HURON-PERTH CENTRE
strengthening individuals & families since 1977

Quality Improvement Report 2018

Annual Report for April 1st, 2018 – March 31st, 2019

Prepared by: Heather Becker, Interim Quality Improvement Manager
In consultation with the Quality Improvement Committee

Shared with Management Team April 11, 2019
Presented to HPC Board of Directors April 11, 2019 for acceptance

Executive Summary:

The Quality Improvement Report for 2018 has been prepared using the current policy as a framework. During 2018 the Quality Improvement Committee has operationalized a new framework to measure against our definition of quality:

"Quality is the degree of excellence related to all aspects of agency functioning as reflected in our Mission Statement. This includes, but is not limited to, overall child, youth and/or family experience; treatment provision delivered by a skilled and competent multidisciplinary team; strong collaborative relationships with community partners and a learning environment that cultivates innovation and evidence-informed practice that leads to positive outcomes. In addition, quality will be maintained through effective use and reporting of public funds and in compliance with accreditation standards."

In following with recommendations from 2017 annual Quality Improvement Report, a number of changes have been made to enable the organization to be more responsive to information that can inform service improvements including:

- Timelines for reporting were shifted to align from the calendar year to the fiscal year as with other organizational reporting.
- The development of the Quality Plan by operationalizing the various aspects or dimensions contained within the Quality procedure. **See Appendix A**
- Quarterly Quality Improvement reports were generated every quarter using the new framework. The period of January 1st 2018 – March 31st, 2018 was used to pilot the new Quality Plan as well as pilot the new quarterly Quality Improvement reports. These reports were shared out to Board and staff each quarter.

This annual report is a culmination of these quarterly reports. For the purposes of this annual report, it will capture data from April 1, 2018 through March 31st, 2019.

During the year Management made the decision to shift the role of Quality Improvement Manager to a staff led leadership role hence the title change from QI Manager to QI Lead. "Quality is in all we do", so I look forward to continuing in the Quality Improvement role as the agency continues to learn and grow in capacity and ability.

On behalf of the Quality Improvement Committee, we present the 2018 Annual Quality Improvement report. It is the culmination of the quarterly reports that has generated this annual report which allows us to reflect on:

- **Progress made/celebration of accomplishments**: clients received first call to initiate services within stated 5 day goal, evidence of a 'good range of services' offered to clients (across all programs), client surveys indicate high rate of satisfaction with services, visible collaboration with community partners, treatment planning with clients was visible at case level, best practices indicated on screening notes and on time sheets and clients show improvements/positive experience after service involvement. It is also impressive that we fully achieved all recommendations noted for action in 2018.
- **Recommendations for improvement:** Improve the quality of data collection used to measure indicators of quality dimensions within the Quality Plan 2019 by providing necessary staff training re: ministry data collection and implementing reporting of indirect service time, implementing interRAI (standardized assessment tool), developing a Performance Measurement Project for all programs

~ Heather Becker, Quality Improvement Lead

THE CENTRE'S POLICY STATEMENT ON QUALITY IMPROVEMENT:

"The Centre will maintain a commitment to the quality of services provided to the community through a variety of processes to promote continuous improvement. The CEO will ensure that there are defined processes to promote quality, improvement and address any issues of quality that may be identified. A Quality Improvement Report will be provided to the Board on an annual basis and will include a summary of all quality assurance activities, any actions taken for continuous improvement and recommendations for future actions."

The following information provides a summary of Quality Improvement processes/activities that occurred in 2018 to promote continuous improvement:

- **Quality Improvement Committee (QIC)** - QIC oversees various activities related to continuous improvement and documents any actions taken that relate to Quality Improvement activities, whether they are led by QIC or externally driven by other opportunities to conduct various activities related to quality. A change in leadership occurred in November 2018 when Amanda MacDonald requested a leave of absence from the QI role. Heather Becker serviced as Interim Quality Improvement Manager and has since accepted an ongoing Quality role as Quality Improvement Lead as of April 1, 2019.

QIC Membership:

- Heather Becker, Huron Counsellor, QIC Lead
- Terri Sparling, CEO
- Cheryl Priestap, IT Support
- Rosemary Nicholson, Perth Counsellor
- Jill Carter, Perth Counsellor
- Mary McInnes, Perth Counsellor (currently on leave from HPC)
- Michelle Evans, Executive Assistant
- Shirley Brooker, Perth Counsellor (left committee March 2019)
- Julie Webster-Waldie, Huron-Perth Child and Youth Worker (left committee January 2019)
- Cathy Graham, Huron Clinical Services Manager
- Jennifer Azzano, Perth Clinical Services Manager
- Val Millson, Huron-Perth Clinical Services Manager for Partnerships & Protocols

In 2018-2019, the Quality Improvement Committee met on the following dates: January 16, March 20, June 12, September 11, November 20, 2018 and January 23, 2019. The Centre for Excellence played an integral role for the HPC in 2018, offering consultation regarding the implementation of quarterly Quality Improvement Plans. During the year new procedures were developed in order to operationalize the quality definition. These processes promote continuous improvement including but not limited to: Quality Improvement Committee, Client Satisfaction Surveys, Community Consultations, Complaint Procedure, File Audits, Performance Evaluation and Program Reviews.

For the full procedure. **See Appendix A**.

- **Client Satisfaction Surveys –** surveys are a key way for us to engage children, youth and families to evaluate effectiveness of services, measure positive outcomes and solicit feedback about services. Clients can offer comments at any point in service delivery through tablets in waiting rooms, survey link on the website, paper submission. Overall we have had a significant increase in surveys and this data provides measurement for a

number of quality dimensions including range of services, child/youth & family engagement, skilled team and collaboration with clients. In 2018, 203 client surveys were completed and reviewed (this includes the client satisfaction survey, TA survey and testimonials), this is a 33% increase from 2017.

- **Community Consultations -** the last community partner survey occurred in Jan 2017 and we have continued to work through on the actions (insert). Plans are underway to send out another community partner survey in June 2019.

- **Complaint Procedure –** Information about the complaint procedure is provided in the Client Handbook and on the website. During 2018 there was one formal complaint related to a consulting professional. Follow up occurred with the client but no action was taken with the professional who no longer provides ongoing services.

  Serious Occurrences - Between April 1, 2018 and March 31, 2019, there were 9 Serious Occurrence Reports (SOR), most of which occurred in the last quarter (Jan-March 2019). During this period we gained new information and interpretation from Avon Maitland District School Board (AMDSB) regarding Behaviour Management System (BMS) that is used in the Care and Treatment Classroom. In consultation with the Ministry all uses of containment will be documented and reported as a SOR, consistent with the changes in the Child, Youth and Family Services Act. This will result in an increase in SORs going forward and should provide a new baseline, currently related to 1 of 2 sites.

- **File Audits -** File audits were conducted during two periods of time: 25% of Child & Youth Mental Health (CYMH) files were audited between August and December 2018, and 25% in CYMH were completed between February and March 2019. The audits indicated a number of areas for correction. Each time key issues were identified and recommendations made to managers. The audit process highlighted that fully electronic files were much easier to review and there is some consideration being given to reduce the number of files that have a combination of both hard copy and electronic reports. A new procedure for File Audits has been developed and the data from audits provides some measurement for the quality dimensions related to range of services, effective use of resources, child/youth & family engagement, skilled staff and collaboration with clients.

- **Performance Evaluation -** we continue to value providing performance reviews on an annual basis. While we continue to struggle to meet this goal, staff receive verbal feedback in a number of ways. 73% of performance reviews were completed within the last year providing measurement for the quality dimension of skilled staff.

- **Program Reviews** – a number of services/service components have received some form of review process throughout 2018. We are examining our procedure and the Program Review Form to ensure we can comply with this process and the accreditation standard as defined by Canadian Centre for Accreditation (CCA). The data from program reviews provide some measurement for the quality dimensions related to timely response, range of services, effective use of resources and positive outcomes.

<u>Progress on Recommendations for 2018</u> – See Appendix B

1. Establish written procedures to operationalize the new definition of quality - **COMPLETED**

2. Implement the Quality Improvement Plan (QIP) for 2018-2019 – **COMPLETED**

3. Provide quarterly reports on the status of the QIP in dashboard format to staff and board **– SEMI- COMPLETED;**

4. Implement and establish a communication plan to support the implementation of the Quality Improvement Plan – **COMPLETED**

Fiscal Year Quality Plan (Q1-Q4) April 1, 2018 – March 31, 2019

Summary of progress/data on quality dimensions as per Quality Plan 2018. **See Appendix C**

TIMELY RESPONSE: Throughout the fiscal year, the average number of days a family waited to hear from a TA clinician was 4.8 days which meets the goal of clients receiving call within 5 days. Despite some times where there was high volume, staffing shifts, we were still able to maintain our goal.

RANGE OF SERVICES: An impressive amount of services were offered to clients in all programs that ensured HPC offered a range of interventions in all programs. EMHware reports demonstrated amount of intervention by program – number of activities and number of hours spent providing interventions to children/youth and families (ie. individual counselling, family counselling, phone contact, groups, case conferences/coordinated meetings, Psychological assessment & consultation and Tele-Mental Health assessments.

EFFECTIVE USE OF RESOURCES: Committees are all reviewing membership and meeting frequency in an effort to formalize for 2019-20; all staff have been actively using V/C as a way to save time/reduce travel and the booking system is well used/demonstrates high use particularly since bandwidth has been increased. An implementation plan to track indirect service hours is in process for Q1 2019-2020. The PD procedure has been revised based on the recommendations of the PD committee. Clearer definition of PD opportunities as well as limits on amount of time spent in PD have been defined.

CHILD/YOUTH & FAMILY ENGAGEMENT: Youth Engagement (YE): Youth Engagement (YE): YE group continue to focus on advocacy through Mental Health fairs and Children's Mental Health Week activities. This year, they created a work plan, had a social media presence and extended YE to both Huron and Perth counties. Through the year, the YE group created/modified and updated YE procedures. They also attend a Disable the Label meeting in Toronto.

Family Engagement (FE): A small core of families met to provide input into the new strategic plan resulting in the pillar "where the voices of children, youth and families matter". The plan was approved and we began to develop a strategy based on an organization-wide survey regarding readiness. The board and management attended orientation sessions on key concepts in family engagement. On the advice of staff we delayed staff education until there was a concrete strategy and implementation plan. We worked to build the core group of parents through two more sessions and this resulted in interest to explore the Family Advisory Council (FAC), a structure to facilitate ongoing engagement for system design and improvement and the group is keen to have their voices influence changes to the service system in Huron and Perth. The group stays connected through email and next steps include a presentation from parents from Sarnia who have implemented a FAC.

SKILLED STAFF: Hiring practices reflected that 100% of counsellors are registered with a College and that future CYW hires meet minimum requirements. Currently, there is training being developed for staff to track indirect service time. Individual supervision and team screenings (client specific) will be captured. There was time spent by CSM's to ensure that newly hired staff and placement students had an appropriate amount of orientation and supervision/mentoring.

LEARNING ENVIRONMENT: Based on the advice of the PD Committee management has deliberated on changes to the PD procedure in order to provide greater clarity on the range and scope of activities for individuals and Centre-wide training balanced between the need for effective use of resources and importance of cultivating a learning environment that supports staff to deliver effective services to clients. The new procedure will be implemented in April 2019.

COLLABORATION WITH CLIENTS: Upon case closure, or at any point during services, clients can complete a satisfaction questionnaire. Clients can access either the Client Satisfaction Survey or the Timely Access Survey in paper copy, on the tablet in wait rooms or by using a website link. There are other surveys in development re: school based services and will be reviewed by teams and then collected/reported on each quarter in the quarterly Quality Improvement plan.

Fiscal total Clients Satisfaction Surveys = 120 Fiscal total Timely Access = 81. Survey's showed that clients felt that services were mostly good/excellent, that most of their needs were met, would recommend HPC services to others and that they were generally aware of next steps in service.

COLLABORATION WITH COMMUNITY: QI Manager receives File Action Checklist's (FAC) upon case closure and reviews each quarter to ensure letter has been mailed to community partners (if applicable) or made note of the details of the contact with client upon closing. Of note, this area will see an increase in the next fiscal year as staff begin to enter indirect/client related activities in the database. Fiscal External Consultations (all programs selected – data needs further examination). We recognize that there will be inconsistency in the data below and will not be used as solid baseline as indirect hours are not recorded consistently. Logging indirect time is an area of growth for the 2019/2020 fiscal year.
Total number of external contacts = 2879 and Total number of external contact hours = 644

<u>Recommendations for Quality Improvement in 2019 as per QIC</u>:

1) Improve the quality of data collection used to measure indicators of quality dimensions within the Quality Plan 2019 by:
    a. Providing staff training on changes to EMHWare as it relates to ministry data collection, evidence of consents to share information
    b. Implementing reporting of indirect service time

2) Implement interRAI, the standardized assessment tool recommended by Lead Agencies

3) Develop a Performance Measurement Project for Counselling & Therapy

<u>QUALITY PLAN April 1, 2019 – March 31, 2020</u>

The Quality Plan for 2019 was developed by the QIC. **See Appendix D**

SECTION – QUALITY IMPROVEMENT OF SERVICES

Procedure Name **QUALITY IMPROVEMENT**

Procedure Number:	4.60.10
Approval Date:	February 6, 2019
Previous Amendment:	August 13, 2015
Procedure Sponsor:	Quality Improvement Committee: Heather Becker, Amanda MacDonald, Cathy Graham, Terri Sparling, Jill Carter, Mary McInnes, Rosemary Nicholson, Michelle Evans, Sarah Anderson, Shirley Brooker
Authority:	Management
Contact:	CEO, Terri Sparling
Review Date:	On or before February 2023

Purpose of Procedure: To outline the process on how we maintain a commitment to quality in all our services.

Definitions:

Quality Improvement Committee:

The Quality Improvement Committee assumes responsibility for formally reviewing issues that relate to the overall quality of services delivered. The committee is comprised of a cross-section of staff whose members hold the following attributes and/or skills:

- Interest in Quality Improvement and continuous improvement
- Knowledge or experience in evidence-informed, evidence-based and promising practice approaches
- Representation from Administrative Support, Direct Service and Management and access to psychology research skills through consultation or purchase of service
- 2 year term with renewal

Quality: Quality is the degree of excellence related to all aspects of agency functioning as reflected in our Mission Statement. This includes, but is not limited to, overall child, youth and/or family experience; treatment provision delivered by a skilled and competent multi-disciplinary team; strong collaborative relationships with community partners and learning environment that cultivates innovation and evidence-informed practice that leads to positive outcomes for children, youth and families. In addition, quality will be maintained through effective use and reporting of public funds and in compliance with accreditation standards."

1. The Centre will maintain a commitment to the quality of services provided to the community and will ensure that there are a variety of processes to promote continuous improvement including but not limited to: Quality Improvement Committee, Client Satisfaction Surveys, Community Consultations, Complaint Procedure, File Audits, Performance Evaluation, Program Reviews all of which have individual defined procedures to ensure

consistent application.

2. The Centre will maintain a Quality Improvement Committee that provides leadership to the development of an annual Quality Plan and monitoring of the plan through a Quarterly report that identifies indicators to measure progress, reports on progress and identifies or continuous improvement projects and other recommendations.

3. The Quality Improvement Committee is comprised of a cross-section of staff whose members hold the following attributes and/or skills:
    - Interest in Quality Improvement and continuous improvement
    - Knowledge or experience in evidence-informed, evidence-based and promising practice approaches
    - Representation from Administrative Support, Direct Service and Management and access to psychology research skills through consultation or purchase of service
    - 2 year term with renewal

4. The Quality Improvement Committee will be led by a representative from the Management Team/designate and will convene the meeting at minimum four times per year, times to be aligned with the preparation of the Quarterly Report and Annual Quality Improvement Report:
    - Quarter 1 (April-June) – Aug/Sept with report to go to Sept Board meeting
    - Quarter 2 (July-Sept) – Oct with report to go to Nov Board meeting
    - Quarter 3 (Oct-Dec) - Jan with report to go to Feb Board meeting
    - Annual Report – April with report to go to May Board meeting

5. The Quarterly Reports and Annual Report will be developed in consultation with Management team, Administrative Support Staff responsible for data and will be reviewed by the Quality Improvement Committee and shared with Management, Board and Staff.

6. The CEO prepares an Annual Report for distribution at the time of the Annual General Meeting which offers key information derived from the more detailed annual Quality Improvement Report. This would include summary information about key findings on Quality Improvement initiatives, any changes to service delivery that relate to quality of service and responsiveness to client need. Copies of this report are available on our website and shared with the Children and Youth Mental Health Network. Key findings may also be shared in various communications to community partners and youth and family members

Applicable Legislation and Regulations

Related References, Policies, Procedures and Forms
4.60.10.10 Client Satisfaction Surveys
4.60.08 Community Consultations
4.60.09 Complaint Procedure
4.60.15 File Audits
4.43.45 Performance Reviews

History
September 25, 2014
August 13, 2015

Progress on 2018 Recommendations:

R *Considerable slippage and a significant risk that the completion date will not be met*

A *A possibility of some slippage but the issues are being dealt with*

G *On track and should be completed by the target date*

1. G	**Establish written procedures to operationalize the new definition of quality.**
Achievements over this period	
COMPLETE: The revision of the procedures took place throughout 2018 to align with the new Quality Improvement Plan (QIP). See Appendix A.	
2. G	**Implement the Quality Improvement Plan (QIP) for 2018-2019**
Achievements over this period	
COMPLETE: The Quality Plan has provided a comprehensive framework built around our new quality definition with increased use of data to measure success. Quarterly Reports have provided more timely feedback and opportunity to make in-year improvements.	
3. A	**Provide quarterly reports on the status of the QIP in dashboard format to staff and board**
Achievements over this period	
SEMI-COMPLETE: Quarterly reports were provided but not yet in a dashboard format	
4. G	**Implement and establish a communication plan to support the implementation of the QIP.**
Achievements over this period	
COMPLETE: QI Lead with QIC Committee prepares the report that is then shared with Management, Board and staff. Data is also shared with the community via the Huron Perth Child & Youth Mental Health Network and the Centre's Annual Report at the Annual General Meeting.	

Quality Plan (Fiscal Year) – Reporting Period - April 1, 2018 – March 31, 2019

HPC Definition of Quality – ***"Quality is the degree of excellence related to all aspects of agency functioning as reflected in our Mission Statement. This includes, but is not limited to, overall child, youth and/or family experience; treatment provision delivered by a skilled and competent multi-disciplinary team; strong collaborative relationships with community partners and learning environment that cultivates innovation and evidence-informed practice that leads to positive outcomes for children, youth and families. In addition, quality will be maintained through effective use and reporting of public funds and in compliance with accreditation standards"***

Quarterly reports will go to management and Board at this interval Q1 – Sept; Q2 – Nov; Q3 – Feb; Q4 – April. Annual report will be provided in April.

<table>
<tr><th>QUALITY DIMENSION</th><th>GOAL</th><th>INDICATOR</th><th>PROGRESS</th></tr>
<tr><td>TIMELY RESPONSE</td><td>Provide a timely response for all services; within 5 days of client call for Timely Access*</td><td>EMHware quarterly reports data will demonstrate response time for clinician contact.</td><td>Throughout the fiscal year, the average number of days a family waited to hear from a TA clinician was 4.8 days which meets the goal of clients receiving call within 5 days. Despite some times where there was high volume, staffing shifts, we were still able to maintain our goal.</td></tr>
<tr><td>RANGE OF SERVICES (programs)</td><td>To ensure that HPC offers a range of interventions in all programs

Provide education to Psychologist regarding new data requirements</td><td>EMHware reports will demonstrate amount of interventions by program that clinicians provide to children, youth and families in the following categories:
*Data is recorded by amount of activities, followed by amount of hours spent completing activities (ie. Individual Counseling – 1783 activities/1320 hrs)
•Individual
•Family
•Phone contact with client
•Group (TG= Trauma/ AS – Adolescence Skills)
•Case Conference/Coordination /mtgs (client present)
•Psychological Assessment/ Consultations
•Tele-Mental Health Assessment (TMA)</td><td>
<table>
<tr><th>Activity</th><th>C&T</th><th>TA</th><th>Inten</th><th>YJMH</th><th>YJCS</th><th>YJD</th><th>YJC-P</th><th>AMDSB</th><th>HPCDSB</th><th>CCSCC</th><th>VAW</th><th>Delta</th></tr>
<tr><td>Ind Counselling</td><td>1783/
1320</td><td>406/
313</td><td>142/
138</td><td>205/
94</td><td>29/
29</td><td>178/
143</td><td>10court/
30hrs</td><td>898/
352</td><td>803/
406</td><td>51/
34</td><td>175/154</td><td>N/A</td></tr>
<tr><td>Family Counselling</td><td>2161/
1691</td><td>822/
689</td><td>176/
166</td><td>52/
45</td><td>13/
12</td><td>37/
34</td><td>.5hrs</td><td>82/
37</td><td>30/
22</td><td>38/
39
Bio&
foster</td><td>N/A</td><td>N/A</td></tr>
<tr><td>P/C with client</td><td>1908/
375</td><td>2083/
292</td><td>119/23</td><td>271/
96</td><td>10/
2</td><td>91/
18</td><td>16/
6</td><td>1/
.5hrs</td><td>157/
35</td><td>74/
15</td><td>82/
27</td><td>23
partner calls</td></tr>
<tr><td>Group Counselling</td><td>34sess
TPG,AS
93hrs</td><td>6sess
AS
9hrs</td><td>5ses
6hrs</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>39gr

156hrs</td><td>39new members
(27men
12women)</td></tr>
<tr><td>Case Conf/coord mtgs</td><td>445/
471hrs</td><td>72/
92</td><td>79/
65</td><td>79/
65</td><td>5/
6</td><td>5/
4hrs</td><td>12YJC
8.5hrs</td><td>11/
13</td><td>38/
43</td><td>107/
88</td><td>N/A</td><td>N/A</td></tr>
<tr><td>TMA</td><td>30/
56hrs</td><td>3/
6hrs</td><td>2/
4hrs</td><td>2/
4hrs</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Psych Consult/Assessment</td><td>150
activities</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>TOTALS: Activity/ Hrs</td><td>6511/
4006</td><td>3392/
1401</td><td>523/
402</td><td>609/
304</td><td>57/
49</td><td>311/
199</td><td>38/
45</td><td>992/
403</td><td>1028/
506</td><td>207/
176</td><td>296/
156</td><td>62
activities</td></tr>
</table>
</td></tr>
<tr><td>EFFECTIVE USE OF RESOURCES</td><td>Maximize staff time to provide direct service to clients</td><td>EMHware reports count indirect service time</td><td>Committees are all reviewing membership and meeting frequency in an effort to formalize for 2019-20; all staff have been actively using video conference as a way to save time/reduce travel and the booking system is well used/demonstrates high use particularly since bandwidth has been increased. An implementation plan to track indirect service hours is in process for</td></tr>
</table>

QUALITY DIMENSION	GOAL	INDICATOR	PROGRESS
			Q1 2019-2020. The PD procedure has been revised based on the recommendations of the PD committee. Clearer definition of PD opportunities as well as limits on amount of time spent in PD have been defined.
CHILD/YOUTH & FAMILY ENGAGEMENT	Integrate client feedback into both service experience and service delivery planning	EMHware reporting & Survey Monkey	Upon case closure, or at any point during services, clients can complete a satisfaction questionnaire. Clients can access either the Client Satisfaction Survey or the Timely Access Survey in paper copy, on the tablet in wait rooms or by using a weblink. There are other survey's in development re: school based services and will be reviewed by teams and then collected/reported on each quarter in the quarterly Quality Improvement plan. Fiscal total Clients Satisfaction Surveys = 120 Fiscal total Timely Access = 81. Survey's showed that clients felt that services were mostly good/excellent, that most of their needs were met, would recommend HPC services to others and that they were generally aware of next steps in service. Client Surveys – Clients were offered either a Client Satisfaction Questionnaire or Timely Access Survey at the end of service. The FAC reminds staff to send the survey's to clients if they weren't completed in person. **Fiscal total Clients Satisfaction Surveys = 122** **Fiscal total Timely Access = 81** **TOTAL : 203**
		Number of New Horizons participants and updates shared at the Long Range Planning Committees	Youth Engagement (YE): YE group continue to focus on advocacy through Mental Health fairs and Children's Mental Health Week activities. This year, they created a work plan, had a social media presence and extended YE to both Huron and Perth counties. Through the year, the YE group created/modified and updated YE procedures. They also attend a Disable the Label meeting in Toronto. Family Engagement (FE): A small core of families met to provide input into the new strategic plan resulting in the pillar "where the voices of children, youth and families matter". The plan was approved and we began to develop a strategy based on an organization-wide survey regarding readiness. The board and management attended orientation sessions on key concepts in family engagement. On the advice of staff we delayed staff education until there was a concrete strategy and implementation plan. We worked to build the core group of parents through two more sessions and this resulted in interest to explore the Family Advisory Council (FAC), a structure to facilitate ongoing engagement for system design and improvement and the group is keen to have their voices influence changes to the service system in Huron and Perth. The group stays connected through email and next steps include a presentation from parents from Sarnia who have implemented a FAC.
SKILLED STAFF	Staff hired meets defined job qualifications Provide ongoing support to each staff	Hiring practices reflect that 100% of Counsellors are registered with a College an future CYW hired meet minimum requirements	Goal met Q1.
		Indirect time – Amount of time spent in individual supervision and team screenings (peer supervision)	Work in progress. Staff training to occur in May 2019.
		Time spent mentoring new staff and students	There was time spent by CSM's to ensure that newly hired staff and placement students had an appropriate amount of orientation and supervision/mentoring.
		Performance reviews identify professional learning goals	We continue to value providing performance reviews on an annual basis. While we continue to struggle to meet this goal, staff receive verbal feedback in a number of ways. 73% of performance reviews were completed within the last year.

QUALITY DIMENSION	GOAL	INDICATOR	PROGRESS
LEARNING ENVIRONMENT	Training in Evidence Based Practice (EBP)/ Evidence Informed Practice (EIP)/ and Promising Practices (PP) are chosen whenever possible for training opportunities	Modify conference/workshop/ in-house training on timesheet to reflect EB, EI, Promising Practice and Best Practice categories	During this fiscal year, time sheets were revised to include recording of EPB, EIP and PP for staff training.
	Staff/Management ensures effective use of PD resources that are aligned with Performance Reviews (time and money) PD Committee ensures that larger team trainings are EBP, EIP or PP	Minutes from PD Committee meetings	Based on the advice of the PD Committee management has deliberated on changes to the PD procedure in order to provide greater clarity on the range and scope of activities for individuals and Centre-wide training balanced between the need for effective use of resources and importance of cultivating a learning environment that supports staff to deliver effective services to clients. The new procedure will be implemented in April 2019.
COLLABORATION WITH CLIENTS	Collaboration (partnering up and co-creation of treatment plan) is visible at the case level (clients)	Audit of client files	A File Audit procedure was developed as well as a file audit process. 2 file audits were completed this fiscal year Aug-Dec 2018 (25% of CYMH file audited=**184**) and Feb-March 2019 (25% of CYMH files audited=**126**). **Fiscal total of audited CYMH files = 310.** Both audits were based on 25% of all open files in CYMH services (note – Feb-March audit did not include school based services). While recommendations show need for correction, there was evidence that staff are completing actions to be taken on audited files. Combined recommendations from both audits suggest that there needs to be training with all staff re: recording practices, suggestion of moving all hybrid files to electronic files, ongoing file audits, CSM's to support staff making a plan to make corrections, develop program specific audit forms, need identified to audit volunteer files, continuing to utilize functions of EMHware for easier access to collaterals and consents.
		Measure # of Treatment Plans with Clients using EMHware	Currently investigating to see if this information can be counted within the EMHware database.
		Use of Social Ecological Approach (SEA) application/ verified through screening notes	New Screening notes were revised and implemented to include the SEA as well as other EBP, EIP and PP.
		Number of File Action Checklist completions indicating letter has been sent to clients	QI Manager receives FAC's upon case closure and reviews each quarter to ensure letter has been mailed to clients or made note of the details of the contact with client upon closing.

QUALITY DIMENSION	GOAL	INDICATOR	PROGRESS
COLLABORATION WITH COMMUNITY	HPC aims to demonstrate visible collaboration with community partner(s) by co-creating plans together	# of File Action Checklist completions indicating letter was sent to community partners	QI Manager receives FAC's upon case closure and reviews each quarter to ensure letter has been mailed to community partners (if applicable) or made note of the details of the contact with client upon closing.
		Number of hours and number of contacts tracked for External Consultation in EMHware	External Consultations (all programs selected – data needs further examination) Total number of contacts = **2879*** Total number of contact hours = **644*** * We recognize that there will be inconsistency in this data and will not be used as solid baseline as indirect hours are not recorded consistently. Logging indirect time is an area of growth for the 2019/2020 fiscal year.
		Implementation plan to be developed for SEA community project.	The Community SEA Implementation Team was formed and commenced meeting in February 2018. There were 4 SEA Implementation team meetings to prepare for 3 day training with Michael Ungar on September 17-19 2018. 72 attended Level 1, 78 attended Level 2. Two teleconference meetings were held in October 2018 to engage with all Charter SEA Organization and all but one organization has officially committed. Implementation team completed its work and is recommending a Phase III to continue to develop a strategy to embed SEA in service responses across sectors. Grant application has been submitted to United Way to support Phase III. Focus group to help formulate a plan to sustain SEA in Community occurred on March 9, 2019.
	Integrate Community Partner feedback into both service experience and service delivery planning.	Number of joint trainings/meetings re: SEA applications with community partners	
		Review Community Partner Consultation Survey	QIC will send out Community Partner Consultation Survey prior to Accreditation in June 2019.
POSITIVE OUTCOMES	Clients report/show improvements/ positive experience after service involvement	Outcome Questions on data elements	**Total case closures in TA, C & T and Intensive April 1, 2018 – March 31, 2019 = 783** Number of Caregivers/Youth Reporting Positive Experience with the Service System • TA = 193 • C&T = 81 • Intensive = 8 Number of Caregivers/Youth Reporting Positive Outcomes • TA = 162 • C&T = 93 • Intensive = 6 Number of Children/Youth with Positive Outcomes (determined by clinician) • TA = 166 • C&T = 98 • Intensive = 9 It is important to note that several factors may result in the discrepancies with the above figures. This may include: Lack of feedback/information from clients/families at time of case closure; No further contact from client/families prior to closure, and/or staff potentially forgetting to complete these questions upon case closure. We continue to work with staff to highlight the importance of completing this section and look for ways to capture this information if the client/family are not available to provide this feedback at the time of case closure. **CAFAS Data**

QUALITY DIMENSION	GOAL	INDICATOR	PROGRESS
	Service is provided within context of safety from staff and clients.	Number of serious occurrence reports (SOR's) and number of incident reports (R's)	Difference Between Average CAFAS Youth Total Score for Initial and most Recent Assessment = 20 (indicates improvement in functioning) *117 CAFAS intake/initial assessments were completed over this review Average CAFAS Youth Total Score on intake/initial Assessment = 62 *114 CAFAS outcome assessments were completed over this review. Average CAFAS Youth total score on initial assessment = 61 Average CAFAS Youth total Score on most recent Assessment = 41 *scores 50-90 indicate that Youth may need additional services beyond outpatient care *scores 100-130 indicate youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care Total number of SOR's from April 1, 2018 –March 31, 2019 = **9**. NOTE: During this period we gained new information and interpretation from Avon Maitland District School Board (AMDSB) regarding Behaviour Management System (BMS) that is used in the Care and Treatment Classroom. An increase of SOR's was noted in Q4 after consultation with the Ministry. All uses of containment at the Anne Hathaway Public School Care and Treatment Classroom will be documented and reported as SOR's. This will result in an increase and should now be viewed as baseline, currently related to 1 of 2 sites. Total number IR's from April 1, 2018 – March 31, 2019 = **15** (6 from SOR's in Q4. The incident reports will be reviewed by the JHSC at the next quarterly meetings.

Quality Plan – April 1, 2019 – March 31, 2020

Quality: Quality is the degree of excellence related to all aspects of agency functioning as reflected in our Mission Statement. This includes, but is not limited to, overall child, youth and/or family experience; treatment provision delivered by a skilled and competent multidisciplinary team; strong collaborative relationships with community partners and a **learning environment** that cultivates innovation and evidence-informed practice. In addition, quality will be maintained through effective use and reporting of public funds and in compliance with accreditation standards.

Mission: The Huron-Perth Centre provides **timely access** to **a range of assessment and treatment services** offered by **skilled professional staff** in **collaboration with children, youth, families and their community.**

Quality Dimension	Strategic Pillar	Goal	Indicator	Improvement Ideas
Mission of: Timely Response	• Quality • Child, Youth & Family Engagement	• Provide a timely response for all services; within 3 days of client fall for Timely Access	• EMHware quarterly reports data will demonstrate response time for clinician contact	• Examine TA Pilot Performance Management Project review and use revised goals (when developed) in Quarterly Plans in next fiscal year. • Develop Performance Management Project for C&T and other programs as time permits.
Range of Services (Programs)	• Quality • Child, Youth & Family Engagement	• To ensure that HPC offers a range of interventions in all programs	• EMHware quarterly reports will demonstrate amount of interventions by program that clinicians provide to children, youth and families in the following categories: ➢ Individual counselling ➢ Family counselling ➢ Group counselling ➢ Psychological Assessments	• Continuous staff education regarding data.
Effective Use of Resources	• Quality	• Maximize staff time to provide direct service to clients	• EMHware quarterly reports will count indirect service time	• Management leadership to staff regarding how time is allocated. • Staff education on inputting indirect client services time into EMHware.

Quality Dimension	Strategic Pillar	Goal	Indicator	Improvement Ideas
Child/Youth/Family Engagement	• Child, Youth & Family Engagement	• Integrate client feedback into both service experience and service delivery planning	• EMHware reporting & Survey Monkey • Number of New Horizons participants and updates shared at the Long Range Planning Committees • Use advice from parent/caregiver survey to inform an ongoing Family Engagement Strategy	• QI Lead will review EMHware and Survey Monkey results from clients, families and community partners on an ongoing basis and report results to QIC, Management, board and staff through Quarterly QIP's. Any areas of strength or concern will shared in a timely way with CSM's and staff. • Modify Client Satisfaction Survey to reflect client experience as needed. • Formalize the Family Engagement Strategy.
Skilled Staff	• Quality	• Staff hired meets defined job qualifications • Provide ongoing support to each staff	• Hiring practices reflect that 100% of Mental Health Therapists are registered with a College and future CYW hired meet minimum requirements • Indirect time – Amount of time spent in individual supervision and team screenings (peer supervision) • Time spent mentoring new staff and students • Performance reviews identify professional learning goals	• Develop an Annual Attestation documentation re: current registrations in relevant colleges. • Strengthen consistency of supervision model. • 100% completion of performance reviews.
Learning Environment	• Quality	• EBP/EIP and Promising Practices are chosen whenever possible for training opportunities	• Modify conference/workshop/in-house training on timesheet to reflect EB, EI, Promising	• Provide staff education

Quality Dimension	Strategic Pillar	Goal	Indicator	Improvement Ideas
Learning Environment Cont'd		• Staff/Management ensures effective use of PD resources that are aligned with Performance Reviews (time and money) • PD Committee ensures that larger team trainings are EB, EI or a Promising Practice	Practice and Best Practice categories • Minutes from PD Committee meetings	
Collaboration with Clients	• Collaboration • Child, Youth & Family Engagement	• Collaboration (partnering up and co-creation of treatment plan) is visible at the case level • The Treatment Service Agreement is developed with and signed by client during clinical session if applicable. Client is offered a copy	• Audit of client files • Measure through EMHware the number of external consults • Use of Social Ecological Approach (SEA) application/verified through screening notes • Number of File Action Checklist completions	• Staff education to ensure consistency in reporting. • Add EMHware data element. • Increase number of SEA champions. • Letters to clients upon file closing.
Positive Outcomes	• Quality • Collaboration • Child, Youth & Family Engagement	• Clients report/show improvements/positive experience after service involvement • Service is provided within context of safety for staff and clients	• Outcome Questions on data elements; CAFAS scores • Number of incident reports and serious occurrences	• Implement interRAI as assessment tool • Continue to monitor SOR's and IR's within current frameworks

Quality Dimension	Strategic Pillar	Goal	Indicator	Improvement Ideas
Collaboration with Community	• Collaboration	• HPC aims to demonstrate visible collaboration with community partner(s) by co-creating plans together	• Number of File Action Checklist completions indicating letter has been sent to community partners	• Communication with community partners/referral sources upon file closing.
			• Number of hours and number of contacts tracked for External Consultation in EMHware	• Develop mechanism to track electronically.
		• Integrate Community Partner feedback into both service experience and service delivery planning.	• Implementation plan to be developed for SEA community project • Number of joint trainings/meetings re: SEA applications with community partners • Review Community Partner Consultation Survey	• Continue to work with Community Partners within the context of the Charter SEA organization. • To be completed in June 2019.