose financial and HR risks to the agency and are consequently monitored and reported quarterly to agency leadership in the PQI Committee.

Programs running at 79% or under census goal are considered 'at risk'. Actions are taken by finance, HR, managers and administrators to correct census.



License compliance and external reviews

Mangers and Directors execute the work necessary to stay in compliance with regulations, and the year saw no compliance concerns. The three PRTF licenses were issued with inconsistent content, but we are assured by DCYF licensing that they will be consistent in the next cycle. There are no concerns given that assurance and they do all state "PRTF". All pre-COVID-19 inspection practices returned with inspectors coming on-site. A new State Fire Marshal was welcomed, and several actions were taken in response to the comprehensive inspection to maximize client, employee and visitor safety.



Client Outcomes

The agency continues to develop expertise in measuring client outcomes. Two types of outcomes are measured at SMHFC. **Treatment outcomes** measure client improvement from intake to discharge, and **post-discharge outcomes** measure how long treatment gains are sustained leaving the program. Both types of outcomes provide valuable data to assess program activities.

Treatment Outcomes

PQI examined the treatment outcomes of 2 outpatient programs during 2021: **SAFFE** and **CFTT**. For both programs, progress was defined by 3 metrics:

- if the client was in a stable placement at discharge
- if the client reduced their risk of further victimization
- if family functioning had improved during treatment.

For the CFTT program, 100% of clients who completed treatment (did not end early) achieved all metrics.

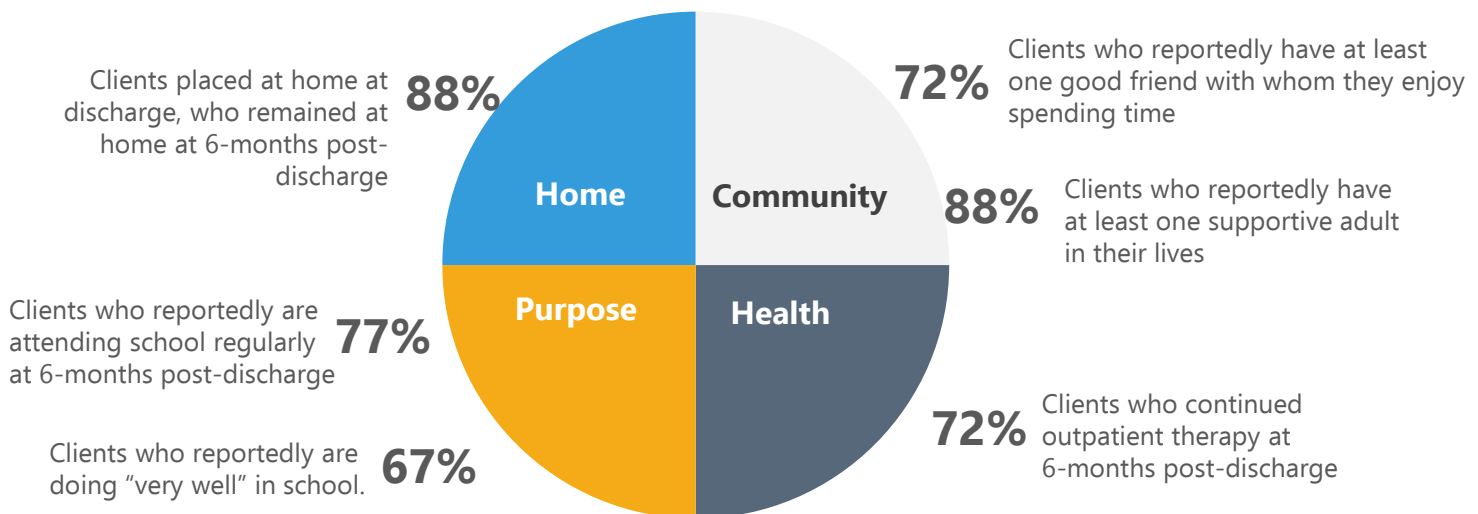
For the SAFFE program, 61% of clients who completed treatment achieved all metrics.

Post-discharge Outcomes

PQI continued to track post-discharge outcomes for all former residential clients. To date there are 73 project participants: 35 from ARTS, 20 from Hills, and 18 from PRTF. Reports summarizing findings are prepared each year.

The PQI team delivered a presentation in October 2021 to the national **CQI Conference** entitled ***How to Measure Post-Discharge Outcomes to Improve Program Quality Programs***. The presentation's goal was to demystify the process of tracking client outcomes, with the hope that additional agencies will begin to measure this important data.

**PRTF Outcomes at 6 months post-discharge
January 2020 – January 2022**



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It is our responsibility to analyze the impact our services have on individuals and groups of individuals so that we can correct what doesn't work and do more of what does.

PQI Department Projects

Program Evaluation

The PQI Program Analyst envisioned, researched and obtained the endorsement of leadership to conduct comprehensive program evaluations in 2021. This is a systematic method for collecting, analyzing and using data to improve programs by evaluating their efficiency, quality, and effectiveness. A Process Evaluation was conducted, which answers the question "Are we doing what we say we are doing?". There is much value in what can be discovered through the evaluation process and results.

Each process evaluation will include an evaluation of client records, a review of program policies, creation of a program process map, review of program training and staff documentation, and interviews with program staff.

Process evaluations will answer the following questions:

- Are we adhering to contract guidelines?
- Are we following our program philosophy?
- Are our program goals clearly stated?
- Do our program activities align with our goals?
- Are staff fully trained?

The Enhanced Outpatient Program (EOS) was the first to go through the evaluation process. In 2022, there will be more to report relative to evaluations and actions taken in response to the results.

Employee Onboarding

The PQI Documentation Specialist led the HR team through a comprehensive improvement process, including interviews, follow-up and analysis. An Excel tool was designed and built, and training plus ongoing support is being provided to help the team achieve results. Key performance indicators can now be obtained and analyzed to help inform decisions and actions, which positively impacts the entire agency.

Purpose : To capture the major milestones of employee recruitment process at SMHFC, an Excel worksheet was created. The Excel worksheet needed to be optimized for this data collection for two main purposes: To perform analyses on the data for Performance & Quality Improvement (e.g. length of time between milestones, average hiring time, etc.), and To submit demographic and/or Diversity, Equity & Inclusion data to interested parties (e.g. reasons for declining job offers, withdrawing from the hiring process or attending only a single shift).

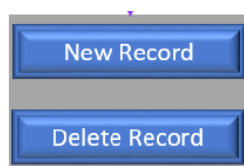
Problem: Current columns for the workbook had several issues:

- Prioritizes position data collection, but not applicant data
- Movement of data from open positions to closed positions tab
- Unused columns
- Missing milestones
- AA data collected in a separate workbook

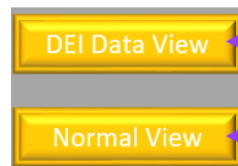
Goals: Identify what needs to be tracked through interviews with HR staff

- Add unique criteria for applicants who enter the hiring process
- Make the process of data collection easier
- Establish consistent data values and formats
- Reduce data redundancy
- Manipulate data efficiently

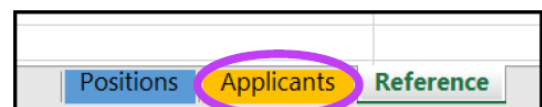
RESULTS



Buttons for 'New Record' and 'Delete Record'.



Buttons for 'DEI Data View' and 'Normal View'.



Tab navigation bar with 'Positions', 'Applicants' (highlighted), and 'Reference' tabs.

DEPARTMENT	POSITION	PROGRAM	POS TYPE	STAFF REQ FOR	NUM IF MU
M DATE	L TIPLE				
Residential	Residential Counselor/ Teacher Assistant	Horton	FT-40hr	08/27/2021	1
Residential	Residential Counselor/ Teacher Assistant	Horton	FT-40hr	08/27/2021	2

The year ahead

2022 PQI Initiatives

Policy and Procedure re-classification

This project has been on the “wish list” for many years. Significant ‘behind the scenes’ work was done to support the project for implementation in early 2022. We are in the transition phase, and much will follow. Highlights include:

- New format for agency policies and forms
- Search feature to help find policies quickly
- Fillable forms – complete electronically
- Visual instructions with hyperlinks to documents
- New classification system that better groups and organized policies
- Separated policies from forms
- Documented e-signature approvals by Directors and Managers
- Re-organization of the “P-drive”, and migration to Google Drive

Dashboards: Residential program pilot

A request was made by the Residential Re-set Workgroup to help create a data collection tool that would provide valuable information to the management team and serve as a checklist/reminder for staff of key duties and tasks.

We have prioritized this project and will expand it by creating several ‘Dashboards’ to display the data collected ‘in-live-time’. We will create three levels of Dashboards to ensure that only what is necessary for the intended purpose, and who has access, is designed to their liking. Project under construction!

Outcomes Tools: Expansion of use with FISA and Equine pre/post survey tools

This project that was desired and envisioned pre-COVID-19 but set aside. The Outpatient Department will be engaged in the implementation of “Outcomes Tools” to more efficiently obtain and analyze FISA (Families impacted by sexual abuse) and Equine Pre/Post Surveys.

2022 Priority Initiatives

Priority Initiatives are selected by agency leadership, and progress toward goals is monitored by the PQI Committee. A Monthly Report indicating successes and set-backs is posted on the agency Drive for all employees to view (Agency/Agency Committees/PQI).

Continued from 2021:

- COVID-19 Surveillance testing
- Use of Isolation Unit
- Vaccination rate

Enhanced from 2021 (new performance targets)

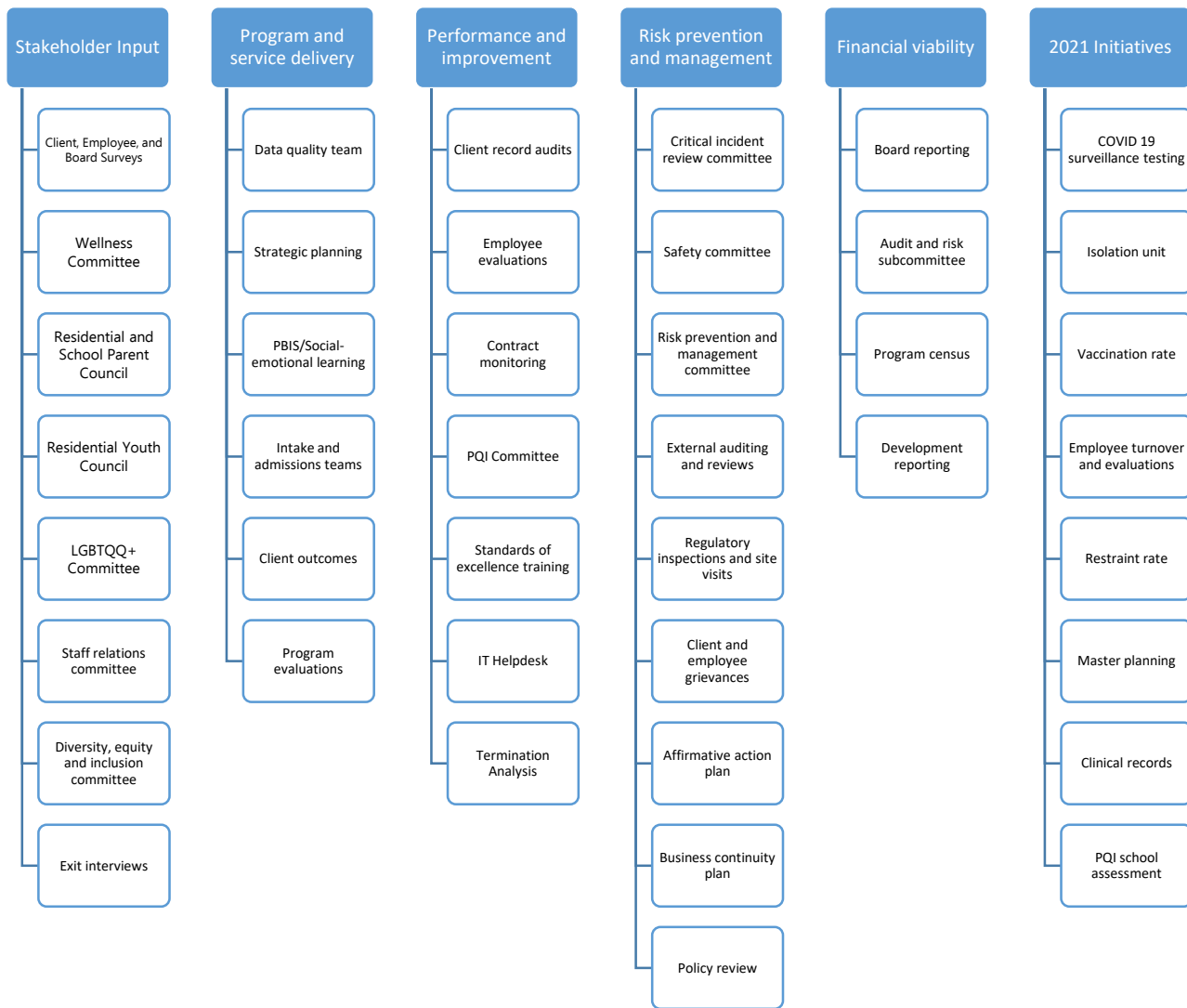
- Employee Retention: Turnover, evaluations, and supervision

New for 2022:

- Medicaid Compliance
- DEI and CLAS standards
- Residential re-set

Innovative	Equity
Person-centered	Respect
Integrity	Excellence
Collaborative	
These values are the threads that run through all we do to better serve clients, employees and the community. We strive to continually improve in order to make a meaningful, and long-lasting positive impact on all who are involved with St. Mary's Home for Children.	

PQI at St. Mary's



10

Number of Critical Incident 'deep dives'

78

Number of outcomes survey phone calls made

399

Number of client records audited, analyzed and reported

5

Number of PQI External reports

5

Number of published Agency CHATS

73

Number of PQI internal reports

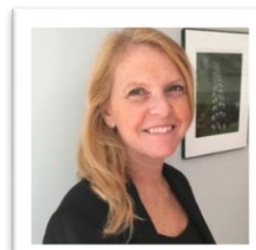
PQI Oversight Responsibility



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