Performance Quality Improvement (PQI) Plan Updated1/28/2020

'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 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 Director of Operations and PQI, an LICSW with PQI experience in residential settings under COA accreditation, is responsible for overseeing the processes and coordinating PQI activities. That is not a dedicated PQI position, and in late 2019 we committed the resources needed to take our PQI processes to a higher level by hiring a full time dedicated PQI Specialist. The PQI Specialist is also a licensed social worker, which aligns with our supportive approach, and also has significant data analysis experience. This dedicated PQI positon has already made positive impact, and we have termed the year "2020 Transformation" due to changes already taking place and in planning stages. The Executive Director continues to maintain a significant and strong role in PQI processes, leading major PQI Initiatives and Action Plans, 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.

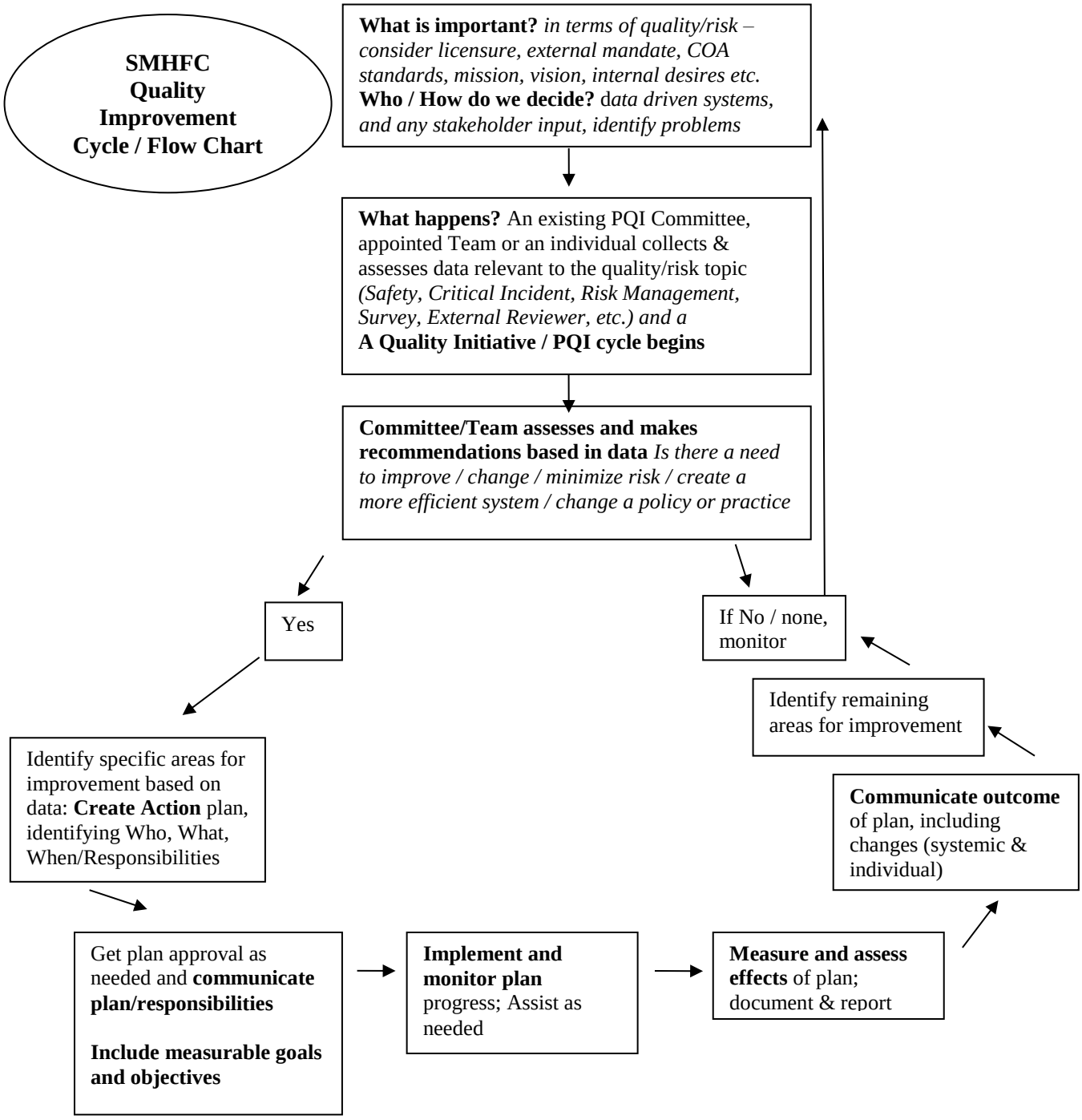
A Quarterly PQI Report is distributed to all employees, interns, the Board of Directors, independent contractors, and is publically posted on the agency website. An annual PQI Report is also distributed highlighting achievements, outcomes, and gains made against goals. These documents transform and become more sophisticated, and will continue to do so, as we elevate our PQI practices due to better data, improved technology and resources.

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. We engage in ongoing efforts to increase participation, and have been successful with a now strong Youth Council and Parent Council in our residential programs. Strategic plans include expanding participation from clients and their families throughout all programs and ultimately Board membership. Committees are open to any employee, intern or independent consultant, and specific individuals are invited in as needed to help address issues and action plan as needed.

The current PQI structure includes:

- Consumers (Client, Employee and Board Surveys; Staff Relations; Wellness; Residential and School Improvement; Youth Council; Parent Council);
- Program/services (Intake/Admissions; Strategic Planning; Intake Teams);
- Performance (Record Audits; Employee Evaluation; Contract Monitoring);
- Risk Management (Critical Incidents; CERT/Safety; External Auditing / Reviews / Regulatory Inspections and Site Visits; Client and Employee Grievances; Risk Prevention and Management at the employee and Board level);
- Financial viability (Board Reporting; Auditing);
- Initiatives and Action Plans (which will transform in 2020 to "Performance Initiatives", and expand to include formal monitoring and reporting); and
- 2020 Transformation includes formal target setting in a structured format.

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
Include measurable goals and objectives
Implement and monitor plan progress; Assist as needed
Measure and assess effects of plan; document & report

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, 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 (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 and Crisis Orders (i.e. physical restraint orders). It is recorded electronically in the Best Notes client record system, and extracted monthly for assessment. In all programs / departments, 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.

Residential and School 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 which includes all program management personnel, Nursing, Clinical, Training and Administrative members. PQI joins monthly for Data review. Every physical restraint 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.

Data regarding all incidents is tracked and reported monthly to the committee by the PQI Specialist, and is included in the Quarterly PQI Report. The Six Core Strategies for Restraint Reduction required 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 escort 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, AWOL or wandering on campus, Police/Fire Assistance, CPS calls and medications issues/errors. It 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, 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. Data and results of systemic plans are communicated in the Quarterly PQI Report.

Assessment Tools

Data collection, review and analysis: The Commercial Sexual Exploitation of Children Screening Tool is used at admission and thereafter as warranted to ensure safety, guide CSEC reporting and treatment planning. This was expanded to the entire agency. Data is collected by the individual clinician using input from Team members as warranted and 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 per the state-wide protocol, recently expanded to include Child Pornography Protocols.

Communicating Results & Action Plan: Results are communicated among the Team, and planning takes place as a part of the Treatment Planning process. Weekly Rounds in residential programs includes a monthly entire-team review, including community and office based providers to ensure coordinated services for youth who are in multiple programs (often those at high risk for commercial sexual exploitation). Data trends are also 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. 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 any program. CSBI data collection is facilitated by the individual clinician from involved treatment team members including parents, school and clinicians/care coordinators. Data is utilized by the Team in treatment planning and review.

The Child Symptom Survey is currently used in office and community based programs, and data is collected from caregivers pre and post treatment. It is reported annually in the PQI Annual Report. In 2020, the Survey is being piloted in the electronic "Outcomes Tools" element of our client record system, and will be administered at quarterly intervals. Presently, data is used on an individual client level, and with the Outcomes Tools we are able to group clients and aggregate data, and use data to drive decisions, in a far more efficient and sophisticated manner.

Additional standardized tools are utilized as warranted and when the administering clinician / psychiatrist 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 are brought to administration through Audit Reports to continually assess effective intervention models and evidence informed practices.

3. FAMILY RELATIONSHIPS WILL BE IMPROVED AND STRENGTHENED

Building Bridges Initiative

Data collection, review and analysis: Implementation of the national BBI model is well underway and has taken hold in the organization's culture. "Family Engagement" stories or successes are shared at the beginning of every meeting agency-wide to reinforce that BBI principle. The PRTF Residential programs actively engage families at referral and include a team of BBI staff – Liaisons, Parent Partners, Youth Mentor and Family Therapist. All other programs develop relationships with clients from referral through intake and thereafter, including clinical, care coordinator, school and milieu staff as applicable.

With the dedicated PQI resources, we've conducted extensive data analysis for youth who did not achieve permanency and have engaged State Child Welfare authorities to begin the conversation of a systemic, public policy approach to permanency. This project also aligns with our Strategic Plan regarding exploration of prevention services, as the data will help inform decisions with new programming / training / education. Our electronic client record system allows efficient extraction of data for analysis, however it was quickly ascertained that extensive early-childhood data is necessary for the analysis. While a slow process, the value has been weighed as very high.

Communicating Results & Action Plan: Ongoing BBI implementation / action planning is communicated and monitored through the Strategic Plan. Two times per month meetings are held on-site with State Child Welfare authorities, administrators and lead BBI management.

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 office and community based 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. In office and community based programs, care coordinators conduct the closed audits and clinicians conduct the open audits (which include a peer contribution). 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 aggregated and reported formally by the Director of Operations and PQI and/or PQI Specialist using best practice and compliance standards as a baseline for expectations. A three point rating system is used to provide clear, objective measures to assess compliance and achievement. PQI writes detailed formal Audit Reports and include recommendations for systemic improvement. Program Directors are responsible for action planning and follow up within their programs, and the Executive Director (who notably participated in the Medicaid audits through 2019) is provided with raw data and final reports as well.

Additionally, on an annual basis RI DCYF conducts a Medicaid Audit of the residential

program, as well as community based programs that are under state contract. Health insurers conduct random audits of both the office, community based and ARTS programs.

Communicating Results & Action Plan: Formal reports are distributed administratively and within the program, and summary results are included in the Quarter 4 PQI, and Annual, 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 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.

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 Director of Operations and PQI for the sole purpose of tracking data (no details or names).

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. 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 and Secretary. PQI staff join for Monthly Data Review, and the PQI Specialist aggregates, graphs, analyzes and reports data and then leads discussion with the Committee on a monthly basis. See earlier section for additional details (*Clients: Children will be free of abuse and neglect while in care: Incident Reporting*)

Communicating Results & Action Plan: A quarterly summary report is written and included in the Quarterly PQI Report, and included in the 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.

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, Residential Clinical Director, Nursing Supervisor, Director of Education 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. Notably, the electronic client system has made the reporting process more efficient.

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

With all data in our client system for the start of 2019, a formal "Intakes Team" was created joining the two intake department's staff, the record keeper, programs' administrative support staff, Director of Operations and PQI as well as the Director of Outpatient Services. The purpose is to ensure consistency with data entry, systems to monitor data, problem solve system challenges and create solutions that are applied consistently across all programs and departments, reporting and continual upkeep of the system and team for cross-training purposes.

Communication Results & Action Plan: Formal Quarterly Intake Reports are written by the respective Intake Coordinator. They are communicated via the Quarterly PQI Report, and include highlights of achievement with regard to systems changes, progress with implementation of electronic client system and 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 and Parent Council

Data Collection, Review & Analysis: Residents meet with the Residential Clinical Director and 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 a formal Parent Council, which saw success in 2019 and the principle will be expanded in 2020-2022 via inclusion in the Strategic Plan.
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 Director of Administration 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 a key 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.

A formal Affirmative Action Program is in place at the agency. It is implemented and monitored by the HR Manager and Director of Administration. It includes data collection, reporting and annual 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 COA survey tool, and survey groups (i.e. Employee/Intern, Manager/Supervisor, Consultants and Board) are utilized so we can 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 the PQI Specialist and Director of Operations and PQI.

The Leadership Team and Directors are used to solicit additional insight to the survey results, and Directors are tasked with action plans.

Communicating Results & Action Plan: The results are shared with all staff, interns, independent consultants, 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 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, Director of Operations and PQI, Director of Administration, Human Resources Manager and as of late 2019 the newly created Director of Information Technology and Chief Operating Officer employees. 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 monitor the Business Continuity Plan and Succession Plan. Other areas of potential risk are reviewed in the Critical Incident Review and Safety Committees.

Additionally, in late 2019, the first meeting of the Board Risk Subcommittee took place, which is designed to ensure active engagement and ongoing conversation with the Board relative to agency risks.

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/Risk 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 CERT/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 all programs and many support departments to help 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 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.

The committee works with the North Providence Police Department with regard to on-site lockdown and evacuation drills, as well as "Run, Hide, Fight" trainings. Beyond CERT/Safety activities, we work hard to maintain solid 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 Report. 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.

PQI Initiatives and Action Plans

Often, we formalize and implement a PQI Initiative or Action Plan. 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. One Initiative or Plan is spotlighted in the PQI Quarterly.

In 2020 Transformation, these will be called "Performance Initiatives" and will have a written monitoring and reporting structure. Measurable targets will be identified, and dashboard systems are under review so that we can introduce live time, efficient, simple and environmentally sound data through a centralized technology platform. See additional details in the Strategic Plan and Annual Plan of Work. The years 2020 – 2022 are significant years for the PQI process at the agency.

F. COMPLIANCE WITH EXTERNAL REGULATORY REQUIREMENTS AND OTHER EXTERNAL REVIEWS

External Review Area	Reviewer
All Residential Treatment Programs	RI DCYF
Additionally, for only ARTS Residential Treatment	NHP, UBH and BCBS Insurance Co.
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 (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 improvement projects
Back flow testing (annually)	Vendor
Kitchen Fire Suppression System	Vendor

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

The PQI process is continually under assessment and review. Changes continue to be introduced incrementally with respect for past systems while building on strengths. We value strengths based language, taking the time to be curious about why a target or goal was not met and empowering staff to try on their own with guidance. Assessment of PQI practices led to the ultimate dedicated FT staff resource which evidences leadership's commitment to PQI principles. We remain committed to compliance, best practices, efficiency, and strengthening of data for use in decision making. 2020 Transformations evidence our commitment to planning ahead.