QUARTERLY PQI SUMMARY REPORT

1ST QUARTER:
JULY, AUGUST, SEPTEMBER 2008

Submitted by:

Best Practices Team
Case Record Review Team
PQI Coordinator
Program Director

OUTLINE
QUARTERLY PQI SUMMARY REPORT

Quarter: 1st 2008 Date: January 26. 2009

I. INTERNAL MONITORING PROCESSES
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         b. **Interpreter's Utilization**
         c. **Waiting Lists for Services**
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II. PERFORMANCE EVALUATION SUMMARY (Best Practices Team)
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      1. **Expected Outcomes/Indicators**
      2. **Data Analysis & Aggregate Report**
      3. **Corrective Action Summary**
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      1. **Expected Outcomes/Indicators**
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      3. **Corrective Action Summary**

III. FEEDBACK & CORRECTIVE ACTION SUMMARY (CQI Director, Program Director, Assistant Program Director)
   A. Trends, Needs, Opportunities Summary
   B. Corrective Action Summary (Trainings, Forms, Policies & Procedures, Revisions, etc.)

SECTION I. INTERNAL MONITORING PROCESS

A. Service Delivery
- **Barriers & Opportunities**
- **Human Resources Utilization, Training, & Supervision**
- **Research Proposals**

B. Risk Management
- **Services & Practices**
- **Client Grievances, Incidents, & Accidents Summary**
- **External Review Summary**

C. Case Record Review
- **Number and/or Percentage of Cases Reviewed**
- **Case Record Review Summary**

QUARTERLY PQI SUMMARY REPORT
July, August, September 2008

I. INTERNAL MONITORING PROCESS

A) Service Delivery

BARRIERS & OPPORTUNITIES

PRODUCTIVITY AND CENSUS:

Exhibit I A - 1 Outpatient YTD Productivity

Source	4th	14th	19E	19W	Agency
Staff Time Sheets*	106.46%	55.72%	55.56%	87.19%	86.22%
FYTD Contract Utilization**	27.14%	16.09%	23.33%	20.35%	22.27%

** 100% = Productivity Requirement* *** 25% per Quarter = Budget Requirement*

Exhibit I A - 2 Residential Quarterly Census

	GH & SA	RHY	DCFS LT & ST	DYS	RHY TLP	HUD TLP	Agency
Budget	26	4	11.5	10	8	20	79.5
Average	24.2	1.39	10.75	8.2	2.2	14.3	61.04

INTERPRETER'S UTILIZATION:

Exhibit I A - 3 Interpreter's Utilization Report

District	# Presentations Made	# Sessions Translated	# Documents Translated	# Trainings Conducted
4	0	25	3	0
19 W& E	0	6	1	0

SERVICES WAITING LISTS:

At the end of the quarter, 14th District had one person waiting for Substance Abuse services and six waiting for Case Management services. 19E district had no waiting lists for outpatient services (substance abuse counseling, mental health counseling, & case management). 19W district had one person waiting for Substance Abuse services and five people waiting for Counseling/Mental Health services, but had no waiting list for Case Management services. 4th district had ten people waiting for Substance Abuse services, eight waiting for Counseling/Mental Health services, and eleven people were waiting for Case Management services.

There were no waiting lists in our residential services at the end of the quarter.

HUMAN RESOURCE UTILIZATION, TRAINING, & SUPERVISION

CIT & CONTRACT COUNSELORS PRODUCTIVITY and / or ASSIGNMENT:

CIT's are optimally utilized given their level of training. 4th & 19E Districts rely on contract counselors for a substantial portion of counseling services.

TRAINING REPORT SUMMARY:

Exhibit I A - 4 Training Report Summary

Training Module	Training Report Summary	
	# Hours	Avg. # Attending
CIT	21	7
New Employee	68	11
RCYCP	36	7
Residential (YCW/Supervisors)	31.8	7
Services	0	
Supervision	0	
Other	47.25	9
Outside Trainings	0	
TOTAL:	204.05	9

Exhibit I A - 5 Employee Training Evaluation Summary

Training	Evaluation Summary (1-5 Scale)			
	Experience	Facilitator	Learning	Overall
CIT	4.66	4.59	4.57	4.56
New Employee	4.68	4.73	4.68	4.66
RCYCP	4.72	4.63	4.72	4.56
Residential	4.64	4.69	4.64	4.64
Services	NA	NA	NA	NA
Supervision	NA	NA	NA	NA
Other	NA	NA	NA	NA
Outside Trainings	NA	NA	NA	NA
TOTAL:	4.66	4.68	4.66	4.63

RESEARCH PROPOSAL

Michael Holland is still currently working on research with the GH/SA clients.

B) Risk Management

SERVICES AND PRACTICES

STANDARD OF PRACTICE INDICATORS:

- There will be 75% compliance with policy and procedure.
- There will be an average of 7 days taken to complete Maintenance request.
- Facilities Safety Checklist standard of practice is still developing.

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I B - 1 Restrictive Behavior Management Interventions

	# Physical Restraints	# Reviewed	# Debrief	# Transports to JDC		# Mechanical Restraint		# Reviewed	# Debrief
				YB	Police	YB	Police		
GH/SA	0	NA	NA	1	0	0	0	NA	NA
BC Shelter	1	1	1	0	1	0	1	1	1
RHY - TLP	0	NA	NA	0	0	0	0	NA	NA
HUD -TLP	0	NA	NA	0	0	0	0	NA	NA
DCFS LT	0	NA	NA	0	0	0	0	NA	NA
P & P Compliance Total:		**100%**	**100%**			**P & P Compliance Total:**		**100%**	**100%**

Exhibit I B - 2 Maintenance Request

Category	# of Request	Average days taken to complete
Computer	280	5
Database	8	5
Maintenance	145	8

NOTE: The Maintenance Requests, Average days taken to complete, is over the 7 days standard because there were two tickets that had been stalled for several months that were finally resolved during the last quarter.

SERVICES AND PRACTICES

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I B - 3 Facilities Safety Checklist

	Checklist	
Program		
BCS	*Still Developing	
19thW		
19thE		
14th Mt. Home	*Still Developing	
14th Harrison		
4th	*Still Developing	
WCS		
RHY - TLP		
HUD -TLP		
RTF (GH/SA)		
ADMIN	*Still Developing	
TOTAL:		

NOTE: This data will be entered once the procedure for reporting data is set up.

SERVICES AND PRACTICES - CORRECTIVE ACTION SUMMARY: **NONE GIVEN**

CLIENT GRIEVANCES, INCIDENTS & ACCIDENTS SUMMARY

STANDARD OF PRACTICE INDICATORS:

Grievances
- A 65% “satisfactory” response rate will be indicated by clients of the grievance investigation process.

Incidents
- There will be 80% compliance with DYS/ADAP/DCFS requirements.

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I B - 4 Type and Nature of Grievance for All Programs

TYPE		NATURE					
Facility	1	Maintenance	1				
Services/Programs	3	Program/Schedule	3				
Staff	29	Staff Behavior	29	Rule Violation	3	Threats	4
Other Client	8	Aggression	0	Sexual	1	Slander	0
TOTAL:	**41**						

Exhibit I B - 5 Quarterly Comparisons of Grievances

	1ST QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
2006-07	32 (14 Staff)	15 (10 staff)	12 (10 staff)	51 (31 staff)
2007-08	63 (49 Staff)	66 (49 Staff)	80 (53 staff)	65 (46 staff)
2008-09	41 (29 Staff)			

CLIENT GRIEVANCES, INCIDENTS & ACCIDENTS SUMMARY

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I B - 6 Type and Number of Incident Reports for All Programs

DYS / OADAP / DCFS Serious		# P&P Compliance	DYS / OADAP / DCFS Non-Serious		# P&P Compliance
Death			AWOL	9	8
-On-Site	0		Assault/Aggression	20	10
-Off-Site	0		Sexual Misconduct	2	2
Neglect			Contraband	1	0
- Off-Site Current	1	1	Suicide Assessment or Suicide Threat	1	1
- Off-Site History	0		Medical	12	7
- On-Site	0		Medication	11	7
Physical Abuse			Theft	1	1
- Off-Site Current	12	12	Aftercare Violation	12	10
- Off-Site History	7	5	Verbal Abuse or Verbal Threat	4	2
- On-Site	0		Disorderly or Disruptive Conduct	39	19
Sexual Abuse			Rule Violation	13	8
- Off-Site Current	4	4	Property Damage	0	
- Off-Site History	0		Other	10	8
- On-Site	0				
TOTAL: Off-Site **24**	On-Site **0**	P & P **22**	**TOTAL:**	Non-Serious **135**	P & P **83**
GRAND TOTAL (Serious On-Site & Non-Serious): **135**					
SERIOUS P & P COMPLIANCE: 92% **NON-SERIOUS P & P COMPLIANCE: 61%**			**P & P Compliance TOTAL: 66%**		

NOTE: After reviewing last fiscal year data, Best Practice Team decided that 90% compliance on policy and procedure was too high and set the new standard at 80%.

Exhibit I B - 7 Quarterly Comparisons of Incident Reports

	1ST QUARTER	2ND QUARTER	3RD QUARTER	4TH QUARTER
2006-07	91 (578)	97 (357)	82 (189)	195 (207)
2007-08	202	110	234	251
2008-09	135			

CLIENT GRIEVANCES AND INCIDENTS - CORRECTIVE ACTION SUMMARY:

Group Home and Substance Abuse Residential programs (RTF) needs to develop and submit to Best Practices Team a plan to increase the percentage of compliance with incident reporting policy and procedure.

EXTERNAL REVIEW SUMMARY

STANDARD OF PRACTICE INDICATORS:

- Three (3) or fewer correctable deficiencies per external review and corrective actions completed within time frames as specified per review.

REVIEW RESULTS SUMMARY:

Exhibit I B - 8 External Review Summary

Date	Source	Deficiencies	Corrective Actions
	None for 1st Quarter		

EXTERNAL REVIEW – CORRECTIVE ACTION SUMMARY: **NONE GIVEN**

C) Case Record Review

CASE RECORD REVIEW

STANDARD OF PRACTICE INDICATORS:

- Indicators for Number and Percentages of Cases Reviewed are listed in Exhibit I C -1. Number of Cases Reviewed is under column "# Cases to Review per quarter" and Percentage of Cases Reviewed is under column "COA Required % per yr".

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I C - 1 Number and Percentage of Cases to Reviewed

Services	#Cases to Review per quarter	#Reviewed	COA Required % per yr	% Reviewed
Group Living:				
DCFS/SA/GH	21	1	48%	5%
TLP:				
HUD/RHY	18	0	100%	0%
Shelter:				
BC	41	1	45%	2%
Outpatient:				
14th	33	3	47%	9%
4th	69	15	40%	22%
19th	96	24	40%	25%
TOTAL:	278	44	43%	16%

NUMBER AND PERCENTAGE OF CASES TO REVIEWED - CORRECTIVE ACTION SUMMARY: **NONE GIVEN**

CASE RECORD REVIEW

STANDARD OF PRACTICE INDICATORS:

- Indicators for case record reviews have been set at 85% correct for all categories.

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit I C - 2 Case Record Review Summary

District / Program	Required Documentation			Confidentiality HIPAA			Standard of Practice		
	# items	# correct	% correct	# items	# correct	% correct	# items	# correct	% correct
14th	159	138	87%	6	5	83%	145	128	88%
4th	795	748	94%	30	23	77%	560	532	95%
DCFS LT	0			0			0		
RHY - TLP	0			0			0		
HUD -TLP	0			0			0		
GH/SA	53	51	96%	2	2	100%	62	51	82%
19th W	742	688	93%	24	23	96%	151	141	93%
19th E	530	492	93%	20	19	95%	164	161	98%
BC Shelter	53	50	94%	2	2	100%	16	16	100%
TOTAL:	2332	2167	93%	84	74	88%	1098	1029	94%

NOTE: The Case Record Review Team felt the Standards of Practice Indicator for Case Record Review was too high so it has been changed from 90% last fiscal year to 85%.

CASE RECORD REVIEW SUMMARY - CORRECTIVE ACTION SUMMARY:

All programs not meeting standard of practice indicators for HIPAA and Confidentiality will submit a plan to Case Record Review Team.

SECTION II. PERFORMANCE EVALUATION SUMMARY

A. Outcome Measures Analysis & Summary
- **Expected Outcomes/Indicators**
- **Data Analysis & Aggregate Report**

B. Consumer Satisfaction Analysis & Summary
- **Expected Outcomes/Indicators**
- **Data Analysis & Aggregate Report**

II. PERFORMANCE EVALUATION SUMMARY

A) Outcome Measures Analysis & Summary

OUTCOME MEASURES ANALYSIS & SUMMARY

EXPECTED OUTCOMES

- 70% improvement on Outcome Measures from pre to post for residential and outpatient treatment programs.
- 70% will successfully complete case management services.

DATA ANALYSIS & AGGREGATE REPORT OF THE FOLLOWING SERVICES:
Counseling, Mental Health, Substance Abuse Counseling, Group Living (GH & SA), Shelter, & Case Management

Exhibit II A - 1 SASSI – A2 Summary

District	Improvement Rates		
	#Clients	**% (alcohol) FVA Improve.**	**% (drugs) FVOD Improve.**
4th	5	60%	80%
SA	6	83%	83%
14th	5	80%	80%
19th W	1	100%	100%
19th E	NA	%	%
Agency TOTAL:	17	76%	82%

Exhibit II A - 2 Health Dynamics Inventory Summary and GAF

District / Program	HDI Self Response Improvement Rates				HDI Parent Response Improvement Rates				GAF	
	# Clients	**MOR**	**GSYM**	**GIM**	**# Parents**	**MOR**	**GSYM**	**GIM**	**# Clients**	**% Improve**
4th	8	50%	63%	50%	9	50%	38%	38%	4	50%
GH	1	0%	100%	100%		%	%	%	NA	%
SA	4	75%	100%	75%	4	100%	100%	100%	3	67%
14th	17	75%	69%	50%	17	75%	94%	69%	NA	%
19th W	9	100%	67%	78%	5	80%	100%	60%	NA	%
19th E	NA	%	%	%		%	%	%	NA	%
Agency TOTAL:	39	74%	71%	61%	36	70%	80%	60%	7	57%

OUTCOME MEASURES ANALYSIS & SUMMARY

DATA ANALYSIS & AGGREGATE REPORT OF THE FOLLOWING SERVICES:
Counseling, Mental Health, Substance Abuse Counseling, Group Living (GH & SA), Shelter & Case Management

Exhibit II A - 3 Adolescent Anger Rating Score (AARS) Summary

District/Program	Improvement Rates				
	# Clients	Instrumental Anger	Reactive Anger	Anger Control	Total Anger
4th	8	63%	63%	63%	63%
GH	6	67%	83%	83%	83%
SA	5	100%	80%	100%	100%
14th	1	0%	0%	100%	0%
19th W	1	100%	100%	100%	100%
19th E					
Agency TOTAL:	21	71%	71%	81%	76%

Exhibit II A - 4 Case Management Services & Completion Report

District	Electronic Monitoring			Community Service			Aftercare		
	Scheduled to Complete	Successful Completion		Scheduled to Complete	Successful Completion		Scheduled to Complete	Successful Completion	
	#	#	%	#	#	%	#	#	%
4th	17	12	71%				4	2	50%
14th				11	7	64%	1	1	100%
19th W	26	20	77%				0	0	NA
19th E							6	4	67%
Agency TOTAL:	43	32	74%	11	7	64%	11	7	64%

NOTE: 14th District has gone through staff changes over this quarter that could be factor in to low percentage.

OUTCOME MEASURES ANALYSIS & SUMMARY

DATA ANALYSIS & AGGREGATE REPORT OF THE FOLLOWING SERVICES:
Counseling, Mental Health, Substance Abuse Counseling, Group Living (GH & SA), Shelter, & Case Management

Exhibit II A - 5 Residential Substance Abuse OADAP Phone Calls

Yes/No Questions Asked to Clients	# Clients that answer Yes to Follow-up Questions & % answering Yes					
	Months					
	3		6		12	
	#Clients	%	#Clients	%	#Clients	%
Abstinent	NA		NA		NA	
Work Force or in Full time Education	NA		NA		NA	
Living Independently	NA		NA		NA	
No Arrests	NA		NA		NA	

OUTCOME MEASURES - CORRECTIVE ACTION SUMMARY: NONE GIVEN

B) Consumer Satisfaction Analysis & Summary

CONSUMER SATISFACTION ANALYSIS & SUMMARY

STANDARD OF PRACTICE INDICATOR:

- The agency will average 4.0 or higher on scale of 1 to 5 with 5 being highest rating.

DATA ANALYSIS & AGGREGATE REPORT SUMMARY:

Exhibit II B - 1 Client Satisfaction Survey Summary

Consumer	Indicator & Average Rating				
	#Surveys	**Staff**	**Service**	**Outcome**	**Facilities**
Client	77	4.61	4.7	4.71	4.73
Parent	57	4.62	4.4	4.35	4.62
Agency TOTAL:	134	4.62	4.57	4.57	4.68

Exhibit II B - 2 Residential Monthly Follow-up Interviews

Question Asked to Clients & Average Rating	#Clients Asked	Program Ratings (scale 1 to 5 with 5 being highest rating)				
		DCFS LT	**BC Shelter**	**GH/SA**	**TLP**	**TOTAL**
How do you rate the Food	NA					
How do you rate the Activities	NA					
How do you rate Counseling	NA					
How do you rate the Scheduling	NA					
How do you rate the Grievance Procedure	NA					
How do you rate the School	NA					
How do you rate the Fairness of Staff	NA					
Availability of Staff if you are in Crisis	NA					
Helpfulness of Case Manager	NA					
Have you put any Money into Savings Account (Yes)	NA					
Do you think that you are closer to being Independent (Yes)	NA					

CONSUMER SATISFACTION - CORRECTIVE ACTION SUMMARY: **NONE GIVEN**

SECTION III. FEEDBACK & CORRECTIVE ACTION SUMMARY

(IMPORTANT INFORMATION FOR PQI DIRECTOR, AREA MANAGER, PROGRAM DIRECTOR AND ASSISTANT PROGRAM DIRECTOR)

A. Trends, Needs, Opportunities Summary

B. Corrective Action Summary

III. FEEDBACK & CORRECTIVE ACTION SUMMARY

A) Trends, Needs, Opportunities Summary

PRODUCTIVITY AND CENSUS

- **According to FYTD Contract Utilization Reports, District 4 met productivity requirements and all other districts were below requirements.**
- **All residential programs were below Budgeted Census for this quarter.**

GRIEVANCES & INCIDENTS

- **Grievances against staff remain the most prevalent type of grievance.**
- **Total number of grievances decreased from the 4th quarter last year.**
- **DYS Incident Reports decreased this quarter from the 4th quarter last year.**
- **Agency total for Policy and Procedure compliance was below standard of practice. Group Home and Substance Abuse Residential Programs (RTF) were below 50% compliance rate.**

CASE RECORD REVIEW

- **Two outpatient districts did not meet HIPAA and Confidentiality Standards. One Residential Program did not meet Standard of Practice indicators.**
- **Not enough charts were either not reviewed or not reported to PQI Coordinator.**

OUTCOME MEASURES

- **Agency-wide Standard of Practice indicators were archived on SASSI, AARS, Electronic Monitoring and Satisfaction Surveys.**
- **Agency-wide, the GIM scores on the HDI did not meet the standard of practice indicator.**
- **Agency-wide, the GAF scores did not meet the Standard of Practice indicators. Also, only seven pre and post GAF scores were submitted.**
- **Scores below the Standard of Practice indicators on Community Service are noted under Exhibit II A-4.**
- **Agency-wide, Aftercare services did not meet Standard of Practice indicator.**
- **No Data was received for Residential Substance Abuse OADAP Phone Calls and Residential Monthly Follow-up Interviews.**

B) Corrective Action Summary

RECOMMENDATIONS AND /OR ASSIGNMENTS

- **Group Home and Substance Abuse Residential programs (RTF) needs to develop and submit to Best Practices Team a plan to increase the percentage of compliance with incident reporting policy and procedure.**
- **Case Record Review Team will continue to develop and implement procedures for improving the Case Record Review process.**
- **All programs not meeting standard of practice indicators for HIPAA and Confidentiality will submit a plan to Case Record Review Team.**
- **Best Practices Team is continuing to investigate the global impairment scale of the HDI.**
- **The trend of low self report scores on the HDI is being addressed through a pilot project utilizing a mid-treatment HDI to evaluate progress during different phases of treatment by Group Home clients.**
- **Counselors will be encouraged to submit GAF rating in a timely manner.**
- **The process for obtaining information for the Interpreter's Report will be reviewed by the Best Practices Team for the next quarter.**
- **The process for monitoring Make-Up trainings will be reviewed by the Best Practices Team at its February meeting.**
- **Beginning immediately, Grievance Investigators will be reminded to submit the Grievance PQI report to the PQI Coordinator indicating the client's satisfaction. Also, this satisfaction report will be added to the PQI Coordinator's Monthly Evaluation Summary.**