Dear Board Members, Staff, Volunteers and Friends,

Sts. Joachim and Ann Care Service promotes a culture that values excellence and continual improvement. We are accredited by the Council on Accreditation (COA) and work hard on adhering to the established standards and accepted best practices. By integrating these standards into everything we do as an agency, we ensure that the service we provide is the highest quality, that our administration is efficient and accountable, and that our resources are fully committed to our mission to serve those in crisis and prevent homelessness and hunger.

Because we believe that quality improvement is so important, we have established a Performance and Quality Improvement (PQI) committee that is responsible for overseeing the full process which is detailed in our PQI Operational Plan. This plan describes how we gather information through many avenues including client surveys, case record reviews, staff satisfaction surveys, the Strategic Plan, and a review of incidents, accidents and grievances. After reviewing the collected data, we identify areas that need improvement and implement changes. We set goals and performance targets in our long and short term planning, and review and revise them annually. This is an ongoing process throughout the organization. The result of our client surveys, staff satisfaction surveys, and financial reports are communicated through the annual report. You can find our latest annual report, the Performance and Quality Improvement Plan, and our annual program survey results on our website, at www.jacares.org.

We are proud of the work our staff does every day helping families in our community get back on their feet. However, it takes all of us working together to really make a difference in the lives of those we serve. It takes a concerted effort to address areas of concern, offer suggestions for improvement, make a change to what isn't working well and celebrate the success of our efforts. We consider you an important part of the team, whether you are a board member, staff member, volunteer, donor, partnering agency, neighbor in our community, or our client. Your input is always valued. For this purpose, we invite you to offer any questions, suggestions or feedback you may have at suggestionbox@jacares.org. Thank you for being a part of this collaborative effort of helping those in need.

Sincerely,

Miriam Mahan

Miriam Mahan
Executive Director

Performance Quality Improvement (PQI) Operational Plan

I. Introduction

A. Care Service's Philosophy of PQI

The Care Service's Performance and Quality Improvement standards promote excellence and a culture that values efficient and effective delivery of services, as well as a commitment to the continual improvement of program service, performance and positive results. This is accomplished through both short-term and long-term planning, the systematic collection and review of service delivery data, and through continual efforts to communicate outcomes and recommendations.

The Care Service's leadership, including board members, executive team, staff members, volunteers and members of the community (our stakeholders), work together to identify strengths and areas of positive practice, and to communicate these achievements throughout the organization. Regular training and support are given to all staff in order to increase the capacity of the agency to sustain and improve performance and quality improvement activities.

The Care Service's PQI Plan not only defines the framework and function of the organization and its commitment to maintaining positive results, but also conveys the agency's dedication to excellence and continual improvement of all services. An example of this plan includes: analyzing quality improvement data from our stakeholders, evaluating program effectiveness, implementing and assessing needed improvements, and communicating findings and progress to staff, the Board of Directors, and the community.

.

B. PQI Structure

The PQI Flow Chart is a diagram that captures the performance and quality improvement mechanisms throughout the agency and the important components of the Care Service's improvement cycle:

- Flow of information is 2-way and transparent.
- Information is collected from all available sources, both internal and external.
- Service improvements are made based on data collection, evaluation and action.
- Overall evaluation is based on expectations and targets from strategic planning, program reports and service goals.

The PQI Flow Chart can be found at the end of this plan to understand how all parts of the organization are integrated into the PQI System.

PQI Committee Structure - The PQI committee consists of the members of our Executive Team: Executive Director, Director of Administration/PQI, Director of Development, Director of Operations, Director of Finance, and Director of Program Services.

C. Stakeholders

Definition of Stakeholders - The Care Service's stakeholders include the clients, volunteers, paid staff, Executive Team/PQI Committee, Board of Directors and partners in the community.

How stakeholders are involved in PQI

Clients
Feedback from clients and their family members is critical to the on-going evaluation of service provided by the agency. All Clients receive a statement of their rights during the interview process. Clients who are unhappy with their service are given a chance to file a formal grievance. Grievances are reviewed by the Executive Director, who decides if any action needs to be initiated and then seeks resolution with the client. In addition to this, regular phone surveys are conducted with a sample of our clients to receive feedback on service delivery. This feedback is assimilated into the Housing Survey Report that is shared with our Board of Directors, posted on our website, and also communicated in our Annual Report.

Volunteers
All volunteers are educated on the Care Service's philosophy of quality improvement during the orientation process. We stress the importance of open communication to volunteers and encourage them to share concerns when they see problems or areas that need improving. They are given a Volunteer Handbook in orientation which lets them know their rights, policies and procedures, and how to file a grievance. During performance reviews they are given a chance to speak of the challenges in their job and where they may need more help to do their jobs better. Regular interactions with the supervisor, informal meetings, and training opportunities also give them a chance to communicate their concerns. Annually, they are given Staff Satisfaction Surveys and are asked to comment on the strengths and weaknesses of the agency. Some of our volunteers are trained to audit case files. Their audits are passed on to the Housing Supervisor for review.

Paid Staff
Paid staff are given many opportunities to communicate feedback on the quality of service delivery: Monthly staff meetings, performance evaluations, annual Staff Satisfaction Surveys, regular informal meetings with the supervisor, and annual staff retreats. They are given an Employee Handbook which informs them of their rights, benefits, policies and procedures and how to file a grievance. Open communication with the staff is vital to the success of the Care Service. There are 13 standards that are maintained for our accreditation, and each standard has a committee which is led by a paid staff member. Most of the staff serve on one or more of the standard committees that meet quarterly.

Standard Leads/Committees
The Care Service is compliant with the following 13 standards: Behavior Support and Management, Case Management, Child and Family Development, Workforce Development, Clients Rights, Ethical, Finance, Governance, Human Resources, Training and Supervision, Risk Prevention and Management and Safety. Each standard has a committee responsible for ensuring that the agency implements and adheres to all components of their respective standards. Each standard is led by a staff member who is ultimately responsible for guiding the committee. The committees meet quarterly and are required to: review the standard thoroughly; watch for standard updates; suggest and implement changes; maintain written policies; procedures and training materials; report any incidents, accidents and grievances; and report any observed areas of risk.

Executive Team/PQI Committee
The Executive Team consists of the Directors from each department and includes the Executive Director. The Executive Team also serves as the PQI Committee. The departments are Finance, Operations, Programs, Development and Administration/Human Resources. With the direction of the Executive Director, the Executive Team is responsible for the implementation of the overall PQI plan and meets quarterly to review the PQI Standard, case file audits, critical incidents, and client surveys. The Executive Team is responsible for the overall implementation of policies and procedures, assisting the board with the development of the strategic plan, setting performance targets, evaluating program service delivery and disseminating information as needed throughout the agency.

Board of Directors
The Care Service is governed by a volunteer Board of Directors which meets monthly. Board members are brought in from the community and possess specific leadership and skill sets that help them lead the direction of the agency. A subcommittee of the board maintains the Governance Standard. Another sub-committee is the Policy Review committee which reviews, edits and approves new policies before they are instituted. The PQI Committee attends the monthly Board of Directors meetings and updates the board with financial reports, program reports, survey results and accidents, incidents and grievances report. The board also coordinates with the Executive Team in developing and updating the long term strategic plan.

Partners in the Community
Partnering agencies, grantors, and donors are all a part of our “Partners in the Community”. Grantors come to the Care Service site to conduct regular audits. All grantors require regular reporting feedback, which demonstrates compliance. We meet with many of the agencies and grantors in community forums, but for donors and the rest of the community at large, our website is an effective communication tool. On our website, we give stakeholders a chance to submit their own input using our suggestion box at suggestionbox@jacares.org. Our website contains information on the work we do in our community, upcoming events, financial information, Housing and Workforce Development survey results, the Annual Report and our Performance and Quality Operational Plan. Our partners are informed about our PQI Operational plan through the thank you letters to our donors, in the signatures of our e-mails and on our fax cover sheets. We publish our website address on our business cards, letterhead, and in many community publications.

II. Measures and Outcomes

A. Long-term Strategic Goals and Objectives

Every three years, the Care Service Board of Directors and Executive Team meet to conduct an organization-wide assessment of strengths, weaknesses, opportunities and threats (SWOT Analysis). From this analysis, a long term strategic plan is developed that identifies goals and objectives that flow from our mission. Updates and revisions are made annually to the current strategic plan. The goals and objectives clarify and confirm the vision and mission of the Care Service, assess human resource needs, and consider legal, regulatory, and funder mandates regarding measurement of outputs and outcomes.

B. Management/Operational Performance

The PQI Committee establishes a periodic review of essential management processes consistent with quality priorities. At each review, responsibilities are assigned to team members for implementation and timeframes are monitored for reporting results. (PQI 2.02d)

Possible management operations outcomes and data sources include (PQI 3.03):

- Financial Viability- Operational effectiveness and efficiency (FIN 5.06a)
- Workforce Stability- Staff retention and job satisfaction (HR 4.03)
- Safety and Security- Effectiveness of risk prevention measures (RPM 2.01)

C. Program Results/Service Delivery Quality

The PQI Committee establishes a periodic review of essential service delivery processes consistent with quality priorities. At each review, responsibilities are assigned to team member for implementation and timeframes.

Service delivery indicators influencing program results include (PQI 4.01):

- Accessibility of availability of services
- Timeliness and comprehensiveness of individualized assessments
- Safety precautions observed in service delivery
- Client respect and rapport

D. Client and Program Outcomes

Client and program outcomes are measured using reports from the client data tracking system, in home assessments, and phone surveys conducted by staff. Client outcomes measured include: change in functional status, permanence of life situation, behavior changes, health, welfare and safety.

III. PQI Operational Procedures

A. Data Collection and Aggregation, Analysis and Review

<u>Case Record Reviews</u>

- A quarterly review of approximately 10% of open and closed case records is done on an ongoing basis to evaluate the presence, clarity, quality and continuity of required documents. While a trained staff member does the review, the entire process is supervised by administration. The Executive Director is responsible for reviewing a small random sample of those files that were previously reviewed by a trained staff member.
- In order to review case records objectively, a Case Record Review Form is used for each file. Each form will show a case record identification number which will consist of the first initials of first/last name followed by the last four digits of the head of household's social security number.
- A trained staff member will check to see that all documentation/information listed on the Case Record Review Form is included in the case record. Some of the information is found in the paper file while other information will be found in an electronic data base (Bell Data).

- As the staff member goes through the Case Record Review Form, they will check the appropriate box next to each piece of documentation/information indicating whether it was complete or incomplete. If the documentation/information is found to be incomplete, then additional notes may be added in the note column further explaining the problem.
- Those case records that are found to have incomplete documentation/information will be listed on the Case Record Corrective Action Form. If corrective action is needed then the action will be listed on this form and any follow up information as well. This form will also contain an overview of the number of case records reviewed and the number that are complete and incomplete.
- A comment needs to be made in the Client Notes section of Bell Data stating that a review was done and any other information related to the review.
- The Executive Director is then given all completed forms (Case Record Review Form and Case Record Corrective Action Form). It is from these forms that the Executive Director will gather a small random sample of the files reviewed and will review them once again following the same process.
- Copies of the Case Record Review Forms and the Case Record Corrective Action Forms will be given to the Housing Supervisor for their information. The Executive Director will keep the original forms in a file to be reviewed at the next PQI committee meeting.
- Quarterly audit sample size will be based on total number of recipients of case management financial services from the previous quarter.
- The quarterly audit report will be completed within 45 days of the end of quarter. For example, for Quarter 2, April through June 30, report would be due by August 15.

Risk Prevention and Management (RPM) Review Procedure

In order to properly identify and reduce potential loss and liability of the Care Service, the RPM committee will meet quarterly to discuss the following areas of potential risk, evaluate RPM effectiveness and report to the Board of Directors regarding status of various RPM objectives.

The RPM committee is led by the Director of Operations and includes the Executive Director, Director of Administration, Director of Program Services, Facility Coordinator and Director of Finance. The internal assessment of overall risk that is to be completed annually will include the following areas:

1. compliance with legal requirements, including licensing and mandatory reporting laws, fiscal accountability, and governance; (FIN, GOV, ETH)
2. insurance and liability; (HR/TS)
3. health and safety, including use of facilities: (ASE)
4. contracting practices and compliance; (FIN, ETH)
5. staff training regarding areas of risk; (HR/TS, ASE)
6. volunteer roles and oversight; (HR/TS, CFD/CM)
7. research involving program participants and other clients' rights issues; (CR/BSM/ETH, CM/CFD)
8. security of information, including client confidentiality; (CR/BSM/ETH, CM/CFD, ASE, RPM)
9. financial risk; (FIN)
10. fundraising; (ETH)

11. conflict of interest; (GOV, HR/TS)
12. employment practices; and (HR/TS)
13. interagency collaborations (miscellaneous)

Each of the above listed items are linked to other COA standards and a calendar of quarterly meetings where these items will be discussed. Areas of risk identified at these meetings are forwarded to the RPM committee for inclusion at the quarterly meeting and in the Board of Directors report.

The quarterly RPM meeting includes a review of incidents, critical incidents, accidents, and grievances related to:

1. service modalities or other organizational practices that involve risk or limit freedom of choice;
2. facility safety issues;
3. situations where a person was determined to be a danger to himself/herself or others; and
4. serious illnesses, injuries, and deaths.

Any incident and accident that involves the threat of or actual harm, serious injuries, and deaths, will involve an extensive review of procedures to:

1. establish timeframes for investigation and review;
2. require solicitation of statements from all involved individuals;
3. ensure an independent review;
4. require timely implementation and documentation of all actions taken;
5. address ongoing monitoring if actions are required and determine their effectiveness; and
6. address applicable reporting requirements.

Client Satisfaction and Outcomes Data

For all of the clients who receive Case Management Services, the Care Service measures total number of recipients who receive direct payments for housing costs, authorized home repair(s) or emergency shelter based on certification/needs assessment. In addition, we measure costs per service provided and total cost provided to family/individual in our calendar years. These outcomes are measured through the client data tracking system (Bell Data). A case worker or trained phone operator attempts to contact recipients of the housing-related services within 6-12 months of payment. The case worker immediately notifies self as part of the Care Service and asks for participation in phone survey. All responses are noted and entire sample is provided to consultant to analyze. The percent of recipients living in an equally safe/secure residence at the follow-up and the percent of recipients able to maintain utility, rent, and mortgage payments long-term are calculated, in addition to the other assessment items noted on the Housing Follow-Up Survey. A summary report is used to discuss the need for program improvements or adjustments, and is completed annually. A similar survey of recipients is also done for the Workforce Development Program. The results from both surveys are posted on our website and shared in our Annual Report.

Operations and Management Data – The staff satisfaction survey is completed by paid staff and regular volunteers on an annual basis with a deadline of report completion for March. Data is captured with Microsoft Excel. The goal of this survey is to identify areas on which to focus improvement efforts in the upcoming year. The retention survey will be completed by February 28th of every year.

An independent audit is completed shortly after every fiscal year end. The results are presented to the Board of Directors by the auditors. The audit is then posted on our website for public viewing.

The PQI committee meets quarterly to review the following: all critical incidents that were filed in the quarter, Case Record Review Forms, feedback from surveys, corrective action completed and corrective action still needed.

B. Data Review and Analysis

All survey reports are reviewed by the PQI Committee. The reports are also disseminated to Directors and Program Coordinators to ensure that their feedback has been received and they have an opportunity to determine the need for change in program operations, service delivery or processes. These three points will be a part of the meeting agenda when reviewing PQI program/operation/management reports.

C. Communicating Results and Linking Data to Implementing Improvements

The PQI committee will discuss what survey and outcome results are to be included in the annual PQI report at the quarterly PQI meetings. As stated in the previous section, survey and outcome results will be regularly reviewed with the PQI committee for dissemination purposes. The Care Service seeks cooperation from multiple invested members of the community and staff. The committee will discuss ways to communicate PQI outcomes results in order to assure that all levels of the organization receive this information.

D. Assessment of the Effectiveness of the PQI Process

The effectiveness of the PQI process is ongoing as plans are implemented and outcomes and survey results are discussed at the quarterly PQI committee meetings. The results are shared in the Annual Report and are communicated to the Board of Directors, staff, volunteers and external stakeholders.

Sts. Joachim and Ann Care Service

Performance and Quality Improvement Flow Chart