

# PCS TRIANNUAL PQI REPORT

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## Introduction

We are excited to introduce our new format to share PCS's PQI information with you. This report is for all stakeholders, including staff, clients, board members, community members, or anyone who has an interest in what we are doing at PCS. PQI is Performance and Quality Improvement, and it is a crucial aspect of our work, and is intertwined in all that we do. This report will highlight areas where we are succeeding and making progress, as well as areas where we need to change or grow. Our intention is to be transparent with this information. We are always open to feedback! You can reach Jennifer Puglia, PCC-S, Director of Quality Improvement, at [jpuglia@pcssummit.org](mailto:jpuglia@pcssummit.org) with any feedback you may have.

## PQI Committee:

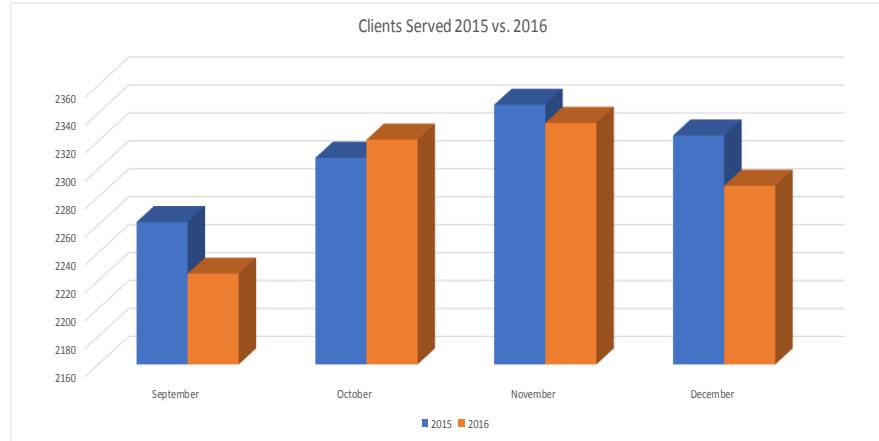
- Jen Puglia  
Nicole Ziemnik  
John Decoulos  
Elaine Elwood  
Erin Christian  
Lindsey Smith  
Kelli Law  
Lesa Bauer  
Matt Smith  
Lesli Eisenhart

PCS established a PQI committee in October 2016! Our goal was to involve more staff, from different departments, in our program. We love the input and collaboration from different perspectives. The addition of this committee brought new ideas and a new energy to our quality improvement processes.

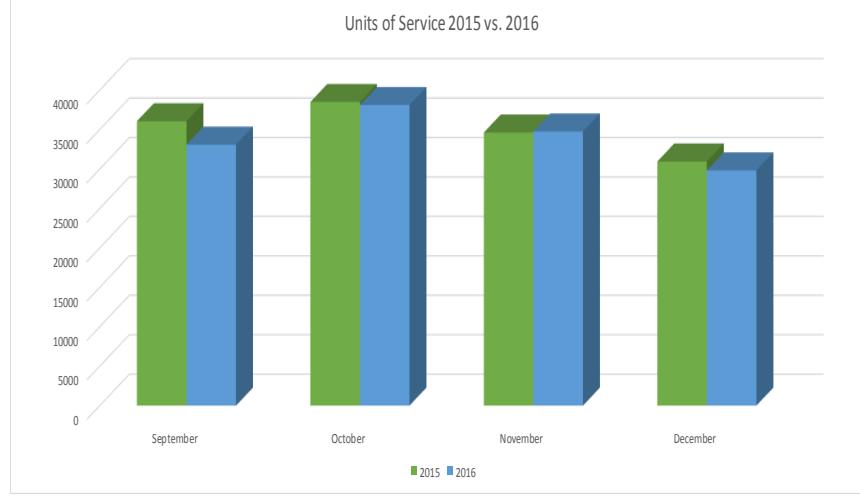


## OUTPUTS

Outputs are the quantitative data that result from the activities provided. Outputs contribute to the outcomes, but they are different because they solely provide us with information, not whether or not the information is indicative of change. Examples of outputs measured at PCS for this PQI report are the number of clients served in September, October, November and December of 2015 compared with the number of clients served in the same months of 2016. The other output we are reporting on at this time are the units of service for the same months listed above.



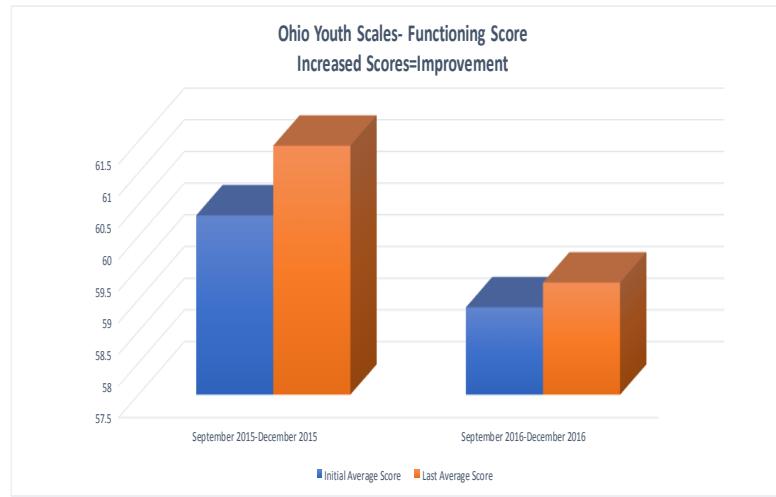
As this chart demonstrates, October was the only month that PCS exceeded the number of clients seen in 2016 as compared to 2015. There could be several reasons for this, but one is staffing levels. We had a couple therapists and a couple CPSTs leave PCS in November and December, which would explain a lower number of clients being seen. Also, a possible explanation for seeing fewer clients in September could be due to a majority of our schools beginning in September this school year, which is later than usual. We will need to analyze this data further and look at trends.



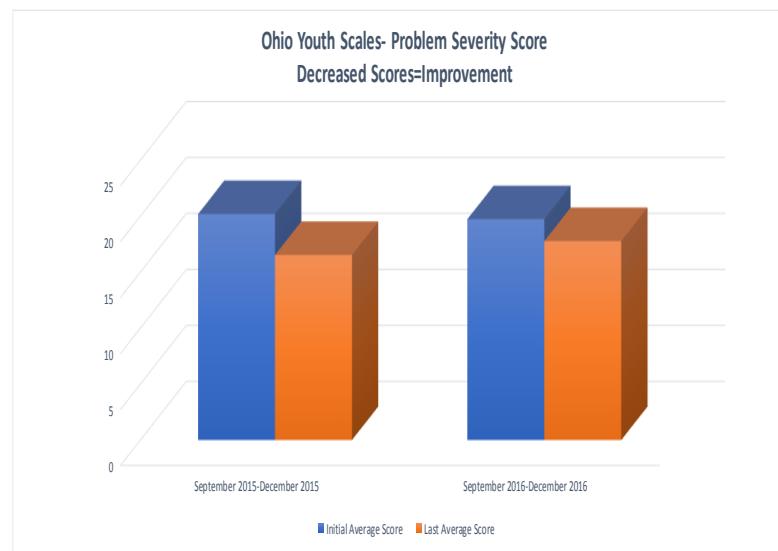
Units of service also demonstrate an overall decrease in 2016 vs the 2015 numbers for the months analyzed. This would make sense given that we had fewer providers overall to provide the service, and had a later start date for our school based staff.

## OUTCOMES

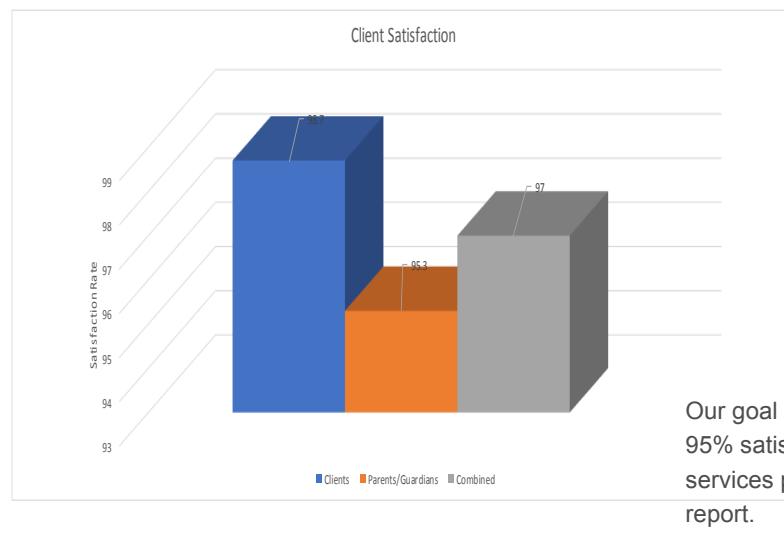
To determine outcomes, we use the Ohio Youth Scales for Children and the DSM 5 Cross Cutting Measures for adults. Both are standardized measures to determine outcomes. We only recently began using the Cross Cutting measures, therefore, during this reporting time we do not have enough data to pull to analyze any outcomes for our adult population, however, we are hoping to be able to report on our adult cross cutting measures with our next report. Additionally, we have had some trouble in extracting out data from our electronic health record for our Ohio Scales, and we will continue to work on obtaining more information. For this reporting period, we were able to pull the client's self report scores on their problems and their functioning.



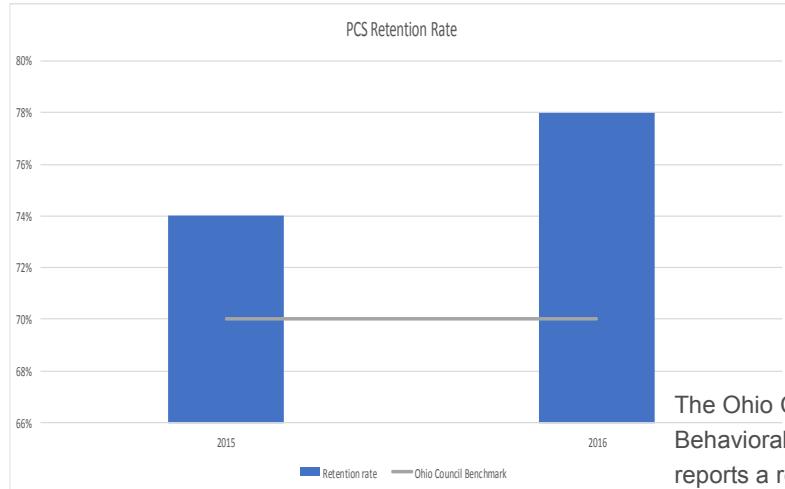
The above chart represents our Ohio Youth Scale Functioning score, as reported by the child client, ages 12-18, and shows us that for the months measured, September, October, November, and December in 2015 and 2016, we were able to gather information that demonstrates that in 2016, our clients were reporting higher functioning scores, which demonstrates a level of improvement.



This graph demonstrates the Ohio Youth Scales scores, for clients ages 12-18 in the area of problems. A decrease in the number demonstrates improvement in this category in regards to problems that the client is reporting, so we are seeing improvement in the reporting of problems in 2016 compared to 2015.



Another area we measure annually is client satisfaction via a survey given to all clients, parents of clients. While this is not reflective of a standardized measure, our annual satisfaction surveys give the opportunity for clients and parents to voice concerns, or provide both positive and negative feedback. Our goal at PCS is to maintain or exceed a 95% report of satisfaction with our services. This data reflects the 2015-2016 school year, and indicates that both clients and parents of clients are at least at a 95% satisfaction rate with the services they receive at PCS.



The Ohio Council for Behavioral Health reports a retention rate of 70% as a benchmark for mental health providers

Retention rate of our staff is another method for us to look at in regards to quality improvement. The average retention rate, according to the Ohio Council on Behavioral Health, is 70% in the mental health field in Ohio. As this graph demonstrates, PCS is well within that target range for both 2015 and 2016. We would like to maintain or exceed this average and will continue to survey staff in order to see in what areas they feel we are doing well, and where there are opportunities for improvement, to increase their work satisfaction.



Our random chart review is another major PQI activity where we track our data, in order to monitor progress and areas needed for improvement. Regular chart reviews allow us to ensure that we have everything in place to provide the best services for the client and follow the rules of our state and accrediting body. Our goal is to maintain 90% compliance or better on all chart review areas. This graph demonstrates that while we meet or exceed the 90% compliance on many areas of our chart review, we have more work to do to continue to work towards documentation of family engagement, and documentation of supervision of cases. We can address these topics that are under the 90% as part of our PQI committee utilizing the Plan Do Check Act model of change.

## **Improvement Plans and Next Steps**

We have been busy on working on our improvement plans in the first few months of the school year. One of our major improvement plans during this first reporting period is instituting a 90% compliance rate with progress note documentation. We are continuing to work on this and seeing progress and improvements across staff. This improvement plan will remain in place.

Another improvement plan that we put into place during this reporting period is a new procedure for verifying insurance with our benefits department. This is also still a work in progress, as we have gone back to the drawing table a couple of times with feedback and data indicating changes need to continue to be made. This improvement plan will also continue to stay in place and be adjusted as necessary.

From the data collected, it looks like we will be adding a new improvement plan in regards to increasing our numbers of documenting supervision and family engagement in our client files on our next report.

We recently added suggestion boxes for both our staff and our clientele in our outpatient center, based on feedback from staff surveys. This feedback is helpful for us and with the addition of the suggestion boxes, we are able to receive continuous feedback throughout the year as opposed to annually at the time of surveys. We will be sure to report back in this document how some of the suggestions we receive and how we are responding.

Also, due to feedback on the employee engagement surveys, the administrative staff also worked hard to provide employees with lower cost, more comprehensive insurance coverage, based on feedback that was received in our last survey.

That wraps up this PQI Triannual plan. We are already working on our next plan and our continued commitment to quality improvement at PCS. If you have any feedback or suggestions regarding this report, please contact [julgia@pcssummit.org](mailto:julgia@pcssummit.org) or at (330) 996-4600.