THE ARC OF CHEMUNG-SCHUYLER
QUALITY IMPROVEMENT PLAN

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Reviewed/Revised:

I. INTRODUCTION

The Arc of Chemung-Schuyler aims to provide excellent, quality services that people are satisfied with by having a responsive and adaptive organization to meet changing needs.

Our Mission: The Arc of Chemung-Schuyler is a family-based organization, providing supports to people with varying abilities. We create opportunities for individual growth, while emphasizing choice. Our passion for excellence is evidenced by our family and community partnerships, quality supports, education, and advocacy.

Vision: The people we support are accepted and valued members of their community.

Values: The people we support are first, quality staff, passion for excellence.

This Quality Improvement Plan (QIP) is intended to help us work with persons supported and their families to ensure we are assisting them in developing their lives to the fullest potential. The QIP is meant to help point the Agency in the direction of quality service and data driven results to improve key processes.

II. Key Quality Indicators

As part of the improvement process, Arc of Chemung-Schuyler focuses on eight areas listed below that require continuous focus and attention to achieve improvement. Key indicators, which relate to the current mission statement of the Arc of Chemung-Schuyler, include the following items:

1. Bureau of Program Certification Reviews
2. Incident Review Committee Annual Report
3. Quality improvement reviews by non-regulatory agencies
4. Self-Audits
5. Satisfaction Levels of the People We Support
6. Satisfaction Levels of our Staff Members
7. Human Resource Issues
8. Board of governance and review with attestation of Quality Improvement Plan

III. Activities to Achieve the Key Quality Indicators

1. <u>Bureau of Program Certification Reviews (BPC)</u>

Statements of Deficiency (often referred to as SOD) are issued by OPWDD following a site survey in which there is at least one significant deficiency noted during the survey process. This may relate to areas such as fire safety, medication administration, health services, nutrition, physical plant, personal allowance, habilitation, etc. In some cases, OPWDD will only make recommendations that do not rise to the level in which they issue an SOD. Other, more serious deficiencies will result in the issuance of a 45/60 day letter. These "letters" are issued by OPWDD when very serious site specific or system issues are identified in a survey and/or the services provided are unsatisfactory and may affect the health or safety of the program participants. These "letters," which are also sent by OPWDD to the CEO and then shared with the Board of Directors, requires immediate action and correction; without satisfactory response, OPWDD may close the program or transfer the auspices to another organization. When the organization receives the SOD, the appropriate program staff develops a Plan of Corrective Action (POCA). This plan addresses the specific matter identified by the citation, as well as incorporates a systemic correction that may be necessary within the site or related programs. POCA files are kept within the Quality Department to ensure all supporting evidence is present. In addition, continuous monitoring occurs of the POCAs including documentation review and site visits to ensure all systemic changes have been implemented and are effective.

The Quality Enhancement Director will oversee and coordinate all OPWDD BPC activities and responses, including:

- Ensure that OPWDD survey teams have access to the information and access to the sites that they need and will assist the survey team during its reviews.
- For all certification reviews that result in a statement of deficiencies, the Quality Enhancement Director shall coordinate a comprehensive Plan of Corrective Action (POCA); findings will be shared with Leadership. POCAS will be pre-approved by the CEO prior to sending it to the regulatory agency.
- For all certification reviews that result in a exit conference deficiency, the Quality Enhancement Director shall coordinate an internal POCA. Program leadership is responsible to ensure all corrective actions are completed and the Quality Department will monitor for completion and the effectiveness of systemic corrections.
- Ensure that all SODs that result in a 45/60 day letter are promptly communicated to The Arc New York State Office.
- Maintain, aggregate and analyze data on the OPWDD surveys.
- Share survey data with Leadership and The Arc New York quarterly as outlined in The Arc New York's Chapter Manual.

2. <u>Chapter Incident Review Committee Annual Report</u>

The Arc of Chemung-Schuyler takes very seriously the issue of reporting and investigating incidents as defined by OPWDD in the Part 624 and Part 625 regulations. All staff, regardless of position is provided with training and information on reportable incidents and occurrences, as well as promoting positive relationships with our program participants. Following this initial training, all staff are given an annual refresher on these topics. Where necessary and sometimes following a specific incident, staff or groups of staff are provided focused information to ensure that all incidents are reported in a clear, concise, and timely manner.

After an incident or allegation of abuse is reported and investigated, an assigned agency investigator who has been trained to perform investigations produces a written investigation report. This investigation report is carefully reviewed by the Quality Enhancement Specialist. Once approved, it is submitted to the agency Incident Review Committee (IRC). At each meeting, the initial incidents, investigations, addendums (to the investigations) are carefully reviewed and discussed. Conclusions are examined to determine that they are adequately supported by the information provided in the investigation. Recommendations of both an administrative and clinical nature are also closely examined. The committee may request additional information-sometimes it is gathered while the committee is in session or occasionally through a clarifying memo or addendum afterwards. Once the committee feels that the program has fulfilled its responsibilities, they will close the case. The program must complete an Event Manager Summary that contains all of the recommendations and actions taken. This provides information to the Committee that the program followed through on the recommendations that will be periodically checked. The minutes of each meeting are carefully documented and all of the information (e.g. initial report, investigation, addendum, minutes…) is entered into the OPWDD IRMA (Incident Review Management Application) electronic record keeping system. Any trends or significant issues will be identified and discussed; trend reports are completed and reviewed quarterly with the committee; these discussions are reflected in the minutes of each meeting. If there are trends or significant issues identified, a plan of correction will be completed and monitored by the Quality Department. The Quality Enhancement Specialist will track trends, significant issues and recommendations involving systemic corrections and complete checks to ensure they have been implemented and are effective; a report will be generated of any findings and corrective actions taken which will be shared with leadership.

On an annual basis, staff develops an annual Incident Trend Report that is required by OPWDD Part 624 regulations. This report is an aggregate of the year's results, includes trends as compared to previous years and makes recommendations for training, policies, physical plant, clinical and program services, etc. This report will be shared with the SRC and Program Leadership and the full Board of Directors.

Program Leadership will be present and coordinate all OPWDD Bureau of Program Certification activities and work with the Quality Enhancement Director to develop an plans of correction. The Quality Enhancement Director will:

- Present the annual Incident Trend report to the IRC, Program Leadership and the Board of Directors.

- Submit quarterly, data for substantiated abuse/neglect cases and annually on total reportable events to The Arc New York State Office.

3. Quality Improvement reviews by non-regulatory agencies

There are a number of external bodies that may also conduct quality related reviews. These include JCAHO, IPRO etc.
The Quality Enhancement Director will oversee and coordinate all external quality related activities and responses including:

- Ensure that external survey teams have access to the information and access to the sites that they need and will assist the survey team during its reviews.
- For all reviews that result in recommendations or findings, the Quality Enhancement Director shall coordinate a written response and communicate such findings and response to Leadership and the Program Committee. The response and plan of action from the findings will be monitored and tracked through the Quality Department for effectiveness and will be reviewed periodically at the Program Committee for discussion and input on continuous quality improvement.

4. Self-Audits:

Based on assessment of risk and need, Chapter personnel shall conduct audits on a sample of programs identified as high risk using OPWDD re-certification checklists and related guidance. Risk can be assessed based on prior survey results, survey outcomes, staff and management feedback, etc.

Chapter personnel will be assigned program audit responsibility and programs at greatest risk will be audited at least annually using OPWDD re-certification checklists and related guidance.

This Chapter's self-survey information will be reported to Chapter Leadership and summaries of findings reviewed regularly with the Board of Directors.

The Quality Enhancement Director/Corporate Compliance Officer will oversee the self-audit process, including:

- Posting the most current versions of OPWDD re-certification checklists on the agency's shared website for easy access. Subsequent versions will be provided as released by OPWDD.
- Each Program Director will be responsible for having all certified programs audited at least once annually using the appropriate OPWDD re-certification checklists. The completed audit will be given to the QE Director. The Quality Enhancement Department may also conduct self-audits to assist Program Directors as needed as well as complete additional audits needed to ensure

corrective actions are effective. Self-surveys that indicate deficiencies will require a POCA to be completed by the Program Director and submitted to QE Director within five business days of completed audit.

- QE Director will summarize findings and share with Leadership and Board of Directors on an annual basis.

5. Satisfaction Levels of the People We Support:

The Arc of Chemung- Schuyler shall ascertain feedback regarding satisfaction with agency supports and services and person-centered planning from the individuals supported, their family members, guardians and advocates through opinion questionnaires/surveys. The results of such surveys will be reviewed by Leadership and Board and used to enhance operations.

The Quality Enhancement Department will gather information about the quality of the services, supports and resources provided to individuals on an annual basis, including:

The first method used to gather information on the quality of provider's actions is the completion of an Individual/Family Satisfaction Survey. Individuals and families are asked to complete the Satisfaction Survey at the time of their annual Life Plan review and either turn it in at the planning meeting, mail or complete online. All responses are sent the QE Department. The survey identifies areas of success and areas in need of growth for the individual; these are discussed at the planning meeting and a plan is developed to ensure continued success and how to address the areas in need of growth.

The QE Director shall Coordinate the following activities:

- Maintain the agency's satisfaction survey for use throughout the agency to obtain feedback regarding satisfaction with agency support and services.
- Planning Coordinators will distribute Satisfaction Surveys to Individuals and their families on an annual basis at Life Plan review meetings.
- Review survey results with Program Leadership and Board of Directors.
- Surveys that resulted in dissatisfaction, more than two areas scored as No/Poor or more than three areas scored as Neutral, will be reviewed with affected Program Directors and a response/solution to the concerns will be documented and reviewed quarterly to ensure appropriate action was taken to address.
- Data from the Satisfaction Surveys will be collected and analyzed on an annual basis and areas of systemic concern will be used to create objectives and focus areas for the upcoming year for improvement.
- Contact information of key staff will be distributed upon enrollment into programs/services by the Program Directors. Upon intake of programs and services, information on how to contact agency personnel and board members with complaints and concerns will also be provided. This information is also

posted on our agency website to allow easy access for people supported, their families and advocates.

6. Satisfaction Levels of our Staff Members:

The Arc of Chemung-Schuyler shall ascertain feedback regarding satisfaction from our employees through opinion questionnaire/surveys. The results of such surveys will be reviewed on an annual basis and compared year to year to identify and revise agency objectives to improve employee satisfaction. This information will be reviewed with Leadership and the Board of Directors to help enhance operations.

In 2021 a staff survey was conducted through the National Business Research Institute, topics of the survey included: Employee Engagement, Ethics, Supervision, Diversity & Inclusion, Intent to Stay, Teamwork, Corporate Compliance, Culture & Climate, Management Style, Fairness, Job Satisfaction, Company Image, Communications, Morale, Work Life.

The results were compiled and shared with Senior Leadership, Board, and staff members. The agency created goals to address the areas of needed improvement based on the survey results which included:

Goal #1: Create a culture where the Arc of Chemung-Schuyler is a desirable place to work and where staff feel valued.

Goal #2: To enhance staff engagement with people we support and job satisfaction.

Goal #3: All supervisors will participate in a training on creating a work environment that encourages staff feedback, questions, and recommendations; and ensures supervisors respond in a timely manner.

The QE Director shall coordinate the following activities:

- The HR Department will develop a satisfaction survey for use throughout the agency to obtain feedback from its employees for 2023.
- The HR Department will distribute the satisfaction survey on an annual basis and review and document the results of the survey.
- The CHRO will review the satisfaction survey results with Leadership and the Board of Directors.
- As directed by Leadership and the Board, any actions that result from responses to the survey shall be implemented under the oversight of the CHRO.

7. Human Resource issues such as staff retention rates, OSHA reportable injuries, adequacy of staffing levels and staff development programs:

Senior Management shall have the means to continually assess the adequacy of staffing levels, staff competence, and staff performance and will have a mechanism to address deficiencies.

One of the domains of the agency's Strategic Plan is Staffing; working on staff retention, adequacy of staffing levels and developing staff are the main goal areas to be focused on for this planning period.

The QE Director shall coordinate the following activities:

- HR department utilizes a dashboard that is kept current that provides at-a-glance information on staffing levels and vacancies by program site.
- The CHRO shall provide the QE Directors/Corporate Compliance Officer with data related to the number of injuries to staff (OSHA Reportable) while on the job. This data is analyzed by the Safety Committee and Leadership on an annual basis to develop recommendations.
- DSP Core Competency Evaluation data will be kept by HR and shared with QE Director to ensure compliance.
- Employees who are not evaluated using the Core Competency Evaluation, will be evaluated using the Arc of Chemung-Schuyler Performance Appraisal form. This will be done on an annual basis and the data will be kept by HR and shared with QE Director to ensure compliance.
- Training profiles are kept current and demonstrate staff competence and outdated trainings.
- The agency has a policy/procedure for ongoing staff development and training, Procedure GA-090, to address the training and development needs of the person and their role at the agency.

<u>8. Board Governance and Review with Attestation of QIP:</u>

- Board review of the Chapter's programs and services to ensure conformity with the Chapter's mission.
- Board participation on the standing committee for incident review
- Board visits to program sites
- Board analysis of Chapter self-surveys and regulatory surveys to identify agency or program specific trends.
- Board awareness of State or Federal regulatory authorities' communications regarding deficiencies in any Chapter program or operation.
- Board assurance that senior management has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies.
- Board assurance that the Chapter has a plan for ongoing staff development and training.
- Board assurance that expectations for ethical conduct be communicated and reinforced for all Chapter employees, volunteers, and Board members.

- Board assurance that Chapter practices will encourage the development and expression of self-advocacy by the people receiving support and services; and assurance that a process is in place for self-advocates to Chapter practices and governance.

The QE Director shall coordinate the following activities:

- QE Director will send a copy of the Quality Improvement Plan and a chapter Board Resolution adopting the plan to The Arc New York State office on an annual basis.
- Each Chapter shall have a mission statement. The Board shall review at least annually the performance of the Chapter's programs and services to determine if there is congruence between the Chapter mission statement, the Arc New York mission statement and Chapter operations.
- Ensure that Board member participation on the Incident Review Committee, which is required by regulation, is completed. QE Director is responsible for maintaining the Incident Management Policy IM-030- Incidents/Allegations Management Review and Monitoring which includes membership requirements.
- Chapter Board members will have regular access to program sites and program participants through both announced and unannounced visits.
    - The Program Services Committee oversees the practice of Board members visiting sites periodically using the "Board Awareness Visit" form developed by the QE department to document results. Visits and results will be shared with Program Leadership upon completion and at Board meetings on a quarterly basis.
    - There is a tentative schedule of at least one visit to a program site per month by a Board member.
    - Special events at program sites that include participants are shared at the Program Services Committee and the Board.
    - Board members are given photo identification cards and fob access to program sites.
- QE Director will update compliance policies/procedures as needed and no less frequently than annually to reflect current practices.
- QE Director will summarize for the Board of Directors the findings at least annually of the performance of the chapter's programs and services on internal audits and external surveys from regulatory agencies.
- QE Director will provide the Incident Review Committee Annual Report, which contains an analysis of trends for incidents, to the Board of Directors. The results of the analysis will be shared with the Board and the information used to improve performance.
- The agency's Standards of Conduct as well as the Justice Center's Code of Conduct for Custodians of People with Special Needs is reviewed with and signed off on by all new hires on their date of hire and annually thereafter.

- All Board members will be provided with a copy of the Standards of Conduct each September and will sign an acknowledgement form at that time.
- Procedure CC-015: Standards of Conduct is provided to staff and board members and details how to carry out daily activities within appropriate ethical and legal standards and how to promote a positive and ethical work environment for staff and people supported.

III. The Arc New York Quality Indicators

To assess the quality of the entire organization, Chapters must periodically provide information to The Arc New York. This information, captured in three areas known as Indicators, is as follows: a) Statements of Deficiencies, b) Incidents, and c) General Programs. Using the Chapter Information System- web-based portal, the QE Director will ensure the following data points have been shared to assist with the Arc New York global quality initiative:

General Program and Operation:

- Total # of full/part-time employees
- Total # of unduplicated individuals served in OPWDD programs ONLY
- # of individuals residing in IRAs
- # of individuals residing in ICFs
- Total # of full/part-time employees that have exited employment
- Total # vacant FTE DSP positions
- Total # of budgeted FTE DSP positions
- Total # of vacant Frontline Management positions
- Total # of budgeted Frontline Management positions
- Total # of Frontline Management employees
- Total # of Frontline Management employees that have exited the position
- Total # of Emergency Room (ER) Visits for individuals residing in IRAs
- Total # of Emergency Room (ER) Visits for individuals residing in ICFs
- Total # of full-time and part-time DSPs employed by the Chapter during this quarter
- Total # of full-time and part-time DSPs who have exited the Chapter during this quarter.
- Total # of full/part-time DSPs that have exited employment within the first 180 days of employment
- Total # of full/part-time DSPs that have exited employment between 181-364 days of employment

Statements of Deficiency:

- Total # of OPWDD Bureau of Program Certification (BPC) surveys

- Total # of OPWDD Bureau of Program Certification surveys resulting in a formal Plan of Corrective Action (POCA)
- Total # of Office of Fire Prevention and Control (OFPC) surveys
- Total # of Office of Fire Prevention and Control (OFPC) surveys resulting in a formal Plan of Corrective Action

Incidents:

- Total # of substantiated investigations of Reportable Incidents - Abuse/Neglect

Annual Data Points:

- Total # of unduplicated individuals served in ALL PROGRAMS
- Total # of unduplicated individuals age 18-65 served in all programs
- Total # of participants gainfully/competitively employed due to agency supports
- # of individuals residing in IRAs
- # of individuals residing in ICFs
- Number of 45 or 60 day letters received
- Total # of Reportable Incidents: Abuse & Neglect (14 NYCRR Part 624)
- Total # of injuries to individuals (14 NYCRR Part 624)

The Arc New York State Office must receive copies of minutes of the Board meeting where the data has been reviewed and the targets for improvement for the coming year have been detailed.

V. Review & Revision

The Quality Improvement Plan (QIP) will be reviewed and revised as needed on an annual basis. The purpose of the review is to keep the QIP usable, reliable, and meaningful to the agency. The QED will take the lead on the review cycle in the first quarter of the year; the QIP will be presented to the Board of Directors for review and approval.

An annual Quality Attestation will be submitted to the Arc New York State Office after Board review/approval of QIP and Quality Indicator Data; this should be completed in April.