Performance Quality Improvement (PQI) Plan

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

A: ORGANIZATIONAL PHILOSOPHY OF PQI

The Performance and Quality Improvement ("PQI") program of St. Mary's Home for Children ("SMHFC") promotes excellence and continuous improvement in all functions of the agency including client care and services provided. 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 impeded efficiency, satisfaction, compliance, service delivery 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.

The PQI plan is broad-based and includes all employees, Board of Directors, clients/consumers and external stakeholders. With input from stakeholders, the Board of Directors and staff establish strategic priorities and goals. Key performance objectives are delineated for all programs and services, and performance and client outcomes are measured in each program area. Our efforts in client outcomes is expected to grow with the late 2015 DCYF-endorsement of the national Building Bridges Initiative. Key objectives include those that have the greatest impact on the quality of care and service the client ultimately receives toward the goal of long-term success. Priority is given to functions which are performed frequently, which 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

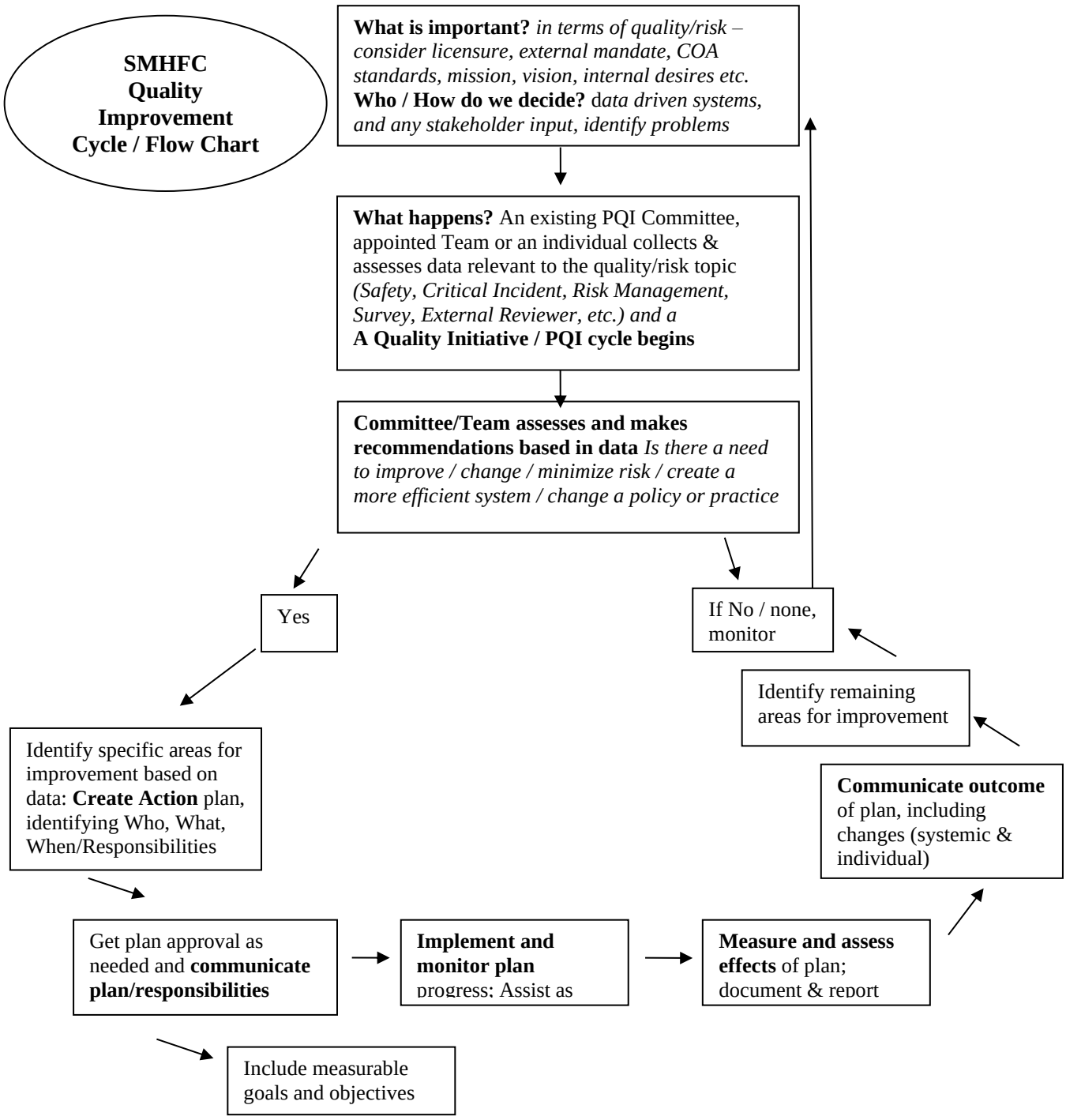
The Director of Operations, an LICSW with PQI experience in residential settings under COA accreditation, is responsible for overseeing the processes and coordinating PQI activities. That includes responsibility for Quarterly PQI Reporting to all employees, the Board of Directors, independent contractors and public posting on the agency website. An annual summary report of gains made against goals is presented at the Risk Prevention and Management Committee meeting, and provided to the Board of Directors as well as employees. All Program Directors and management/supervisory level staff, as well as Committee Chairpersons are responsible for conducting business under the SMHFC PQI philosophy and practices.

Significant emphasis is placed on employee led and empowered committees in the PQI structure, each tasked with a specific area of risk, consumer engagement or performance to address. Committee and Leadership Team Minutes are distributed via email to employees to communicate activities, promote transparency and in an ongoing effort to engage additional employees into participation. Committees are open to any employee, and individuals are invited in as needed to help address issues and action plan as needed. Among the many committees is the PQI Committee which consists of the Director of Operations, Executive Director, several Program Directors, a Training Department representative and residential representation.

The current structure includes:

- Consumers (Client and Employee Surveys, Staff Relations, Wellness, Residential and School Improvement, Youth Council);
- Program/services (Intake/Admissions, Strategic Planning);
- Performance (Record Audits, Employee Evaluation, Contract Monitoring);
- Risk Management (Critical Incidents, Safety, External Auditing/Reviews, Grievance, Risk Prevention and Management); and
- Financial viability (Board Reporting, Auditing).

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 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
Measure and assess effects of plan; document & report
Include measurable goals and objectives

C: STAKEHOLDERS

Stakeholder involvement is a significant component of St. Mary's PQI process. Stakeholders include: service recipients, families of recipients, employees, independent contractors and consultants, interns, volunteers, governmental entities, funders, community partners, and members of the Board of Directors. Stakeholders are engaged in the PQI process through the various committees and surveys described in this Plan and our Strategic Plan, and 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 task-force; Commercial Sexual Exploitation of Children (CSEC) task-force), 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 Marshall, Department of Health, etc.).

D: OVERVIEW OF THE IMPROVEMENT CYCLE

Data from committees, external review and participation on external committees is used to identify trends, areas of concern, risk and/or highlights of achievement (see PQI Cycle / Flow Chart). Within the committee structure, data is collected and shared first within the group via verbal or written report for use in assessment, action planning, implementation and monitoring/re-assessment. Minutes are shared internally, and then highlights of achievements are reported in the Quarterly PQI Report (shared internally and externally). External reviews are assessed by Teams for action planning as needed (minimally in any area assessed as below standard or where recommendations are made), and may be shared in summary via the Monthly Employee Newsletter and/or Leadership Team Meeting Minutes (both distributed agency-wide). Data from participation on external committees is typically assessed administratively and used in short and/or long term strategic planning, and action planning implemented to stay ahead of state-wide trends and/or policy needs.

E. MEASURES / OUTCOMES / PQI DATA MANAGEMENT PROCEDURES

CLIENTS: CHILDREN WILL BE FREE OF ABUSE AND NEGLECT WHILE IN CARE

Incident Reporting:

Data collection, review and analysis: Data is collected from Incident Forms, Special Incident Reports, Child Protective Services Forms / Investigations. It is recorded electronically in the Access Critical Incident system, as well as hard-copy within the client's record. Any reported, disclosed or observed incident of abuse and/or neglect while the child is in care is reported to state Child Protective Services, police authorities as warranted, and additionally to accreditors as mandated.

Residential and School incident reports involving allegations of abuse or neglect, physical

restraint or escort, self-injury, physical altercation, community incidents, SI/HI or medication error are formally examined no less than weekly by the Critical Incident Committee. Agency-wide Special Incidents are also reviewed by the committee.

Data regarding all incidents is tracked and reported monthly within the committee by the Director of Operations, and as a part of the Quarterly PQI Report. Data includes physical restraint and escort statistics by unit and child, rate of restraint by unit and program, incidents of self-injury, Psychiatric Evaluation and Hospitalizations, AWOL or wandering on campus, Police/Fire Assistance, CPS calls and medications issues/errors. It is analyzed by the committee for concerning trends; identification of individual clients in need of support/additional services; system, practice or policy changes; identification of employee training needs; etc.

Communicating Results & Action Plan: Action plans are communicated, implemented, monitored and results assessed within the committee and as tasked to Teams outside the committee. Data and results of systemic plans are communicated in the Quarterly PQI Report.

Assessment Tools

Data collection, review and analysis: The Rapid Screening Tool for Child Trafficking is used at admission and thereafter as warranted to ensure safety, guide CSEC reporting and treatment planning. Data is collected by the individual clinician using input from Team members as warranted / able including the client, family, past providers, referral source, etc. and is incorporated into the treatment plan / treatment plan reviews. The CSEC policy reporting process begins if and when indicated agency-wide per the recently released state-wide protocol.

Communicating Results & Action Plan: Results are communicated among the Treatment Team, and planning takes place as a part of the Treatment Plan. Data trends will be brought to administration by Program Directors for use in continued improvement with regard to CSEC advocacy, policy, training needs, program evaluation and strategic planning.

2. CHILDREN WILL EXHIBIT IMPROVED DAILY FUNCTIONING & EMOTIONAL HEALTH

Standardized Tools

Data collection, review and analysis: The Child and Adolescent Needs and Strengths (CANS) assessment and Youth Problems, Functioning, and Satisfaction Scales (OHIO Scale) are administered per state mandate to residents upon admission and at each three month interval thereafter, coinciding with treatment plan reviews. Prior to state mandate, the CAFAS was utilized. CANS and OHIO data is collected and utilized by the individual clinician as a part of Treatment Planning / review, and additionally reported into the state-wide Portal for additional external assessment and review.

The Child Sexual Behavior Inventory standardized tool is used as indicated for individual clients in residential and outpatient programs. CSBI data collection is facilitated by the individual clinician from involved treatment team members including parents, school and

clinicians/case managers. Data is utilized by the Team in treatment planning and review.

Data from the Symptom Survey, created and implemented in the outpatient programs, is collected from clients and/or caregivers pre and post treatment in outpatient programs. Symptom Survey data is facilitated by the individual clinician, and sent anonymously for aggregation. Aggregation plans are to be implemented in 2016 for use in the PQI structure. Throughout 2017, the surveys saw their best implementation and a subsequent 2017 Annual Pre/Post Symptom Survey Report. The report includes plans for continued improvement with obtaining data to assess.

Additional standardized tools are utilized as warranted and when the administering clinician / psychologist is appropriately trained / certified to do so.

Communicating Results & Action Plan: Results of standardized tools are communicated among the Treatment Team, and action planning takes place as a part of the Treatment Plan process. At this review, the State has not provided aggregate clinical data back to the organization however has reported on timeliness of tool administration. Data trends will be brought to administration by Program Directors for use in continued improvement with regard to continual assessment of effective intervention models and evidence informed practices.

3. FAMILY RELATIONSHIPS WILL BE IMPROVED AND STRENGTHENED

Building Bridges Initiative

Data collection, review and analysis: We are now in year three of BBI implementation. Residential programs actively engage families at referral with assistance from Parent Support Partners. Each client is identified as Youth or Family Track, and data collection for the appropriate track begins. All other programs continue developing relationships at referral through intake and thereafter through engagement by the clinician in assessment and service plan development.

In residential programs, family engagement and outcomes is measured using the DCYF approved matrix which includes but is not limited to frequency of family therapy appointments, frequency of telephone communication, frequency of time with child and staff in the home, participation in family and community nights, and participation in treatment planning development and reviews. Data collection is tailored for youth in the Youth Track to ensure active advocacy efforts toward permanency, and engagement of the youth in activities that have been proven to improve long-term outcomes and permanency.

Communicating Results & Action Plan: Ongoing BBI implementation / action planning is communicated and monitored through the Strategic Plan. Data reporting to RI DCYF is required effective spring, 2016 and has been incorporated into the current PQI structure.

PROGRAM RESULTS / SERVICE DELIVERY QUALITY

Case Record Review

Data Collection, Review & Analysis: Case Record Review is conducted 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 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 exception, inherently representing open and closed records. In outpatient programs, COA guidelines are followed under random selection, including a sample of open and closed records. Clinical level staff participate in residential Medicaid reviews, and both clinical and intern level individuals participate in all other reviews. The appropriate program forms including peer contribution forms are distributed and 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 assessed and reported formally by the Director of Operations using best practice and compliance standards as a baseline for expectations. Detailed formal Reports with data highlights are written quarterly, and include recommendations for systemic improvement. Program Directors at that point are responsible for action planning and follow up within their programs, and the Executive Director (who notably participates in the Medicaid audits) is provided with raw data and final reports.

Additionally, on an annual basis RI DCYF conducts a Medicaid Audit of the residential program. Health insurers conduct random audits of both the outpatient and ARTS programs.

Communicating Results & Action Plan: Formal reports are distributed administratively and within the program, and summary results are included in the Quarterly PQI Report. Actions plans are created, implemented and monitored by administration.

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. The committee puts recommendations for improvement in writing in minute format and after consultation with the Executive Director may respond in writing to the person filing the complaint.

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 additionally provides only notification the Director of Operations/PQI Coordinator, with no details for monitoring of the system purposes in re: employee grievances.

Critical Incident Review

Data Collection, Review & Analysis: Residential and School 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. Agency-wide Special Incidents are also reviewed when relevant to campus systems or programming. The committee includes the Executive Director, Residential Program Coordinator and Assistant Coordinator, Residential House Supervisors, Clinicians (rotate), Staff Development Coordinator, Nurse, School Behavior Support Specialist and Secretary. Minimally, one Clinician and one House Supervisor must be present to hold a committee meeting.

Through review of incident forms, data is analyzed by the committee for concerning trends; identification of individual clients in need of support/additional services; system, practice or policy changes; identification of individual or program-wide employee training needs; etc. From this, action planning (systemic and individual) takes place and is implemented then monitored and re-assessed by the committee or Team identified in the action plan for improvement. Implementation of individual corrective action or termination of employment (as needed) is enforced by the Program Director and overseen by the Executive Director.

Additionally, data regarding all incidents is tracked and reported monthly to the committee by the Director of Operations/PQI Coordinator. That data includes physical restraint and escort statistics by house and child, rate of restraint by house and program, incidents of self-injury, Psychiatric Evaluation and Hospitalizations, AWOL or wandering on campus, Police/Fire Assistance, CPS calls by type and medications issues/errors. Action plans and initiatives may result from the data review. Those are monitored and reported in the monthly Data Review Minutes.

Communicating Results & Action Plan: A quarterly summary report is written and included in the Quarterly 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 Meetings and through individual supervision as needed.

Intake/Admissions

Data Collection, Review & Analysis: The Residential Admissions Committee meets weekly to discuss cases referred for residential treatment. Members of the committee include the: Residential Intake Coordinator, Clinical Director of Residential Services, Nursing Supervisor and Director of Education. Finance representation was added in 2017 in response to the need for pre-determined LEA responsibility. The committee makes a

determination regarding the agency's ability to meet the youth and family needs. 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 outpatient programs, there is no committee although the Outpatient Intake Coordinator and Director of Outpatient Services, Assistant and Program Coordinators maintain a more case-specific structure of assessing ability to meet client needs. Reporting still takes place.

Communication Results & Action Plan: Formal Quarterly Intake Reports are written by the Intake Coordinator in both the outpatient program and residential programs. They are communicated via the Quarterly PQI Report, and include highlights of achievement as well as action plans for continued improvement.

Client Satisfaction & Outcome Survey

Data Collection, Review & Analysis: At discharge in both the Outpatient and Residential Programs, the parent/guardian and/or child are given a survey to complete anonymously. The survey addresses satisfaction with services, respectful treatment, client's perceptions of issues, reduction of symptoms/problematic behaviors, unmet needs, and recommendations for improvement. Outpatient survey results are compiled/analyzed, and a report is written, by the Director of Outpatient Services. The Clinical Director compiles data from the residential programs, and writes a summary report. Areas for improvement are identified and action plans developed as needed by the Program Director and included in the reports.

Communication Results & Action Plan: Reports are included in the Quarterly PQI Report, which as noted is communicated agency-wide and externally. Action plans are monitored by the respective Director.

Youth Council

Data Collection, Review & Analysis: Residents meet with the Residential Clinical Director (and in 2018 the new position of Youth Engagement Specialist is being included) to express ideas and address concerns on a regular basis. As a part of the strategic plan, this committee was significantly formalized throughout 2017 and continues going into 2018.

Their successes have been significant and include policy revision, participation in the interview process for potential milieu staff and more. Plans for engaging parents in a formal PQI process as a part of the Building Bridges Initiative have not seen success to this date, however efforts will continue.

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

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.

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

Communicating Results & Action Plan: Every other month the financial summary report is presented to the full Board. Adjustments are made and initiatives identified as trends are recognized. Data is also used in Strategic Planning. Financial information is reported at monthly Leadership Team Meetings, and those Minutes are distributed to all employees. Financial information is also an element of risk reporting, which is included in the annual formal Board Risk Report (presented by the Director of Administration).

Workforce Stability

Data Review & Analysis: The Director of Administration conducts a workforce analysis annually in preparation for budget development meetings. The information reviewed is a combination of internal workforce trends and projections for growth/decrease in service need in accordance with the Agency's long-term goals and short-tern annual objectives.

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

In February of 2017, a formal Affirmative Action Program and plan was put in place at the agency. It is implemented and monitored by the HR Manager and Director of Administration. It includes data collection, reporting and training.

Communicating Results & Action Plan: Identified trends, concerns, and opportunities are reported to board Personnel Committee, and data is used as a part of Strategic Planning.

Employee Satisfaction Survey

Data Review & Analysis: Annually, an Employee Survey is distributed to all staff to identify areas of satisfaction and areas in need of improvement. The survey is based on Employee Engagement, and components include: work environment, supervisory relations, team interactions, job satisfaction, commitment, and knowledge of policies and committees. In years of COA re-accreditation, no survey is sent as it is in close time-frame. The results shared by COA are used in that year. Survey data is collected and aggregated using surveymonkey.com by the Director of Operations/PQI Coordinator.

The Survey Committee consists of all agency Directors. The Leadership Team and Directors are used to solicit additional insight to the survey results, and Directors are tasked with action plans for improvement to show commitment at the highest level to improvements.

Communicating Results & Action Plan: The results are shared with all members of the agency and the Board of Directors. Directors address areas of needed improvement via written action plans. Data and progress on action plans is included in the Quarterly PQI Report.

Board of Directors Self-Assessment

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

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 his/her 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, Director of Operations, Director of Administration and Human Resources Manager. Data from areas that are assessed include: compliance with legal and licensing requirements, insurance and liability, human resources practices, contracting practices and compliance, client rights and confidentiality issues, ability to pursue strategic goals, financial risk and conflicts of interest. This committee is responsible for reviewing essential management and operational compliance and processes, documenting trends, developing performance improvement indicators and recommending a course of action to the Board of Directors. Other areas of potential risk are reviewed in the Critical Incident Review and Safety Committees.

A Business Continuity Plan (BCP) was introduced in 2016 / 2017, resulting in a formal 'living document' that is actively developed as a part of overlapping PQI committees / processes. Because it is a risk-management driven document, it is being noted here.

Communicating Results & Action Plan: The above-stated areas of potential risk to the organization are presented to the Board of Directors on an annual basis. The Board reviews the information provided and makes recommendations to mitigate risk to the organization. Additionally, an annual Financial Audit is conducted by an accredited independent certified public accounting firm. The responsibility of the independent auditor is to conduct the audit using professional standards to provide an opinion that the financial statements are fairly presented in all material respects in conformity with generally accepted accounting principles. As part of the audit, the auditors review internal controls. This information is brought to the Audit Committee of the Board of Directors. The Executive Director and Director of Administration are responsible for ensuring that Board recommendations are carried out and for making the appropriate adjustments/corrections as noted in the management letter of the audit. Based on the Board's recommendations, the Executive Director and Director of Administration report the actions taken and results to the Board of Directors. Risk Prevention reports are written quarterly for the Quarterly PQI Report and annually for the Board of Directors for review.

CERT / 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, special incident, 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 human resources, administrative support, facilities, supervisory / management level, direct care staff members from all programs and representation from outpatient programs to ensure assessment from all perceptions.

Additionally, the committee accepts input from any stakeholder regarding a safety concern, and many employees send concerns through this committee for action planning. Minimally, the committee reviews staff and client injuries to assess if a systemic change could prevent the injury from happening in the future. The committee also oversees testing of the Emergency One Call system.

In 2016 external training in Community Emergency Response Teams (CERT) was introduced into the agency and was integrated into the committee. Inclusion of outside authorities in drills is beginning in 2018.

Communicating Results & Action Plan: Formal reporting is included in the Quarterly PQI Report. Communication of changes based on action plans takes place regularly, as well as reminders (seasonal, as concern arises, etc.) sent typically via email or sent to Directors / Managers / Supervisors for communication / reinforcement at department/Unit meetings.

PQI Initiatives and Action Plans

At various times the agency will formalize and implement a PQI Initiative. This language is used in the PQI Cycle/Flow Chart when a group or team has been assigned to assess, make recommendations, implement, monitor and re-assess a needed or desired change.

As there are many plans and initiatives, additional efforts to centralize monitoring of PQI Initiatives and Action Plans has been added as of this review. See the PQI Initiatives and Action Plans 2017 – Present document for details.

F. COMPLIANCE WITH EXTERNAL REGULATORY REQUIREMENTS AND OTHER EXTERNAL REVIEWS

External Review Area	Reviewer
All Residential Treatment Programs	RI DCYF
ARTS and Outpatient Treatment	NHP, UBH and BCBS Insurance companies
Special Education License	RI Department of Education
Agency Accreditation	COA
Food Business License	RI Department of Health
Kitchen/Food Inspections	RI Department of Health
State Fire Marshall Inspections	RI State Fire Marshall Office
Fire Alarm testing	Vendor, required per DCYF
Sprinkler System testing	Vendor, required per DCYF
Fire Extinguisher testing	Vendor, required per DCYF
Radon Testing	Vendor, required per DCYF
Pest Control / Asbestos / Lead / Other testing	Vendor, as needed

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

The PQI process is continually under assessment and review. Systems in place are continually assessed with intention to build on identified agency strengths, and challenge ourselves to continually enhance the PQI structure and processes. Changes continue to be introduced incrementally with respect for past systems while building on their strengths.

Assessment of PQI practices is based in compliance, best practices, efficiency, and strengthening of data for use in decision making. The Quarterly PQI Report is used as an ongoing means to communicate PQI activities and data, and as a way to report progress and be accountable to past goals. Annual Reporting was strengthened in 2017 and resulted in various new reports for consideration in our PQI processes.