Performance Quality Improvement (PQI) Plan

Updated 11/27/2023

'Promoting excellence & continuous improvement for clients and employees'

The Agency is undergoing a new phase of change and growth, including the area of PQI. Specifically, a Chief Operating Officer will oversee the PQI Manager, who leads a team of PQI Program Analyst and PQI Data Support Specialist. This transition is taking place in Q3 of 2023. It can be expected that the PQI Plan will be updated in 2024 to reflect implementation changes that take place in the upcoming quarters. This PQI Plan dated 11/21/23 reflects processes as of that transition time.

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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 the agency including client care, client services and administrative efforts.

Leadership endorses the collection and constructive use of data to promote high learning and high performance results. SMHFC values a culture where all stakeholders are encouraged to identify problems through use of data, assess possible solutions, create and implement action plans for positive change, and monitor/assess impact of the plan.

Emphasis is placed on correcting systems that impede efficiency, stakeholder input, satisfaction, compliance, service delivery, outcomes and overall continual improvement.

Performance and outcome expectations are communicated in a supportive manner and ensure protection for employees who identify areas of needed improvement. A strengths based and curious approach is taken in all PQI activities. Celebration of successes and gains made, small or large, are prioritized. They can include simple congratulations & compliments, up to gift-cards or funded parties.

The PQI plan and processes are 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 programs and services, and performance and client outcomes are measured. Priority is given to functions that are performed frequently, that can be high risk or problematic, and/or for which there is a unique interest in the data to be collected.

B: RESPONSIBILITY FOR OVERSIGHT OF PQI / PQI STRUCTURE

The PQI Manager, a qualified computer coding expert with extensive data classification experience, and experience in the residential, school and outpatient settings under COA accreditation is responsible for innovating, designing, coordinating & monitoring PQI activities while leading the PQI department team. Emphasis on skill set, strengths and interests dictates task and project assignment.

The PQI Manager is a member of the Agency Leadership Team, supervised by a Chief Operating Officer, coached by the Director of Technology and has full access to the Executive Director.

A full time dedicated PQI Program Analyst, an LICSW with a macro social work focus leads the residential outcomes research and program evaluation efforts.

A full time dedicated PQI Data Support Specialist leads efforts relative to data collection and entry, as well as supporting the multiple projects in the PQI department.

The Executive Director maintains a significant and strong role in PQI processes, leading PQI Priority Initiatives, Strategic Planning processes, employee and board sub committees that monitor high risk practices and more.

All Program Directors and Management/Supervisory level staff, as well as Committee Chairpersons, are responsible for conducting business under the SMHFC PQI philosophy.

A 16-person leadership team is assigned to participate on the PQI Committee, which is guided by a data driven standard Monthly Report. All departments and programs are required to report PQI projects and processes according to schedule. This structure promotes visibility to improvement projects; ensures PQI initiatives are aligned with Strategic Plan goals; leverages expertise; and ensures we have a forum where process, policy, and technology can be integrated with improvement projects.

In addition to annual, quarterly and Ad Hoc PQI Reports, a user-friendly visual Quarterly PQI Newsletter is distributed to all employees, interns, the board of directors, independent contractors, and is publically posted on the agency website. An Annual PQI Report is also distributed, and summarizes achievements, outcomes, and gains made against goals.

Significant emphasis is placed on employee led and empowered Committees as well as alternative engagement efforts in the PQI structure. The agency is driven by a "Voice and Choice" philosophy, including employees and clients. Ongoing efforts to increase client and family participation has been successful with a Residential Youth Council and Residential Parent Council. Employees, interns and independent consultants are encouraged to participate in PQI Committee opportunities, and some are assigned to participate based on their role & responsibilities.

The current structure includes:

- Consumers (Client, Employee & Board Surveys; Staff Wellness & Appreciation; Youth Council; Parent Council; former Client family member on Board of Directors);
- Program/services (Intake/Admissions; Strategic Planning; Master Planning);
- Performance (Client Clinical Record Audits; Employee Evaluation; Contract Monitoring; Program Evaluation; Medicaid Compliance; CLAS Standards; Termination/Exit; Retention; Training);
- Risk Management (Critical Incidents; Safety; External DCYF Medicaid Auditing; Regulatory Inspections and Site Visits; Client & Employee Grievances; Risk Prevention and Management; Board Risk & Audit; Facilities Strategic Planning; Business Continuity Planning & Emergency Activities);
- Financial viability (Board Reporting; External Auditing);
- Data Driven Priority Initiatives (Set annually)

Current PQI Committee opportunities include the following, and the structure is monitored by the PQI Manager & the Agency PQI Committee (assigned leadership):

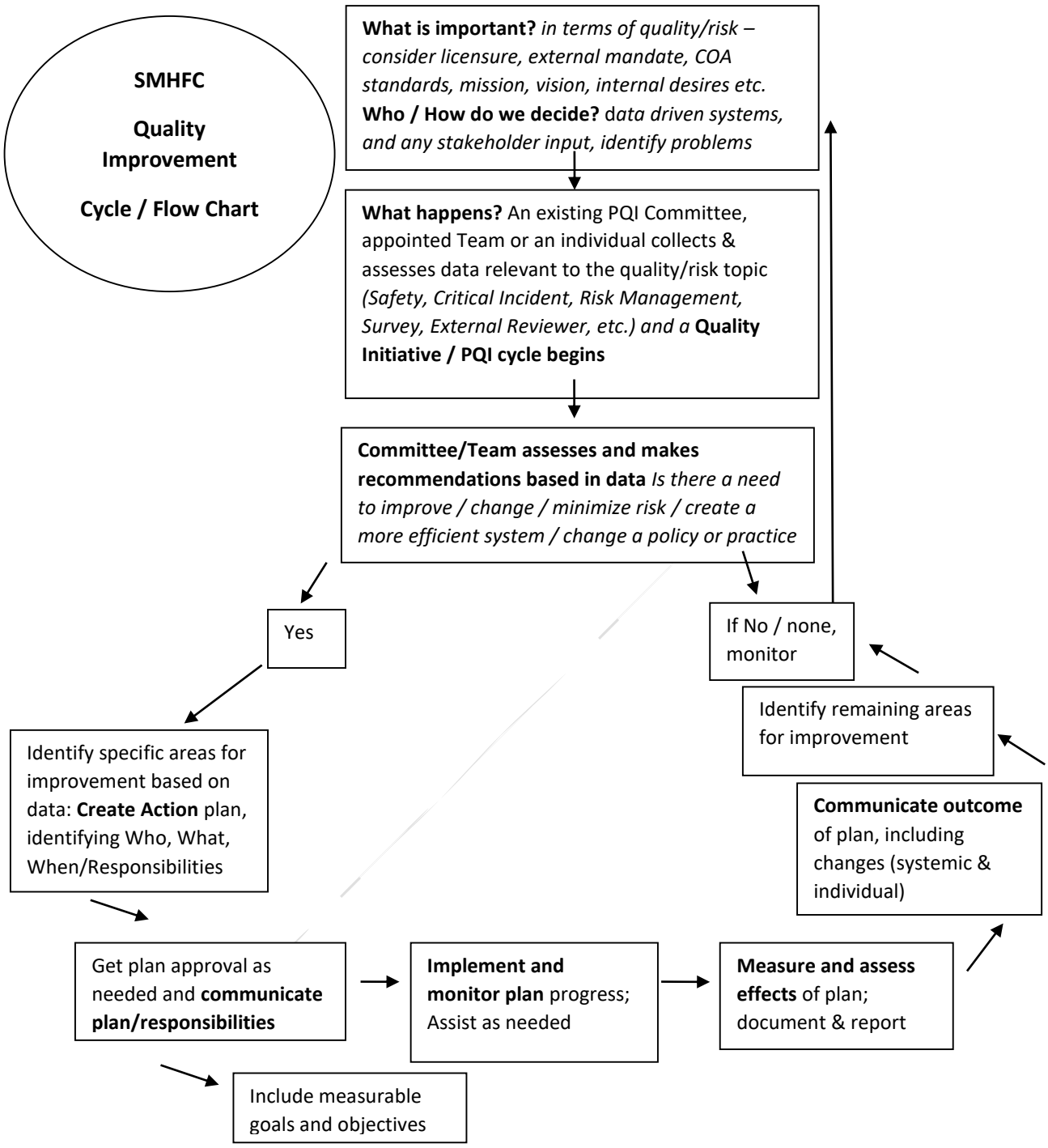
- Medicaid Compliance Team (assigned)
- Safety Committee (open)
- Wellness & Appreciation Committee (open)
- Diversity, Equity and Inclusion (DEI) Committee (open)

- Risk Prevention & Management Committee (assigned)
- Critical Incident Committee (open & assigned)
- School Technology Committee (open & assigned)
- Residential Youth Council (open)
- Residential & School Parent Partnership (open)

Committees are led by a Chair & Co-Chair. The model promotes a 1-year commitment to the role, with the Co-Chair learning from the Chair and working toward taking that role over after a year. The model promotes a new Co-Chair volunteering from an active committee member. The model promotes staff empowerment, skill development and professional growth. An annual Celebration is held to recognize the work of the committee Chairs & Co-Chairs, and allows for communication of new responsibilities or changed practices within the Committee structure.

There is significant connection between the Committees and administration. When problems are identified that align with the goals of a Committee and fit within their authority, it is sent to them for analysis, action planning, implementation and monitoring.

C. OVERVIEW OF THE IMPROVEMENT CYCLE Visual flow chart follows on next page.


SMHFC
Quality Improvement
Cycle / Flow Chart
What is important? in terms of quality/risk – consider licensure, external mandate, COA standards, mission, vision, internal desires etc.
Who / How do we decide? data driven systems, and any stakeholder input, identify problems
What happens? An existing PQI Committee, appointed Team or an individual collects & assesses data relevant to the quality/risk topic (Safety, Critical Incident, Risk Management, Survey, External Reviewer, etc.) and a Quality Initiative / PQI cycle begins
Committee/Team assesses and makes recommendations based in data Is there a need to improve / change / minimize risk / create a more efficient system / change a policy or practice
Yes
If No / none, monitor
Identify remaining areas for improvement
Identify specific areas for improvement based on data: Create Action plan, identifying Who, What, When/Responsibilities
Communicate outcome of plan, including changes (systemic & individual)
Get plan approval as needed and communicate plan/responsibilities
Implement and monitor plan progress; Assist as needed
Measure and assess effects of plan; document & report
Include measurable goals and objectives

D: STAKEHOLDERS

Stakeholder involvement is a significant component of St. Mary's PQI process. Stakeholders include: clients, families of clients, employees, independent contractors and consultants, interns, volunteers, government entities, funders, community partners, and members of the board of directors. Stakeholders are engaged in the PQI process through the committee structure as noted as well as surveys, program evaluation, outcomes work, strategic planning and other methods described in this plan. Their input is also incorporated through SMHFC's active participation on multiple state-wide committees and organizations (e.g. RI Coalition for Children and Families; LGBTQQ state-wide task-force; Commercial Sexual Exploitation of Children (CSEC) task-force, Active Contract Management, state-wide System of Care etc.), and through our participation in multiple external reviews (e.g. State Medicaid Record Audit, RI DCYF Licensing, DCYF Safety Reviews, COA Accreditation, Financial Auditing, Health/Safety including OSHA, Fire Marshal, Department of Health, etc.).

E: PQI DATA MANAGEMENT PROCEDURES

Data, best practice research, external reviews, audits, laws, public policy, as well as participation with local and national organizations all help inform trends, areas of concern, areas needing improvement, risk and/or highlights of achievement.

Data is collected and shared via written PQI Monthly Report for use in assessment, problem-solving, action planning, evaluation, monitoring and re-assessment. PQI staff provide additional value to workgroups and committees through guided exercises such as process mapping and more complex practices such as program evaluation, research & outcomes insight, and more.

A structure of data analysis and reporting responsibilities is maintained by the PQI department and includes but is not limited to:

- Monthly critical incidents reporting
- Quarterly client clinical record auditing and reporting
- Quarterly demographic data reporting (client, employee, management, board comparison)
- Bi-annual medical record audit reporting
- Annual termination and exit interview reporting
- Annual PQI report
- Annual board risk reporting
- Annual program outcome reports and program evaluations
- Strategic Planning reports re: Annual Plan of Work progress no less than annually
- Ad hoc client data deep dive reports
- Ad hoc PQI reports
- Every two-year Affirmative Action Plan data analysis and reporting
- Monthly policy review compliance
- Program Evaluation, 3-4x per year
- Annual Progress Note timeliness analysis

The structured reporting schedule maximizes opportunities to catch and correct data errors and drifts that occur with practices. It also ensures continual monitoring of all electronic systems from which data is extracted. The structure itself is being continually improved.

Client data comes predominantly from the electronically stored clinical records. That data is monitored and scrubbed by the PQI team members. PQI maintains an active lead in the upkeep of the electronic clinical record, supported by the IT department. A Medicaid Compliance Team, consisting of Clinical Program Directors, Director of Technology, Nursing Director, PQI Manager, Chief Financial Officer and Chief Operating Officer is in place to ensure consistency with implementation, and are led by policy.

Financial data comes predominantly from finance department systems, HR from the HR department and so forth. All data is classified according to the agency Data Classification Policy & is treated by PQI as sensitive. Reports that are of a sensitive nature are provided to the appropriate Director and/or Executive Director before being shared broadly.

F. PROGRAM RESULTS / CLIENT OUTCOMES & PROGRAM EVALUATION

Outcomes data helps us to increase program effectiveness, contribute to policy discussions, and prevent recidivism. Board approval was obtained to implement an outcomes survey in the residential programs, and it is a significant project of the PQI department. Caregivers of former residential clients are contacted at 6, 9 and 12 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); and Health (has the youth sustained basic physical and behavioral health, and overcome or manage health challenges). Building Bridges Initiative (BBI) research and tools are utilized in the project, and data is managed in an adjunct system of our electronically stored record.

A comprehensive report and analysis is generated annually by the PQI department which serves as a guide for discussion and to inform decision making. Findings are reported to the residential administrative team, administration and the Board of Directors. Additionally, presentations regarding the importance of this project are communicated & presented to the state child welfare department (RI DCYF) by PQI and the Executive Director.

Program evaluations are implemented on a schedule for all agency programs. This is a systematic method for collecting, analyzing, and using data to improve programs by evaluating their efficiency, quality, and effectiveness. Teams are guided through activities to define program goals, define the theory of change, create or refine their program logic model and identify indicators of their program functioning. PQI analyzes program data, and a report is produced and shared with the team and administration to help inform decisions about what to do next.

Standardized tools and evidence based or informed tools are utilized whenever possible as a measure of change. Tools that are required by funders are utilized on the required schedule. Depending on the program, these can include but are not limited to: CANS, OHIO, CSBI, CSEC Screening Tool, FISA Pre/Post Survey and TSCC.

G. PROGRAM MONITORING

There are many PQI activities which take place to help monitor programs. Among them are:

Critical Incident Reporting:
Data collection, review and analysis: Residential and School program incident reports involving allegations of abuse or neglect, physical restraint or escort, self-injury, physical altercation, community incidents or medication error are formally examined no less than weekly by the Critical Incident Committee. The committee includes the Executive Director, Residential Program Manager and Assistant Manager, Residential House Supervisors and Assistants, Clinicians (rotate), Staff Development (Training) Coordinator, Nurse, School Behavior Support Specialist, PQI team members and Secretary.

Data is collected from Incident Forms (IF's), Physical Restraint Reports (PIR's) Child Protective Services Forms (CPS), Crisis Orders (i.e. physical restraint orders), and Debrief Notes. It is recorded electronically and analyzed monthly by PQI for discussion with the Critical Incident Committee.

Any reported, disclosed or observed incident of abuse and/or neglect is reported to state Child Protective Services, police authorities as warranted, and additionally to accreditors as mandated. Every physical restraint, physical transport or missing from care incident is followed within 24 hours by a formal debriefing to analyze what happened, and includes the youth, parent/caregiver, staff involved, administrators, clinical and nursing staff. Action plans formulated at the debriefing are implemented through the youth's treatment team.

Residential and School reports involving allegations of abuse or neglect, physical restraint or transport, self-injury, physical altercation, community incidents, SI/HI or medication error are formally examined no less than weekly by the Critical Incident Committee which includes all program management personnel, Nursing, Clinical, Training and Administrative members.

The PQI department aggregates, analyzes, and reports data to lead a data review with the Committee on a monthly basis. Data regarding all incidents is tracked and reported monthly to the committee by the PQI department. The Six Core Strategies for Restraint Reduction data points are included in the analysis, as well as data points the committee finds valuable. This includes but is not limited to physical restraint and transport data by House / Classroom, day of week, shift, time of day, employees involved, injuries to youth and staff, debriefings, rate of restraint, incidents of self-injury, Psychiatric Evaluation and Hospitalizations, missing from care or wandering on campus, Police/Fire Assistance, CPS calls and medications issues/errors. Race, ethnicity, age and gender data points are analyzed to ensure monitoring and correction relative to equitable treatment takes place. Data is analyzed by the committee for concerning trends as well as positive interventions or actions that should be done more often. Clients who appear to be struggling are referred for a PQI 'deep data dive' to help assist the entire treatment team create a plan of support/additional services. System issues or drifts, practice or policy changes, equitable treatment issues and assessment of the need for employee training are all informed by the data and discussions.

Communicating Results & Action Plan: Action plans are communicated, implemented, monitored and results assessed within the committee and as tasked to Teams outside the committee. Summaries and results are can be included in PQI Monthly, Newsletter and Annual PQI Report. Additionally, members of the committee communicate information more frequently through dissemination of action plans or information at weekly Group Supervision, at House / Department / School Meetings and through individual supervision as needed. Celebrations are held for residential houses that are restraint-free in any month, and includes celebrations for staff and youth.

Client Record Review

Data Collection, Review & Analysis: Client clinical records are reviewed quarterly in outpatient and residential programs to analyze and evaluate clarity, content and continuity of open/closed records; to determine if client's needs and strengths are being assessed appropriately; to assess appropriateness of interventions in relation to presenting needs; and to monitor and create improvement plans for Medicaid / third party / best practice compliance in regard to key clinical documentation requirements (e.g. timeliness, content, etc.).

In residential programs, 100% of youth open during the quarter under audit are included in the sample with few exceptions, inherently representing open and closed records. In office and community based programs, COA guidelines are followed under random selection, including a sample of open and closed records.

PQI staff conduct the quantitative audit, and masters level clinical staff conduct the qualitative audit. A peer contribution element is included in all open audits. In office and community based programs, care coordinators conduct quantitative closed audits. All reviews are conducted under the standard of reviewing only those cases in which an individual has not provided service or for which there is no conflict of interest. All records reviewed are subject to the Agency's Confidentiality Policy.

All audit data is aggregated and reported formally by the PQI department utilizing best practice and compliance standards as a baseline for expectations. Points are earned for compliance and timeliness, and a three-point rating system is used to provide clear, objective measures to assess overall compliance and achievement.

On an annual basis, RI DCYF conducts a Medicaid Audit of all contracted programs, including residential and community based. Health insurers conduct random audits of both the office, community based and ARTS programs.

Communicating Results & Action Plan: Formal reports are distributed to the Executive Director, COO and Program Director to share with teams. Summary results are included in the PQI Monthly and in the Annual PQI Report. Actions plans are created, implemented and monitored by the program director. Successes are celebrated, particularly when a program had been struggling and made improvements.

Client Grievance Review

Data Collection, Review & Analysis: The Grievance Committee is an ad hoc committee that meets as a grievance is brought forth in any program or department per agency policy (Employee or Client). When a grievance reaches the Executive Director level pursuant to the policy, the Executive Director informs the Grievance Committee chairperson and a committee meeting is scheduled. The committee reviews the grievance, documents obtained, actions taken and makes recommendations for change as indicated and per agency policy. The committee puts recommendations in writing and after consultation with the Executive Director, respond in writing to the person filing the complaint. Grievance policies are reviewed no less than every two years to ensure they remain guided by current best practice and/or laws, rules or regulations.

Communicating Results & Action Plan: The Executive Director informs 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 Chair notification to the PQI Manager for the sole purpose of tracking data (no details or names).

Intake/Admissions

Data Collection, Review & Analysis: The Admissions Committee meets weekly to discuss clients referred for residential treatment and the School. Members of the committee include the: Residential Intake Coordinator, Residential Clinical Director, School Administrator, Nursing Supervisor and Finance representative. The committee makes a determination regarding the agency's ability to meet the youth and family needs based on intake criteria. The Intake Coordinator tracks and reports 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. Assessment and analysis includes reasons for delays and processes that could be put into place to expedite the intake process and/or increase referrals.

In office and community based programs, the Outpatient Intake Coordinator, Director of the Outpatient Department and Team Leaders meet weekly to form a Team and maintain a specific structure of assessing client needs and program ability to meet client needs.

Communication Results & Action Plan: Demographic Reports are published Quarterly by the PQI department and include client, staff, management and board demographics.

Client Satisfaction

Data Collection, Review & Analysis: Surveys are distributed by PQI annually. Until 2023, the same survey that COA uses was used to assess changes and improvements over time. All residential & school youth are given opportunity to participate, and all adult clients and parents of minors who have an email on file are given the opportunity to participate.

Communication Results & Action Plan: Reports for all surveys are created by PQI and distributed to the leadership team. Results are also utilized in PQI Monthly meetings to help inform decision making. Action plans when created independently are monitored by the respective Director. The Youth Council is engaged to use the survey results in their advocacy and empowerment work as well.

Youth Council & Parent Council
Data Collection, Review & Analysis: Residents meet with the Youth Mentor to express their ideas and address concerns on a weekly basis in as formal Council. Their successes have been significant and include policy revision, participation in the interview process for potential milieu staff and more. Parents of residents and school students are invited to participate on a formal Parent Partnership, which continues to evidence success as a small but supported group. They have been instrumental in practice changes related to admissions and welcoming processes.

Communication Results & Action Plan: The Quarterly PQI Newsletter includes a summary of achievements and goals relative to client input.

H. MANAGEMENT / OPERATIONAL PERFORMANCE

Financial Stability
Data Review & Analysis: 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.

Communicating Results & Action Plan: The following reports are reviewed by and acted upon by the Chief Operating Officer and Executive Director every-other week: 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.

Every other month a financial summary report is presented to the full Board. Adjustments are made and initiatives identified as trends are recognized. Financial information is a part of the Monthly PQI Report, including quarterly at-risk census reporting.

Workforce Stability
Data Review & Analysis: The Chief Financial Officer 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-tern annual objectives.

Additionally, HR analyzes workforce needs and patterns for reports at quarterly Personnel Committee meetings. Employee survey reports, exit interview reports, payroll reports (including overtime reports), employee turnover data, hiring data, benefits data, Department of Labor & Training statements, Workers' Compensation data are generated and reviewed.

A formal Affirmative Action Program is in place at the agency. It is implemented and monitored by the HR Director and Chief Operating Officer. It includes data collection, reporting and annual training as required.

Communicating Results & Action Plan: Employee Turnover is reported to the PQI Committee as a part of the Monthly Report. Identified trends, concerns, and opportunities are reported to board Personnel Committee, and data is used as a part of Strategic Planning. All Managers & Supervisors participate in an annual training that includes the AAP / AAPV and their roles & responsibilities, as well as a review and discussion of the data.

Employee Satisfaction Survey

Data Review & Analysis: Annually, an Employee Survey is distributed to all staff. The COA survey tool, and survey categories (i.e. Employee/Intern, Manager/Supervisor, Consultants and Board) were utilized until 2023 in order to collect data and assess improvements, trends, or sharp regressions over time. The survey components include: work environment, supervisory relations, team interactions, job satisfaction, commitment, and knowledge of policies and committees. Survey data is collected and aggregated using surveymonkey.com by PQI staff. The PQI Committee and Directors are used to solicit additional insight to the survey results. Opportunity exists to change this Survey given changes with the Annual COA Survey to three open-ended questions.

Communicating Results & Action Plan: The results are shared with all staff, interns, independent consultants, and the Board of Directors. Results are also shared with PQI Committees doing related work to help inform their decision making. Directors address areas of needed improvement via written action plans. Data and progress on any independent action plans is included in the Quarterly PQI Newsletter and PQI Committee.

Board of Directors Self-Assessment

Data Review & Analysis: Until 2023, annually, the Board of Directors completed the same survey used by COA which is distributed via surveymonkey.com. Additional questions have been added to help measure the members' understanding of Board role and responsibilities, mission of SMHFC, Board effectiveness in monitoring progress toward strategic goals, and Board's efforts in setting fundraising goals. It also 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. Opportunity exists to change this Survey given changes with the Annual COA Survey to three open-ended questions.

Communicating Results & Action Plan: 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 their presentation to the Board.

Risk Prevention

Data Review & Analysis: Administrative review is conducted no less than quarterly to assess areas that pertain to administration/operations. The review committee consists of the Executive Director,

Human Resources Director, Chief Financial Officer, Nursing Director, Director of Technology and Chief Operating Officer.

Areas assessed include: compliance with legal and licensing requirements, insurance and liability (including Workers Compensation), human resources practices, technology risks, contracting practices and compliance, client rights and confidentiality issues, high risk practices, 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. They additionally monitor the Business Continuity Plan and Succession Plan. Other areas of potential risk are reviewed in the Critical Incident Review and Safety Committees.

The Board Audit Committee was expanded to become a Risk/Audit Committee in 2019, which is designed to ensure active engagement and ongoing conversation with the Board relative to agency risks. Risks are presented using a dashboard and visualized data to engage members.

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 review internal controls.

Communicating Results & Action Plan: The above-stated areas of potential risk to the organization are presented to the full Board of Directors on an annual basis. The Board reviews the information provided and makes recommendations to mitigate risk to the organization. This information is brought to the Risk/Audit Committee of the Board of Directors. The Executive Director and Chief Financial Officer are responsible for ensuring that Board recommendations are carried out and for making the appropriate adjustments/corrections as noted in any management letter of the audit.

Safety Review

Data Review & Analysis: The Safety Committee meets monthly to conduct a review of all issues regarding employee and client safety by focusing on facilities, practice/policy, and risk management. Data from Incident Reports (client and employee injury reports) related to safety and risk are pulled and reviewed protecting confidentiality. Action plans are created, implemented, monitored and re-assessed by the committee. More important, a pro-active stance is taken by members by anticipating issues and facilitating needed change prior to an incident occurring. The committee includes representatives from all programs and support departments to help ensure assessment from all perspectives. They focus on facilitating systemic changes to prevent incidents from happening in the future. The committee facilitates practice of emergency activities two times per year, and they include all participants as listed in the Business Continuity Plan. They also oversees testing of the emergency alert system.

The committee works with the North Providence Police Department with regard to on-site lockdown and evacuation drills, and works hard to maintain active relationships with both Police

and Fire Departments. This includes social activities so youth see them outside times of crisis, quarterly data analysis meetings, and attendance at their Roll Call to promote and share our expertise in trauma-informed care which is so valuable for them to have in the community.

Communicating Results & Action Plan: Formal reporting is included in the Quarterly PQI Newsletter. Communication of changes based on action plans takes place regularly, as well as reminders (seasonal, as concern arises, etc.) sent via email, Newsletter or for department / program meetings.

Strategic and Master Planning

Data Review & Analysis: Strategic planning is integral to the PQI structure. Professional experts are utilized approximately every-other planning cycle to ensure that climate surveys, client interviews, staff focus groups, management assessment reports and other strategic planning tools & activities are used to ensure a comprehensive process and resulting Plan. Annual Plans of Work are generated from the Strategic Plan document.

To address the lack of space needed to provide services & programs desired as a part of the most recent Strategic Plan, professional guidance was needed. Board Committees including Strategic Plan/PQI and Buildings & Grounds were identifying similar needs in regard to aging property, disorganized flow and the desire to identify where to invest repairs & replacements. An architect firm was awarded the project and a comprehensive Master Plan is in place.

Communicating Results & Action Plan: The resulting plans are posted on the agency website and widely distributed in-house and with the Board. They are used in fund development, media and grant writing activities. Annual Plans of Work are utilized by staff and board only. They are detailed and include assignment of responsibility, and timelines for task completion.

I. PQI Priority Initiatives

PQI Priority Initiatives are selected annually based on areas in need of attention or improvement, or that are of significantly high risk. For example, the COVID-19 pandemic initiated a "Surveillance Testing & Isolation Unit Use' initiative. Data regarding each Initiative is included in the monthly PQI Report and monitored by the PQI Committee. A structured report is utilized to ensure measurable targets are identified, and includes a dashboard type visualization. One initiative is also spotlighted in the Quarterly PQI Newsletter.

J. COMPLIANCE WITH EXTERNAL REGULATORY REQUIREMENTS & OTHER EXTERNAL REVIEWS

External Review Area	Reviewer
All Residential Treatment Programs	RI DCYF
Additionally, for only ARTS Residential Treatment	NHP, UBH and BCBS Ins.

Special Education License	RI Department of Education
Agency Accreditation	COA
Food Business License	RI Department of Health (DOH)
Kitchen/Food Inspections	RI DOH and private vendors
State Fire Marshall Inspections	RI State Fire Marshall Office
Fire Alarm testing (quarterly)	Vendor
Sprinkler System testing (quarterly)	Vendor
Fire Extinguisher testing (annually)	Vendor
Radon Testing (every two years)	Vendor / DCYF monitors
Pest Control	Vendor, monthly contract and PRN
Asbestos / Lead / Other testing	Vendor, PRN for projects
Back flow testing (annually)	Vendor
Kitchen Fire Suppression System	Vendor

K. ASSESSMENT OF THE EFFECTIVENESS OF THE PQI SYSTEM / PLANNING AHEAD

The PQI process is continually under assessment and review. There is a PQI department transformation taking place as a new leader emerges, with a focus on innovation, advancement and expansion. PQI changes continue to be introduced throughout the agency incrementally, with respect for past systems while building on strengths. Sustained change is achievable by an incremental and systemic approach. Strengths based language is valued, and taking the time to be curious about why a target or goal was not met. Empowering staff to try on their own with guidance and fostering a mistake tolerant yet safe environment is valued.

Assessment of PQI practices led to the ultimate growth of multiple dedicated FT staff PQI resource which evidences leadership's commitment to PQI principles. The Agency is committed to compliance, best practices, efficiency, and strengthening of data for use in decision making. Participation in training, webinars and conferences takes place when able, and PQI team members have presented nationally in Chicago at a CQI Conference (virtual) and at the Association of Children's Residential Centers (ACRC) once virtually and once in-person post-COVID 19. The Agency Alliance/COA membership resources are utilized regularly.