Performance and Quality Improvement Plan for 2019

Section 1: Introduction and GVBR's Philosophy of PQI

Goshen Valley Foundation is a non-profit organization providing services to foster children in North Georgia. Located in Cherokee County, GA, the organization's flagship program, the Goshen Valley Boys Ranch, opened in 2001 caring for our first young man. The Foundation cares for foster children through three programs: Goshen Valley Boys Ranch, Goshen New Beginnings and Goshen Homes. The Boys Ranch program has the capacity to serve 47 young men, ages 11-18 in a family-model, group setting. The New Beginnings program provides independent living services to young men and women in foster care, ages 18-21, living in an apartment setting in Canton, GA. The Homes program provides foster homes for sibling sets that need to be reunified or remain together.

The Performance and Quality Improvement (PQI) program of Goshen Valley promotes excellence and continuous improvement in all programming in all of programs: Room Board Watchful Oversight Program, Independent Living Program and Child Placement Program. Goshen Valley, its Board of Trustees, CEO, Executive Directors and supervisory staff place top priority on Performance Quality Improvement and strive for excellence. Our Goshen Valley Foundation CEO endorses the collection and constructive use of data, which assists in evaluating every program, their services and all individuals and families served. In addition to regular evaluation and monitoring; planning, remediation, and improvement ensure our commitment to Performance Quality Improvement that creates a high-learning, high-performance, results-orientated environment.

Our PQI plan is broad and encompasses all employees, Board of Trustees and identified stakeholders. More specifically, all levels of staff will be involved in our PQI program through annual training, staff meetings, data collection, annual surveys and quarterly feedback opportunities. All stakeholders and referral sources participate in annual surveys and we specifically encourage this involvement and believe that the bottom up approach will benefit our organization as a whole. Lastly, our Board of Trustees works with the senior staff of each service area to develop a 3 Year Strategic Plan to identify long term goals as well as a yearly Operational Plan. Below is a diagram that illustrates the basic model for quality improvement.

Section 2: Stakeholders

A major facet of our PQI programming comes through continual interaction with our stakeholders. This provides us with an ongoing understanding of community and organizational needs, areas of improvement, understanding of community impact and collaborative ideas for the future. The following demonstrates our major stakeholders and how they engage in the PQI process.

Stakeholder Group: CLIENTS

Description: The clients served within our foundation are our primary stakeholder group. They consist of foster children, ages 11-21 who are recipients of residential care, independent living programming and child placement.

What data do they provide?

Clients provide the foundation with satisfaction data from annual and ongoing surveys. In addition, clients also provide outcome data through our program outcome measurement tools. Continuous feedback is received from clients through direct care staff and communicated at weekly staffing meetings.

What information do they receive?

Clients have access to our quarterly PQI reports and receive information that is specifically important to them in regards to any concerns or desired changes arising from feedback through posters updated in our office common areas.

Stakeholder Group: FOSTER PARENTS

Description: The Foster Parents and Respite Parents that serve children in our Goshen Homes program.

What data do they provide?

Foster parents provide general and overall program feedback in our annual survey. They provide specific, ongoing feedback to our program, processes and outcomes to their case managers on a weekly basis.

What information do they receive?

Foster parents have access to our quarterly PQI reports, annual PQI reports and the Foundation Annual Report.

Stakeholder Group: DIRECT CARE STAFF

Description: Direct Care staff include house parents, and life coaches that work in all three of our programs.

What data do they provide?

Direct Care staff provide overall program feedback in our annual survey and suggestions at any time throughout the year. They also provide important data that is used to analyze program outcome measures. This data is collected in the form of reports, weekly staffing meetings and weekly notes that pertain specifically to the clients. Finally, direct care staff are often included in PQI meetings, when possible, to provide insight into outcomes, tracking and new perspectives on information.

What information do they receive?

Direct Care staff have access to our quarterly PQI reports, annual PQI reports and the Foundation Annual Report. Direct Care staff also receive results of the annual staff and client surveys.

Stakeholder Group: PROGRAM & ADMINISTRATIVE STAFF

Description: Program and Administrative staff include positions relating to recreation, facilities, administration, development and interns.

What data do they provide?

Program and Administrative staff provide overall program feedback in our annual survey and suggestions at any time throughout the year. They might also provide data related to outcome measures within their particular area of involvement.

What information do they receive?

Program and Administrative staff have access to our quarterly PQI reports, annual PQI reports and the Foundation Annual Report. Direct Care staff also receive results of the annual staff and client surveys.

Stakeholder Group: EXECUTIVE AND MANAGEMENT STAFF

Description: Executive and Management Staff includes Executive Directors, Program Directors and any other supervisory staff.

What data do they provide?

Executive and Management staff provide overall program feedback in our annual survey and suggestions at any time throughout the year. They also provide reports on outcome data that are then

analyzed by the PQI team. The Executive and Management staff provide important information about suggestions received by Direct Care staff and new trends or mandates by oversight agencies. All Executive and Management staff are a part of the PQI team. They also provide program reports to the Board of Trustees and quarterly meetings.

What information do they receive?

Executive and Management staff have access to our quarterly PQI reports, annual PQI reports and the Foundation Annual Report. They also receive results of the annual staff surveys, client surveys and external stakeholder surveys. Executive and Management staff attend Board of Trustees meetings and receive all information that is pertinent to the organization at a board level.

Stakeholder Group: BOARD OF TRUSTEES

Description: The Board of Trustees includes all elected board members of the Goshen Valley Foundation

What data do they provide?

The Board of Directors completes an annual survey and provides feedback during quarterly board meetings. Feedback is also given informally during monthly information exchanges between executive staff and board members.

What information do they receive?

The Board of Directors receives quarterly PQI reports, annual PQI reports and the Foundation Annual Report. They see results to all staff, client and external stakeholder surveys. They receive all documentation pertaining to governing finances including the annual audit and 990. Any other governing or legal information is also received by the board at quarterly meetings or earlier if need be.

Stakeholder Group: REFERRAL & FORMAL PARTNERS

Description: Referral and Formal Partners include referral sources such as DFCS and DJJ, combination sources such as MAAC and CASA, and formalized partnerships or collaborations such as FFTA and Together Georgia.

What data do they provide?

Referral and Formal Partners provide annual survey data, quarterly feedback through strategic meetings and insight into community needs from a state perspective.

What information do they receive?

Referral and Formal Partners receive annual PQI reports and the Foundation Annual Report. They also receive any data that is specific to an important topic, trend or current legislation.

Stakeholder Group: COMMUNITY PARTNERS AND FUNDERS

Description: This group refers to any ongoing, two-way partnerships that involve community engagement and/or funding. Examples of this are area churches, businesses and civic groups that we have an ongoing relationship with, the United Way, invested individual donors and foundations.

What data do they provide?

Community Partners and Funders provide annual survey data and ongoing feedback from particular meetings or events.

What information do they receive?

Community Partners and Funders receive annual PQI reports and the Foundation Annual Report. They also receive any ongoing data that is specific to the impact of their relationship.

Stakeholder Group: VOLUNTEERS

Description: This group refers to any one-time, occasional or regular volunteers within the organization.

What data do they provide?

Volunteers provide annual survey data, one-time event survey data, and ongoing feedback for those who work with our organization at least once per month.

What information do they receive?

Volunteers receive annual PQI reports and the Foundation Annual Report. They also receive any ongoing data that is specific to the impact of their relationship.

Section 3 – PQI Infrastructure

The Goshen Valley Foundation initially developed infrastructure to support our PQI programming in 2011. Since then we have refined our team, our structure and our outcome measures to continue involving the entirety of our stakeholders as well as challenge ourselves in the area of outcomes and improvement.

The PQI Coordinator spends 30% of the time for this position working on the following activities:

- Organizing PQI schedule, meetings and deadlines
- Maintaining the PQI Committee Structure and recruiting additional members
- Working with the Board of Trustees, CEO and Executive Leadership to maintain involvement, feedback and data collection
- Analyze all data collected by programs and surveys
- Facilitate work committees
- Produce Quarterly and Annual PQI Reports
- Coordinate and execute annual maintenance of accreditation and reaccreditation every 4 years

The PQI Committee is comprised of the other following positions:

- CEO
- Executive Directors
- Program Directors
- Clinical Staff from each program area
- Direct Service Staff member from each program area
- Director of Administration
- Director of Risk and Analytics

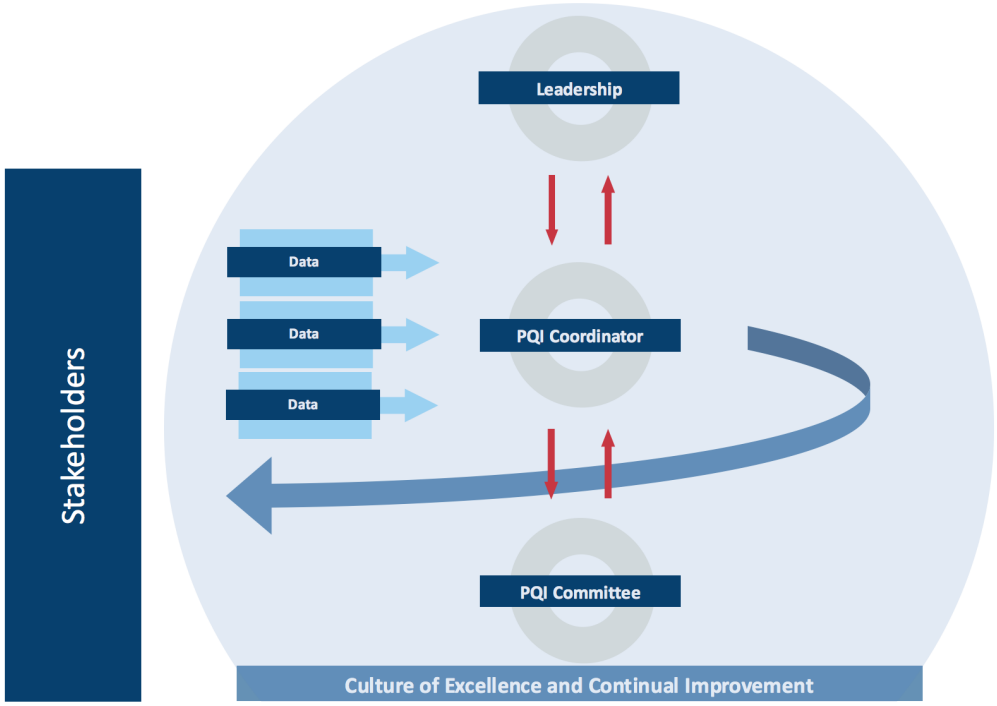
The PQI Committee meets on a quarterly basis with sub-committees meeting on a monthly basis. Sub-committees gather data to report to the larger PQI Committee and analyze trends in order to express trends or possible conclusions during the quarterly meetings. The sub-committees include:

- CIRT (Critical Incident Report Teams)
- Finance
- Development
- Program Quality Review Teams

The main activities conducted by the PQI committee include:

- Review of data analysis summaries to identify trends, strengths and weaknesses
- Review any survey data received from stakeholders in a given quarter and then implement any needed work groups to address areas in need of improvement
- Review improvement plans and the progress towards completion of any improvement plans
- Discuss any new trends or conclusions that may yield areas of further study.

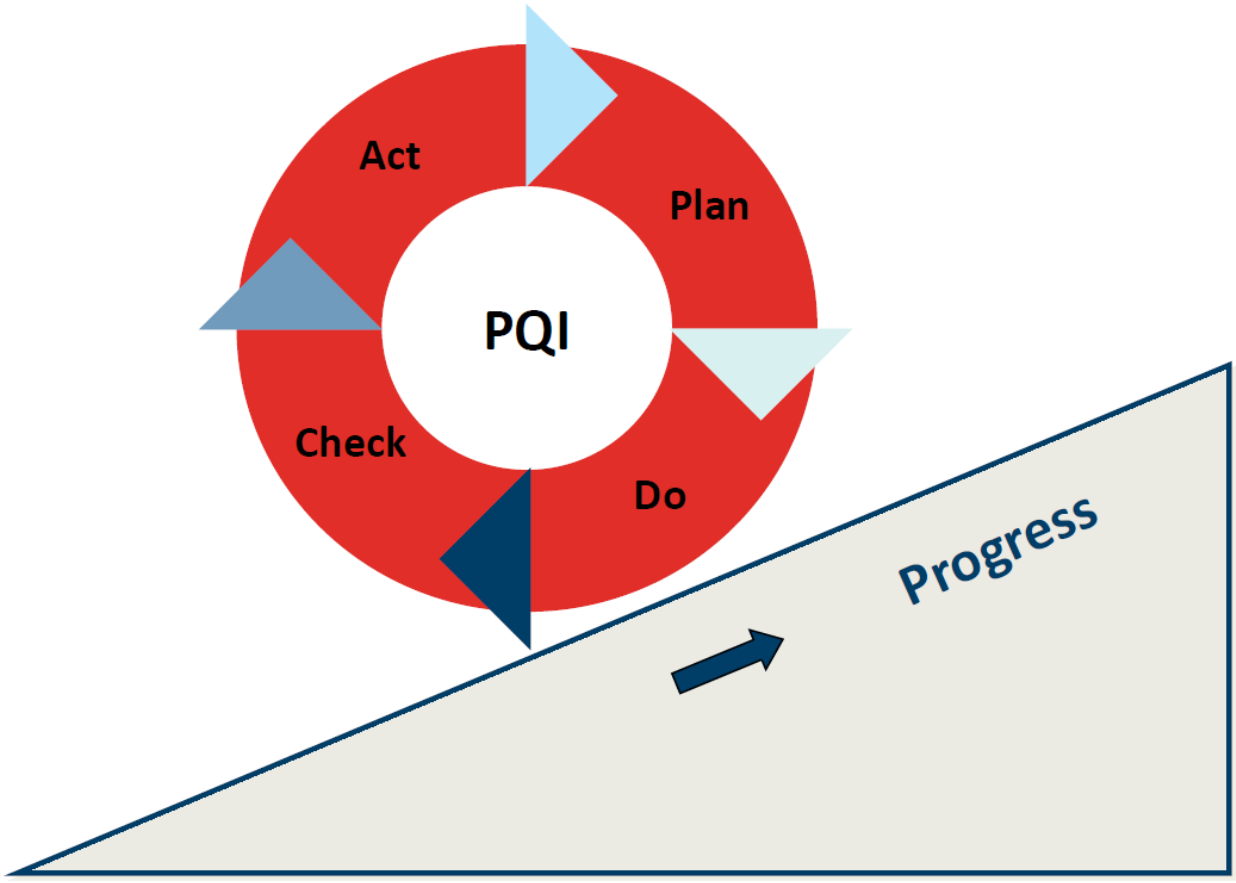
This is a chart that shows how information is exchanged within the infrastructure of the PQI Program, including all stakeholders, leadership and governance.



Data is first received by our stakeholders. It is filtered through the PQI Coordinator to assemble and present the data and findings, including strengths, weaknesses, opportunities and threats. The PQI Coordinator communicates this to the PQI Committee where much of the work is done to create improvements. The information is also communicated to the Board of Trustees in order to implement a fully cohesive improvement plan.

Section 4 – Change Model

If it has been determined that change is needed in any capacity, Goshen Valley utilizes the Plan, Do, Check and Act (PDCA) model.



This model helps us to scenarios in all programs and enviornments that may be in need of improvement. Any confidential information contianed within an improvement plan is only shared with those persons who are “need to know.”

PLAN: This phase allows us to fully identify what the problem or area of improvement is, create a list of data to be collected, persons involved and a timeline. We will identify goals, objectives and measurement outcomes to ensure that once the plan is enacted we are able to measure its success and address any byproducts of the plan.

DO: The proposed plan is put into motion with check-ins and monitoring from the team as stated in the improvement plan.

CHECK: In this phase, the work is reviewed for positive and negative aspects of the change put into place. The plan will be compared with set measurement outcomes and evaluated to determine efficacy.

ACT: We will make the determination if the change that was implemented was an improvement. If so, the change will be accepted and implemented. If it was not an improvement or the changed produced

highly negative byproducts, we will return to the previous mode of operation and implement the model of change again in order to develop a new plan for improvement.

Section 5 – Improvement Plans

An Improvement Plan will be implemented for the the following reasons:

1. When data colected through PQI indictaes an area of concern (opportunity, weakness or threat)
2. To increase administrative fuctions that need greater efficiency
3. Correct under-performing programs
4. Provide guidance to staff who's performance that is not meeting expectations
5. For successful programs that Goshen Valley would like to see grow or meet a new need
6. Increase involvement from the Board of Trustees

Improvement plans are helpful in the documentation and tracking of areas that need work and are not meant to be punitive. By having an ongoing improvement plan for our entire organization, we hope to demonstrate our dedication to a culture of improvement. Goshen Valley has established two types of improvement plans:

a. Proactive Improvement Plans – utilized when an area of improvement for a specific program or department based on observation or data, an incident requiring change has not taken place
b. Corrective Action Improvement Plans – implemented when there has been an issue, audit result or incident and action must take place to address the problem

Improvement plans follow these guidelines:

- Must address an area of opportunitiy not simply a part of of the normal expectations, unless expectations are not being met
- Must have a noted beginning and end
- Must be measurable

Section 6 – Areas of Measurment

Data is collected from several sources in regards to the 3 major programs, Goshen Valley Boys Ranch, Goshen New Beginnings and Goshen Homes, and our Administration and Finance including:

A. Peer Record Review (all Programs) is conducted at least bi-annually to analyze and evaluate clarity, content and continuity of open records to determine compliance with DHS, OPM and ORCC regulations and standards. A sample of records will be reviewed before audits by OPM and ORCC. The PQI assistants or designees will then aggregate data and the COA Coordinator will analyze it.

B. Records Review (all Programs) will be conducted quarterly to evaluate the presence, clarity, quality and continuity of required documents using a uniform standard of care. The standard of care will assist in determining the completeness of each file. The PQI Coordinator or designee will review records collectively and will notify the Human Service Professionals and the Executive Director of any deficiencies. Data will then be aggregated. Deficiencies will be remedied within a reasonable time period. The Executive Director and the case management team will identify any needed organizational improvements. Each year, the Records Review audit form will become increasingly more detailed while the goal of 90% will remain in-tact for all service areas.

C. Safety Audits (all Operations) are completed monthly by the Facility and Safety Compliance Officers. This includes an environmental/physical plant audit. The officer will use a Facility Standard of Care, which reviews safety issues in the home and vehicles. Review of medication administration and storage are examined. Compliance officer will report findings to the Executive Director during routine PQI meetings. Data is compiled and used to determine where improvements need to be made.

D. RPM Risk Assessment (all Operations) is completed by the CEO or designee. We will gather information on all incident reports, manual restraints, behavior management practices, medication, child grievances, and accidents.

    a. Incident reports will be collected regarding the total number of incidents, number of incidents reported to OPM and ORCC, number of incidents per house, number of incidents per individual staff, and follow up actions taken.

        i. Trends of incident reports (internal and externally reported) will be analyzed each quarter and annually to assess any organizational or program changes to be made.

    b. Manual Restraints will be collected regarding total number used, number of restraints per house, number of incident per individual staff. We strive to be a restraint free organization and will use a restraint only as a last resort.

    c. Behavior Management practices are evaluated by reviewing progress notes and personnel interviews.

    d. Medication is reviewed through the safety audits, which are conducted every month.

    e. Client grievances are submitted according to GVBR policies and are reviewed by the Executive Director.

    f. Accidents of all types are reviewed and documented in incident reports.

E. Internal Evaluations

a. Employee satisfaction surveys are dispensed annually. A non-standardized satisfaction survey is completed. Components of the survey include: communication, compensation, respect for employees and staff satisfaction.

    i. Survey questions will be evaluated and re-written every 3 years

    ii. Supervisory meetings will be held to review surveys and create a plan of action for any needed change

b. Staff grievances: The Goshen Valley Foundation Administrative Director addresses staff grievances according to policy. At quarterly PQI meetings she submits unidentified staff grievances. Discussion takes place and trends are analyzed and recommendations are made.

c. Stakeholder surveys are conducted annually to solicit input from the broader community on the quality of the agency and how to improve. Stakeholders are defined as DFCS SSCM, CASA workers, DHS personnel and other referring agents. Components of the survey include a review of the organizations overall performance.

    i. An incentive plan will be developed for Stakeholder Surveys due to low return rates in previous years.

d. Financial Review: The Board Chair and Executive Director review the budget each year to establish financial viability and ascertain patterns/trends indicating a need for action. Reviews of Monthly P&L are conducted by our Administrative Director.

e. HR reviews: The administrative director audits all personnel files. She collects data on staff retentions and administers a staff exit survey. The staff exit survey components include: reason for leaving, job satisfaction, respect, communication.

f. Client satisfaction surveys: Client's and their families when possible fill out satisfaction surveys yearly.

g. Operational Plan Reviews: Each quarter prior to PQI meetings, the Executive Director will meet with the ED of each service area in order to evaluate and track progress of Operational Plan goals. This information will be submitted at PQI meetings and any key highlights will be discussed in group setting.

h. Adherence to and implementation of all Evidence Based Practice Models

i. Staff training and effectiveness

j. Utilization of assessments in measuring creating plans and measuring progress

F. External Evaluations

a. Office of Provider Management is a monitoring agency appointed by DHS. The Office conducts annual audits on our RBWO program. The Executive Director and other personnel attend the exit interview. This information is reviewed and integrated in our PQI annual report.

b. Office of Residential Child Care conducts annual audits. The Executive Director and other personnel attend the exit Interview. This information is reviewed and integrated in our PQI annual report.

c. Financial Audits: An accredited independent certified public accounting firm conducts an annual audit. To assure that we are financially accountable. Proper accounting practices. An annual cost report is created by our Administrative Director. DHS uses the cost report to view all of our child care costs. In addition TANF requires a yearly audit.

G. Client Outcomes:

a. GPA , grades and life-skills/vocation will be collected each semester. They will be charted and reviewed against previous years and semester to analyze trends.

b. Length of stay's and discharge outcomes assess permanency trends. This will allow us to track client outcomes related to permanency.

H. Intake Outcomes:

a. The Intake Coordinator will report quarterly on current census demographics by county.

b. Discharges will be compared to intake interview score.

c. Intake strategy is discussed in reference to projected discharges in order to remain full with appropriate placements.

I. Therapeutic Engagement:

a. Director of Clinical Services will report on progress made in processes and communication of all clinical matters.

b. Strategy for integrating results of counseling and psychiatry appointments into house parenting strategies will be tracked and added to the overall case plans for each resident.

c. Trauma Score language will be integrated into all parts of care including initial intake, behavior management, academic performance and overall case plan.