RHD ALLIES

Quality Assurance Annual Plan

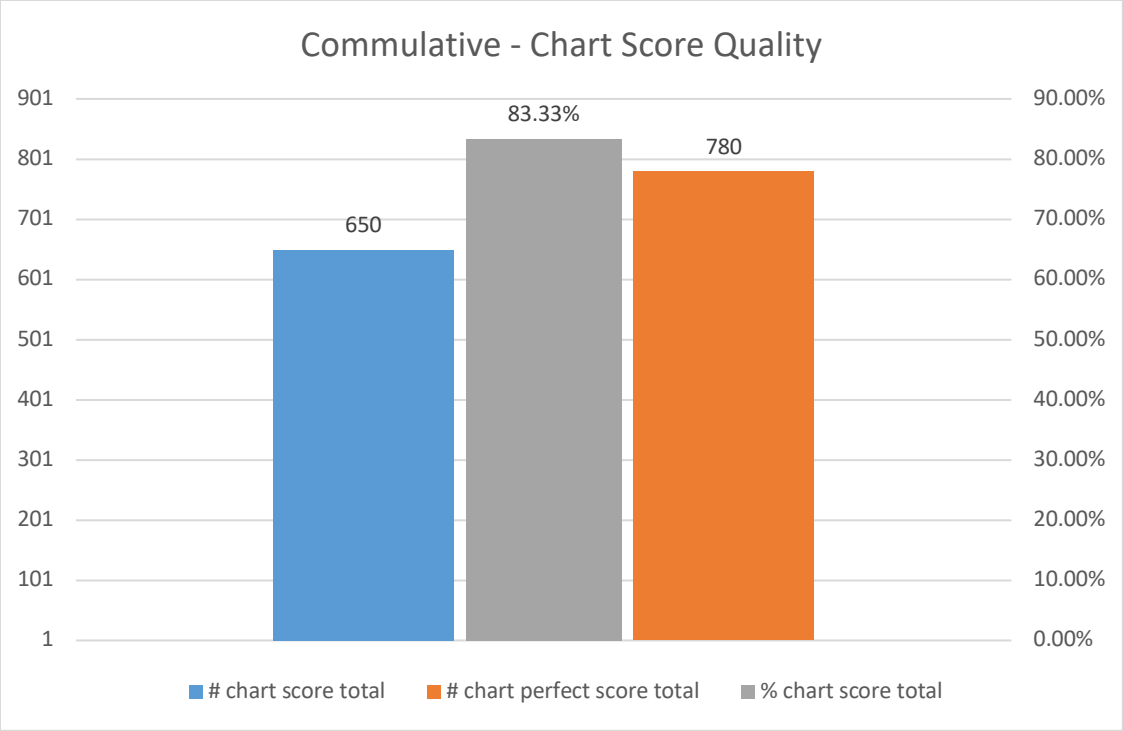
From January 1, 2024 – December 31, 2024

This plan was created by RHD ALLIES Quality Improvement Team (CQIT). This plan will be published and made available on the RHD website. The ALLIES Director with the support of the Quality Improvement Team which consist of consumers on the Advisory Board, CPS staff, and CART (Consumer Action Response Team), assist in quality assurance activities. This plan "provides for an annual review of the quality, timeliness, and appropriateness of services", as stated in 55 Pa. Code § 5230.81. This plan is a guide, and Quality Improvement is alive and demands change by its very nature. Adaptations, improvements, and tweaks to this plan shall be documented by the Quality Improvement Team as needed. Implementation of this plan is intended to measure the overall effectiveness of the CPS program and adherence to the service description by, but not limited to:

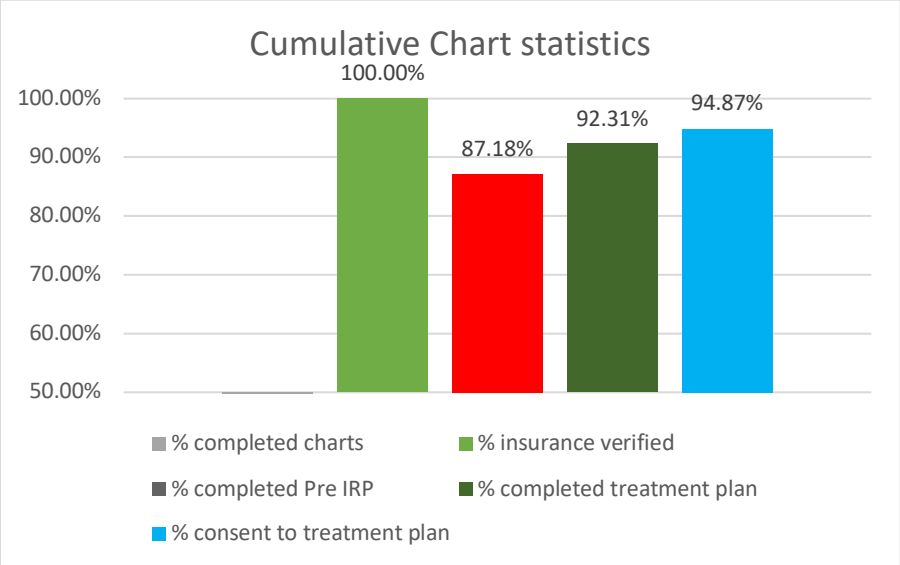
1. **Individual Client Record Reviews**
    a. Chart Audit- A monthly chart audit will be done for one participant per staff caseload
        i. Done by program supervisor or his delegate monthly
            1. Chart Audit measures compliance to regulations and agency service description.
            2. See attached standard chart audit form.
        ii. The charts will be randomly selected by the Data Manager
        iii. Our goals are to
            1. Audit at least 50% of the charts per year.
            2. Bring all chart up to compliance.

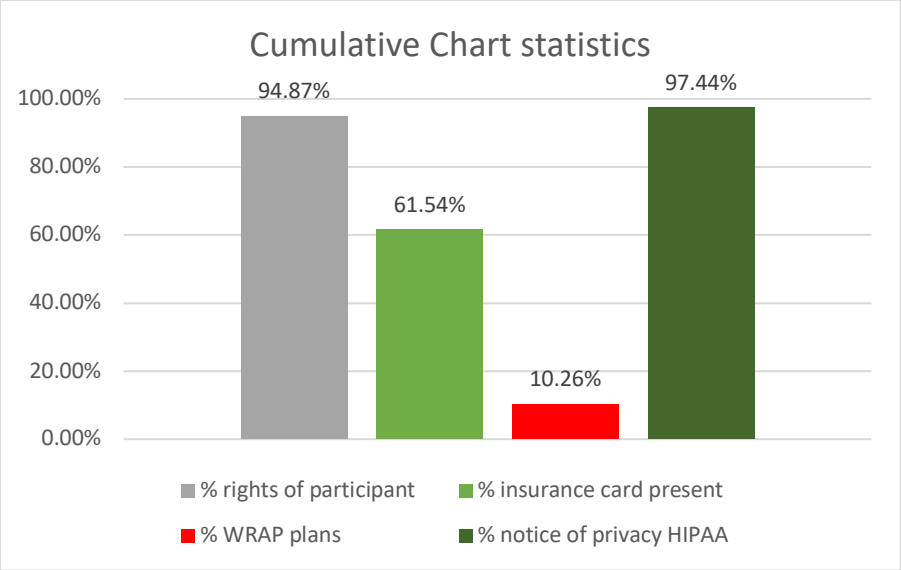
Analysis:

RHS Allies has 66 active and 9 discharged participants for a total of 75. 39 charts were audited for a coverage of 52%. Lack of supervisors impacted manpower and time in conducting the audits.

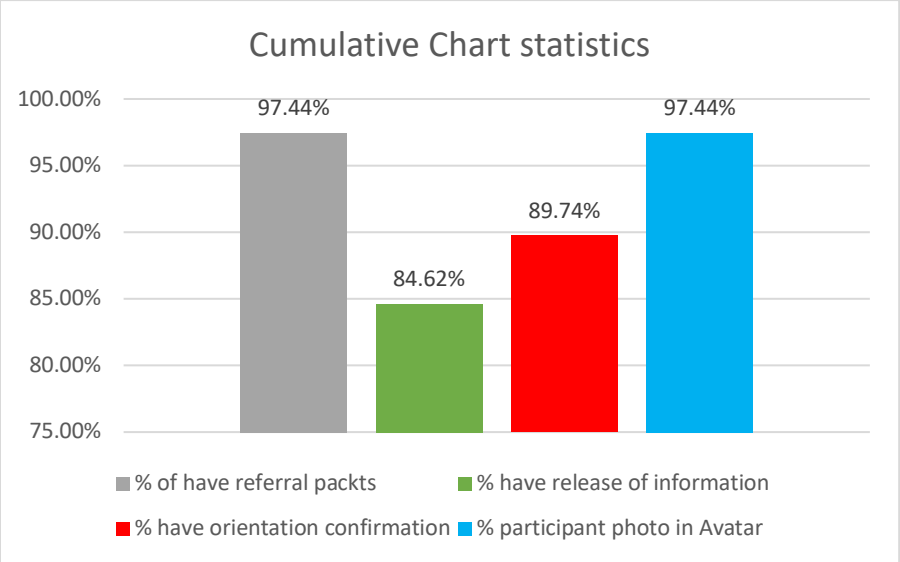


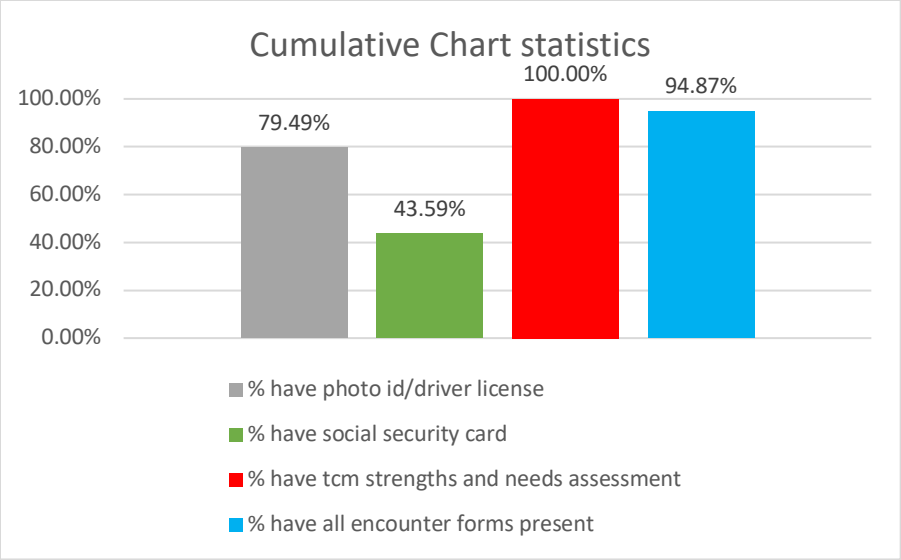
The chart score is 650 out of 780. While no chart was perfect, most of them were good. Our analysis tool does not distinguish between an outlier empty chart or all charts being almost complete.

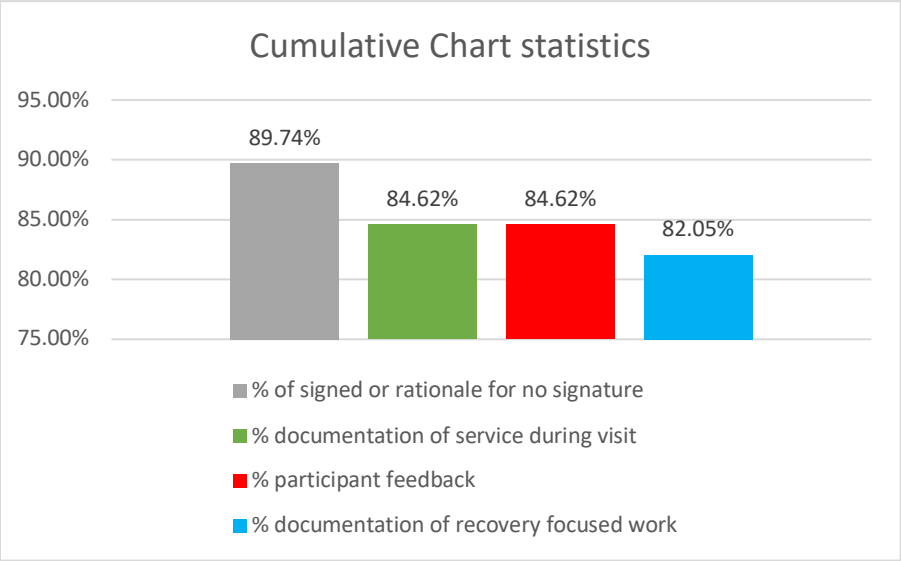




WRAP Plans are optional for our program.







We were able to identify some systemic deficiencies: half the charts did not have copies of insurance cards or SS cards.

Actions to address annual review findings: Individual Client Record Reviews

The issue with ID and Social Security cards is that our population loses them, and we need to develop a process to ensure that we get them new cards within the first 3 months of service.

2. **Phone Survey- Monthly phone calls are made to one participant per staff caseload**
(Typically the participant that a chart audit was performed for.)

    i. Done by program supervisor or his delegate monthly

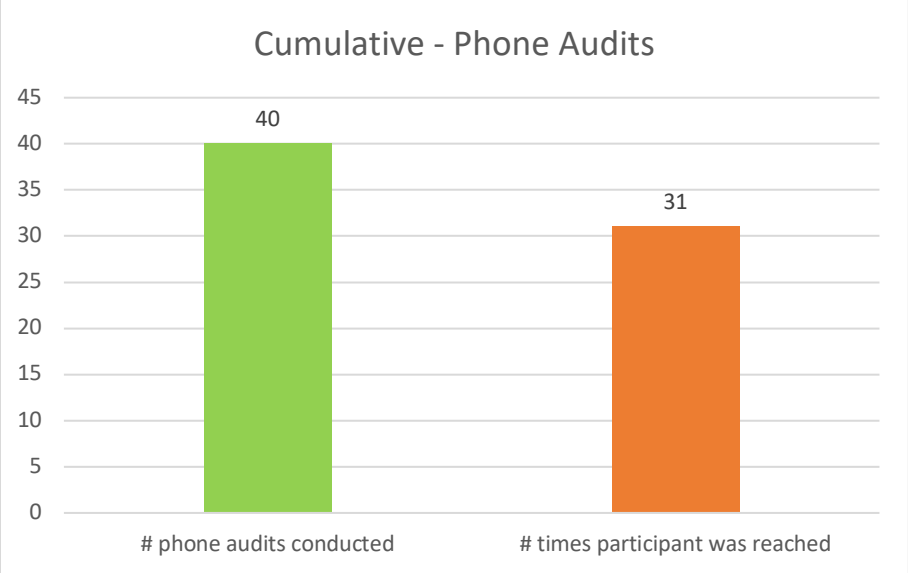
        1. Call measures timeliness and appropriateness of service.

        2. See attached survey form

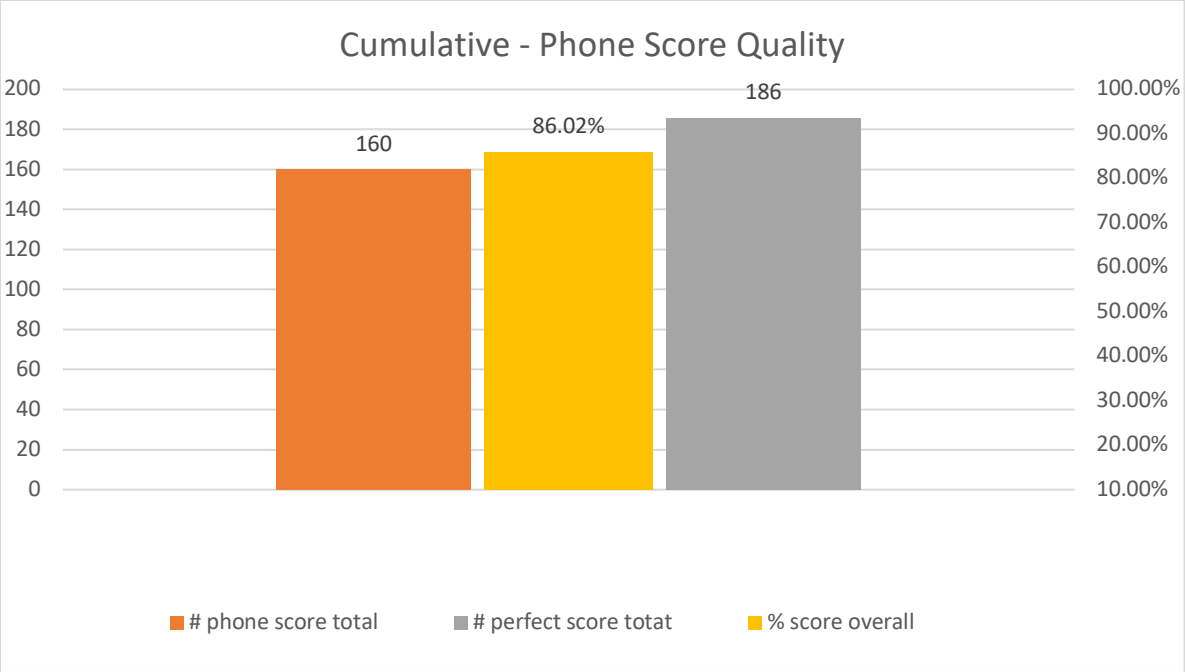
    ii. The charts will be randomly selected by the Data Manager

    iii. Our goal is to call at least 50% of our participant pool per year

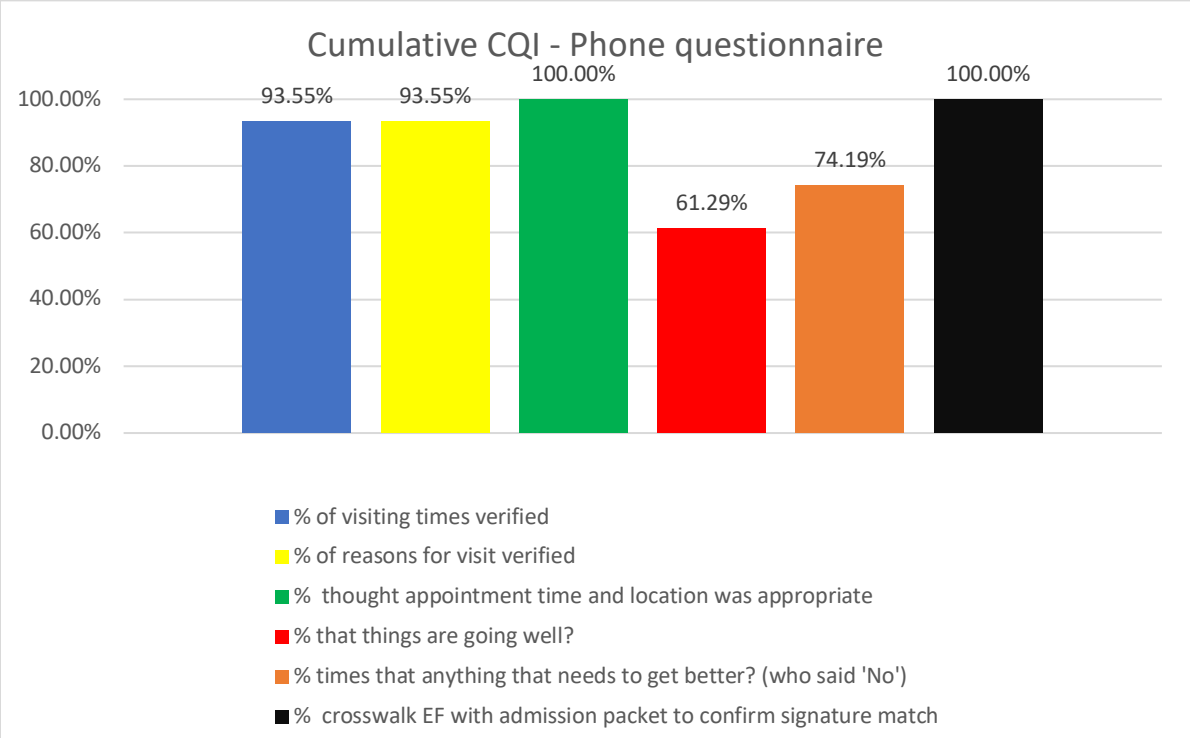
Analysis:



40 phone audits were conducted (53%), with 31 participants being reached.



The phone score is 160 out of 186. High scores occurred in correctness of documentation and participant convenience.



40 phone audits were conducted (53%), with 31 participants being reached. As in the cart audit we met our goal of 50% of participants audited. Phone score is 160 out of 186. High scores in correctness of documentation and participant convenience. Poor scores in "things are going well" and "things need to get better". However, the questioning was vague, and we aren't sure the participants' answers apply to our services or just life in general

Actions to address annual review findings: Phone Survey

For the phone audits, we rephrased some questions to clarify that they apply to our services. For the question: "Is there anything that is going especially well?" We clarified it to "Is there anything that is going especially well with our services?" Prior to the clarification, 53% of participants said yes. After the clarification, 80% said yes.

For the question: "Is there anything that needs to get better?", was rephrased to "Is there anything that needs to get better with our services?". Prior to the clarification, 75% of participants said no. After the clarification, 83% said no.

When we rephrased those 2 questions so that it was clear we were asking about our services, participants' answers may better reflect the quality of our services.

3. ALLIES Forensic CPS Dash Board

a. Weekly Dash Board reports
    i. Done weekly by program manager or their delegate to measure:
        1. IRP due dates
        2. Authorization due dates
        3. Missed Participant contacts report

Analysis:

Weekly Dashboard reports effectively maintain compliance with our payer, and match our agency service description. The results of these reports indicated that we were consistently compliant with meeting IRP, and authorization due dates. Quality Assurance efforts made in this way demonstrate that we are committed to being a reliable and exemplary provider CPS services.

These reports ensure staff, and supervisors can monitor IRP updates. In supervision this information is brought to the open forum of director, supervisor, and staff to give feedback for improvement quality, timely, and appropriate services.

In summary, it shows that participants were never seen longer than ten days apart unless circumstances beyond the control of the practitioner prevented an interaction. The Treatment plans were able to remain current due to the regular reporting of the status of these documents. Each of these metrics are critical to the proper operation of the business unit and are maintained diligently.

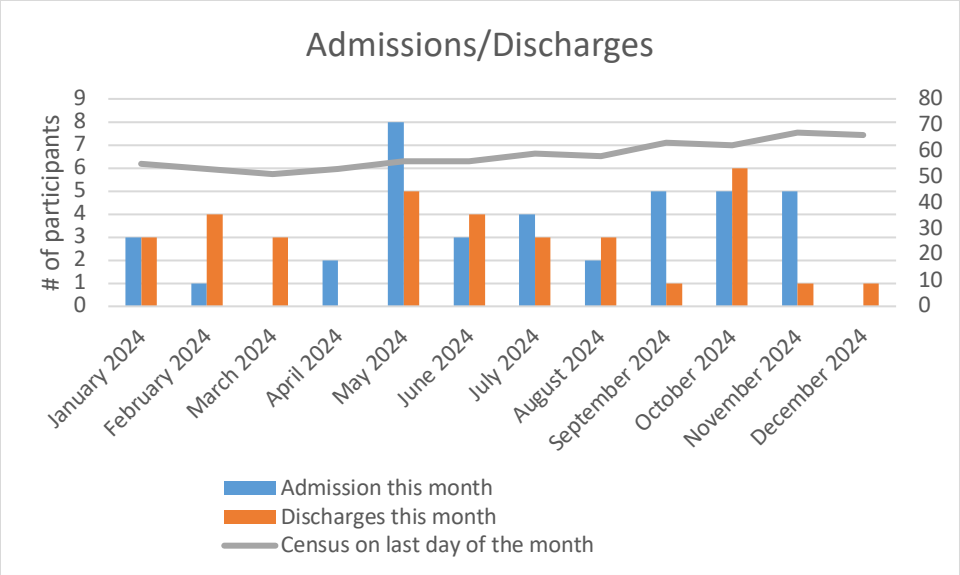
Actions to address annual review findings: Weekly Dash Board reports

4. Monthly Metric

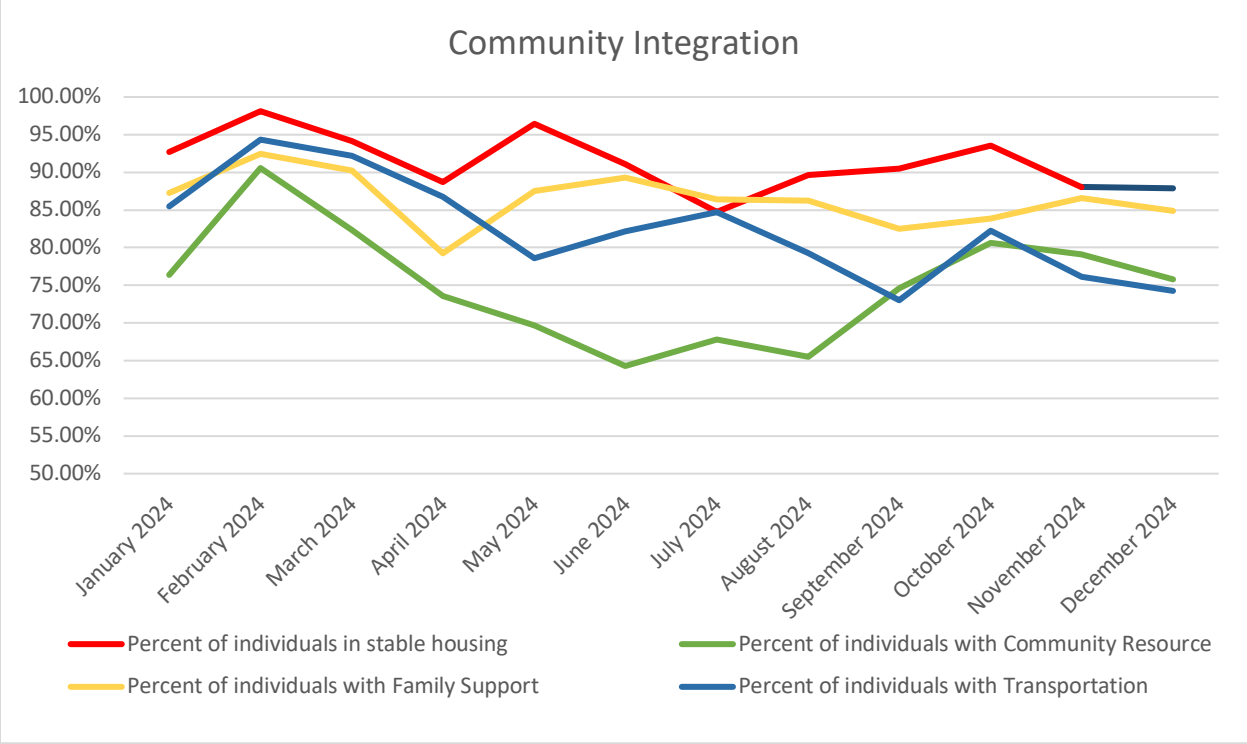
i. Done by staff monthly for every participant to track:

1. Track hospitalizations, criminal activity, living, vocation, income, attachment to community, transportation, education, status of mental health and substance abuse treatment.
2. Track discharges and the events related to discharge, and transition events.
3. See attached metric form

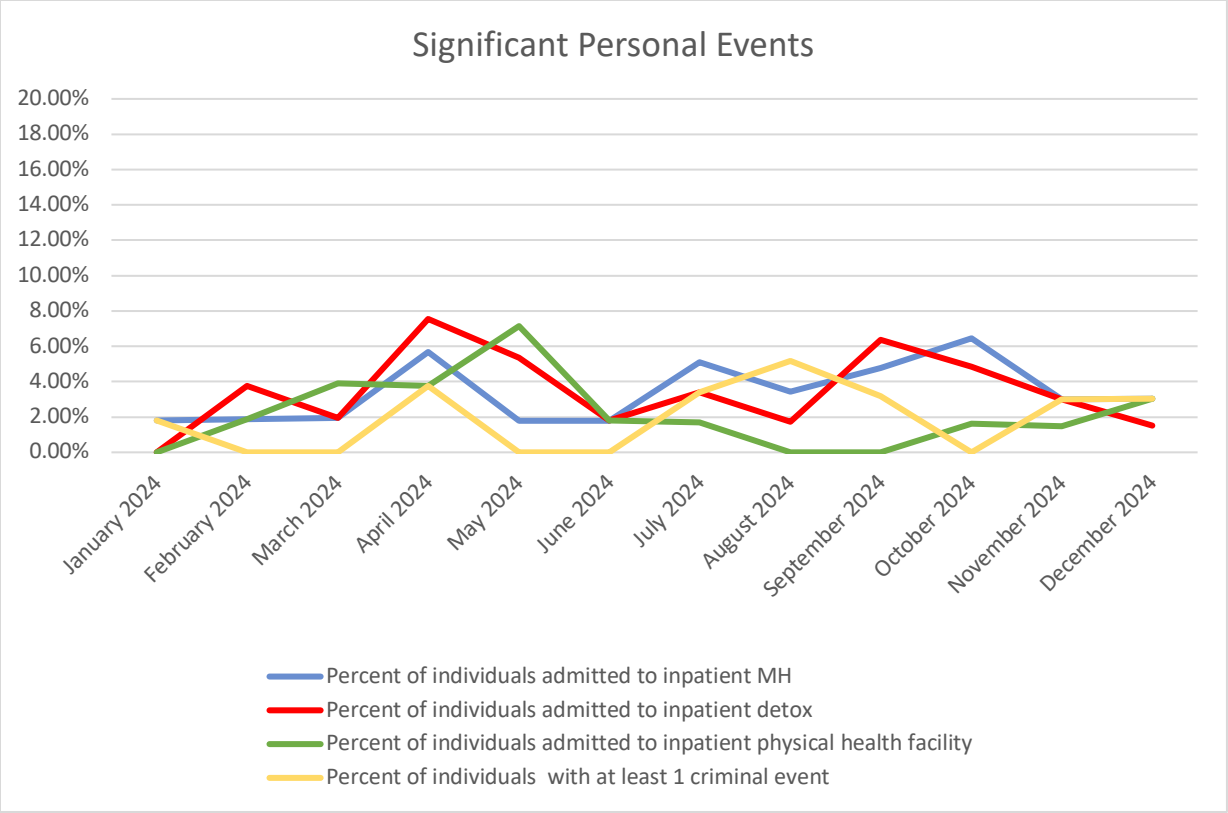
Analysis:



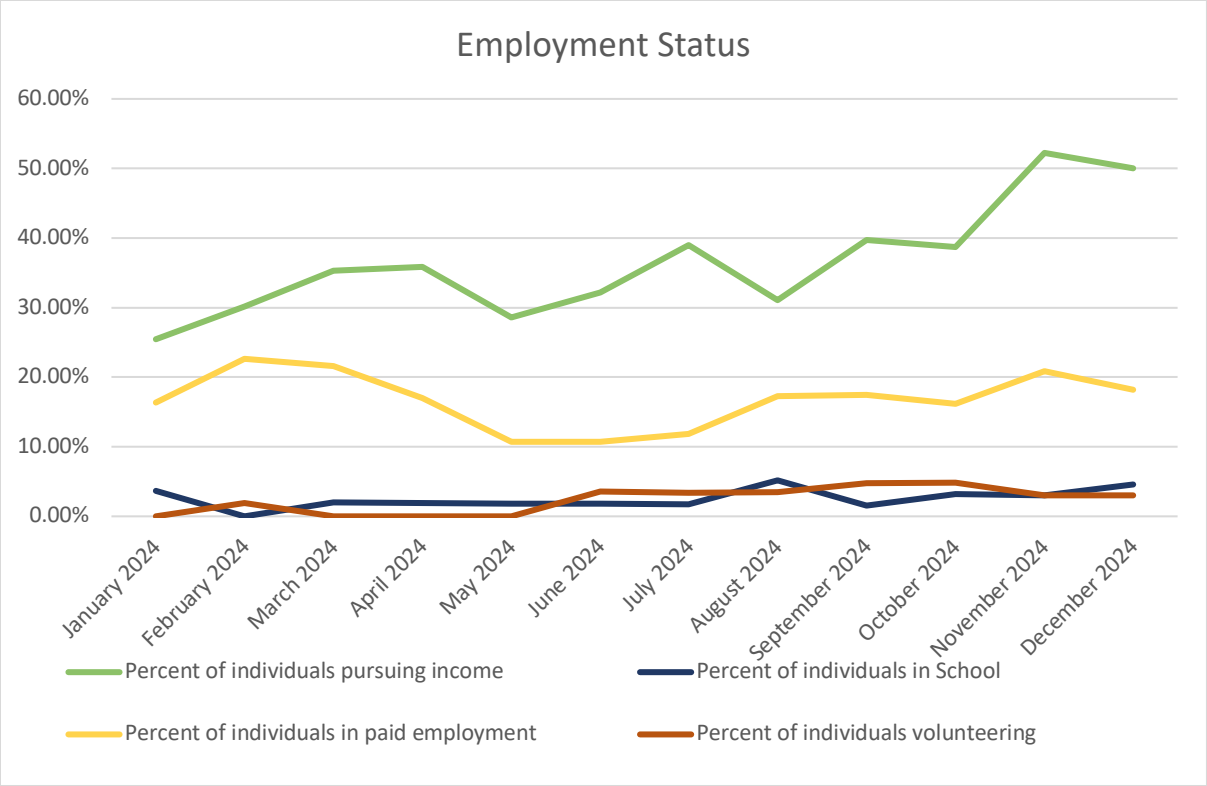
Our census increased by 11 participants, reversing last year's loss of 11.



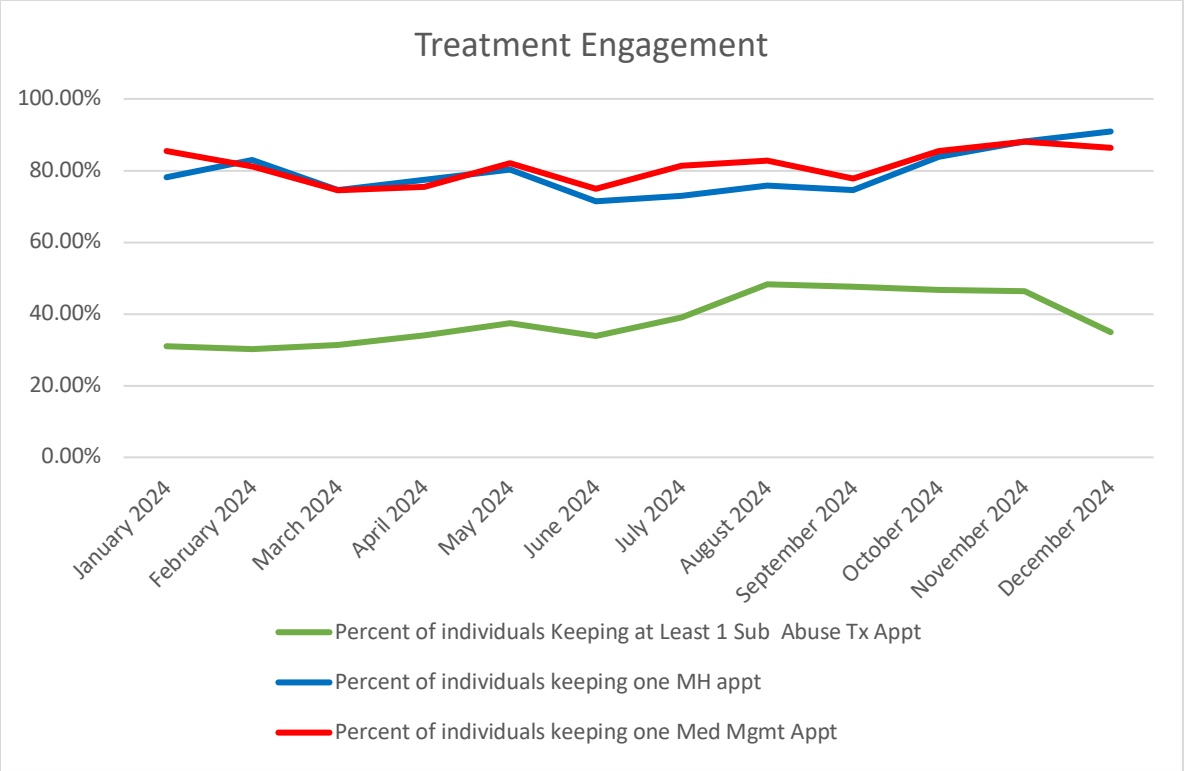
After a peak in February 2024, community integration was down across the board, but the fluctuations are similar to the previous year. An increase connections in community resources after the summer months occurred and we will need to research why this occurred.



The percentages of participants admitted to various inpatient facilities continue to be the same as last year. Once in service admissions stay below 8%



Individuals with jobs fluctuate between 10% and 20%, however, we are seeing an increase in individuals pursuing employment. We will monitor to see if there will be a rise in employment in the next year.



There were a high number of admissions to Inpatient Mental Health and Rehab. Upon closer examination, there were 3 participants that were admitted for some entire months, which is not representative of most of our clients.

Comparison of Before and During RHD Services

In 2024, there were 39 "Before RHD Services" surveys completed.

Admisson to Inpatient:	Total Days Prior to RHD For 39 surveys	Total Days During RHD Services For an avg. of 58 particp/mon
Mental Health	371	318
Drug/Alcohol, Rehab	434	388
Physical Health	3	125

The table shows that we have a lower number of Mental Health and Rehab admissions overall compared to before participants joined our program. Admissions to the hospital for physical health vastly increased after joining our program.

Actions to address annual review findings: Monthly Metric

Now that we know the 3 participants that are outliers, we will work with the CPS to see if a treatment Team meeting needs to be held. We also created time in staffing called "Clinical Discussion" to discuss these cases and create a plan to support

5. Individual Satisfaction

a. RHD Corporate Survey

i. Due to the ownership chain, we did not have a corporate Satisfaction Survey

Analysis:

We will reach out to corporate to see if we can replicate the RHD Survey from 2023 this year.

b. CART Survey

i. Completed by CART(consumer action response team) annually with all willing participants

ii. Results are sent to unit director

iii. Report will be reviewed with Participant Advisory board and staff

Analysis:

The CART survey was conducted on June 28, 2024. **We had face to face interviews and it doubled our response rate. The 15 respondents are not the 50% we wanted but it is a step in the right direction. In order to get a larger number, we may need to do 2 days. Having an event was beneficial and we will certainly replicate it next year.**

On 34 of the 37 scales, we had a perfect score. We did well in "Overall Satisfied and Respect

Actions to address annual review findings: CART Survey