THE ARC OF CHEMUNG-SCHUYLER
QUALITY IMPROVEMENT PLAN

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Reviewed/Revised:3/27/2024

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 five 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:

- OPWDD Bureau of Program Certification(BPC) Surveys
- Chapter Reportable and Significant Incidents
- Self-Audis/Surveys
- Quality of Life/ Satisfaction of People Supported
- Quality and Satisfaction Levels of the Chapter's Workforce

III. Activities to Achieve the Key Quality Indicators

<u>OPWDD Bureau of Program Certification(BPC) Surveys</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 and Compliance 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 & Compliance 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 & Compliance 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.

Total Number of Surveys in 2023	41
Surveys Resulting in Statements of Deficiency	9
Annual Percentage of BPC Surveys that resulted in a SOD	21.9% (4% decrease from 2022)

Deficient Standards-ICFs
K352 Sprinkler Systems
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K 712 Fire Drills
W 153- Staff Treatment of Clients

W153- Staff treatment of Clients
W 189- Staff Training Program
W120- Services provided with outside sources.
W418-Client Bedrooms
W435- Space & Equipment
W448- Evacuation Drills
Trends Identified: Both 8th St ICF and Liberty ICF received a deficiency for the sprinkler systems missing a data plate that should have been completed when the system was installed. Both sites now have the data plates installed and this should not be an issue moving forward. There was also a deficiency at each ICF location for W 153- Staff Treatment of Clients, however the findings were not similar in nature and no trend was identified.
Deficient Standards-IRAs
2a-2: DSP staff know how to contact the RN using the site/agency mechanism
2a-11: The site ensures that in-home, routine support/care necessary for individuals' health needs is provided per their service plan.
10b-3: There is evidence that the staff implement required care and monitoring following discharge.
8-8 The CSIDD Provider operates at least one (1) Resource Center in their designated region.
6-7: People have access to food at any time.
4-8: The home has a mechanism to offer individuals keys to their bedrooms (or other mechanism to secure and access their bedroom independently).
10i-3: Behavior Supports are revised as needed.
3a-1: An Individual's cash on hand funds do not exceed the monthly congregate level 3 amount + $20.
Standard 10i-1: Behavior Supports are provided per the written plan
Standard 10i-3: Behavior Supports are revised as needed
OPWDD Personal Allowance Manual, Voluntary Community Residences and Voluntary Individual Residential Alternatives are provided funds twice a year by OPWDD that are to be used for clothing, cultural events, trips and incidental.
Trends Identified: There were repeat deficiencies in the area of Behavior Supports. The area of Behavior Supports has been identified by the agency as an area that needs more resources and has been added to the Strategic Plan. There were also repeat deficiencies received during Person-Centered Reviews for lack of community outings and integration.

Goal(s): To decrease the total number of Statements of Deficiencies for the calendar year.

Measurable action(s): A trend was identified in the area of Behavior Supports, receiving multiple deficiencies across various sites. The Arc of Chemung-Schuyler will increase behavior support to the Residential sites through the addition of Behavior Support positions. Program-specific training and assessment of behavioral support will be completed. The number of statements of deficiencies related to behavior supports will be measured in 2024 to determine the effectiveness of adding these positions related to this identified trend.

Measurable action(s): The two ICF locations, 8th St and Liberty St, received ten of the deficiencies in 2023. The audit tool used for the internal reviews will be updated to better reflect the regulations specific to ICFs and reviews will occur twice for both sites in 2024 which will also include a follow-up site visit from the Quality Department after the reviews are completed to ensure all corrective measures have been put in place and are effective. The number of statements of deficiency at the ICF locations will be measured for 2024 in comparison to 2023 to determine the effectiveness of the internal review process.

Chapter Reportable and Significant Incidents

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 & Incident Manager. 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 & Incident Manager 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 & Compliance Director to develop plans of correction. The Quality Compliance 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.

Residential Site	**Number of Incidents Filed in 2023**
8th St ICF	23
Canal St	19
Burkeshire	11
Tug Hollow	11
Wellsburg	10

Goal(s): To decrease the total number of substantiated incidents of abuse/neglect.

Measurable action(s): Based on the identified trend of nine of the substantiated Neglect cases in 2023 were a result of staff not maintaining proper supervision levels within certified IRAs: Arc of Chemung-Schuyler will add review of supervision levels as a standing agenda item to Residential staff meetings. The number of substantiated incidents as a result of staff not maintaining proper supervision levels will be measured in 2024 to determine if there was a decrease from 2023 as a result of the increased training and discussion with staff.

Measurable action(s): Based on the 2023 IRC Annual Report, it was discovered that the below Residential sites had 10 or more incidents filed in 2023. There will be a standing agenda item at staff meetings to discuss incident management and will include scenarios and "real life" examples of incidents received and how the situation could have been handled differently. The Quality Department will also attend at least one staff meeting at each of the locations identified in 2024 to allow staff to ask questions and review any trends noted as well as corrective actions

taken place. The number of incidents will be measured in 2024 to determine if the identified sites had a decrease in reportable incidents.

Goal: To improve the compliance rate of completing investigations within the 30-day requirement.

Measurable action(s): Based on a report sent from OPWDD of incidents from 10/1/22 through 1/1/24, the agency's rate of compliance relative to completing investigations within 30 days is 68%. The minimum compliance average for performance measures required to comply with the HCBS Waiver Health and Welfare assurances is 86%. The Quality Department will complete a re-training on timely completion of investigations and implement a new process for receiving and reviewing investigations before the 30-day time requirement. The number of incidents not completed within the 30-day timeframe will be measured from 2/1/24 through 8/1/24 to determine if improvement measures have been effective in increasing the compliance rate.

Self-Audits/Surveys

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.

Residential Managers will complete site observations on varying shifts, with at least one third of the observations occurring on the evening shift; observation findings are reflected in the monthly managerial reports reviewed by program leadership. These observation reports will be reviewed during self-audits to ensure completion and any follow-up action needed.

The Quality & Compliance 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 Quality & Compliance Director. The Quality 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 Quality & Compliance Director within ten business days of completed audit.

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

Goal: To improve staff training compliance.

Measurable action(s): Based on the results of internal audits completed in 2023 for the Residential program, a trend was identified of staff being out of compliance with their required training. The Training Department will create a how-to tool for Managers to run their training compliance reports in Therap, as well as develop a schedule for in-person training days for annual refresher training. A training compliance report from January 2024 and the compliance report from December 2024 will be compared to determine if these actions had an impact on the training compliance rate.

<u>Quality of Life/Satisfaction of People Supported</u>

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 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 it online. All responses are sent to the Quality 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 Quality & Compliance Director shall Coordinate the following activities:

- 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.

Goal: To increase satisfaction and a feeling of respect for ideas and choices of people supported.

Measurable action(s): Based on the Person-Centered Reviews completed by OPWDD and the satisfaction surveys completed by people supported in 2023, a trend was identified of people supported not having enough involvement in their communities and meaningful activities outside of the house. New Employee Orientation now includes an in-person training on the Home and Community -Based Services(HCBS) Final Rule Standards, this training was previously completed as a virtual offering. This training will include discussions on ensuring people supported receive services in the community to the same degree of access as people not receiving Medicaid HCBS and optimizing individual initiative, autonomy, and independence in making life choices. Site audits completed in 2024 will include a section on HCBS and will talk with people supported and review outing logs to determine if individuals are being supported in being involved in the community and doing activities outside of the house of their choosing. The results of the site audits and satisfaction surveys will be compared from 2023 to 2024 to determine if the actions taken had an impact on people feeling satisfied and respected for their ideas and choices.

<u>Quality & Satisfaction Levels of the Chapter's Workforce</u>

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

The Quality & Compliance Director shall coordinate the following activities:

- The HR Department will develop a satisfaction survey and exit survey for use throughout the agency to obtain feedback from its employees for 2024.
- The HR Department will distribute the satisfaction survey on an annual basis and review and document the results of the survey.
- The HR Department will distribute exit survey to staff who have given a formal notice.
- The CHRO will review the satisfaction survey and exit survey results with Leadership and the Board of Directors.

- As directed by Leadership and the Board, any actions that result from responses to the surveys shall be implemented under the oversight of the CHRO.
- 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 Quality & Compliance Director 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 Quality & Compliance 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 Quality & Compliance 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.

Goal: To improve the quality and satisfaction levels of the Arc of Chemung-Schuyler's workforce.

Measurable action(s): The Arc of Chemung-Schuyler instituted a DSP wage increase effective March 24, 2024. DSP turnover and vacancy rates will be measured pre- and post- wage increase implementation, to determine if this has had an impact.

Measurable action(s): The Arc of Chemung-Schuyler added a new position at the end of 2023, Success Coach, to specifically work with Residential DSPs to train on site and help them feel more comfortable in their role. Three Success Coaches were hired and have begun working with new staff at their assigned sites. DSP turnover and vacancy rates will be measured from 2023 Q4 to 2024 Q4 as well as results from the 2024 Staff Satisfaction Surveys to determine the impact of adding these positions to the training program for DSPs.

<u>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 Quality & Compliance Director shall coordinate the following activities:

- Quality & Compliance 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. Quality & Compliance 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.
    - There is a tentative schedule of at least one visit to a program site per month by a Board member. The results of these visits will be reviewed with Program Leadership and at Board meetings on a quarterly basis.
    - Special events at program sites that include participants are shared at the Program Services Committee and the Board.
- Quality & Compliance Director will update compliance policies/procedures as needed and no less frequently than annually to reflect current practices.
- Quality & Compliance 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.
- Quality & Compliance 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.

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 Quality & Compliance 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.

QIP Review & Approval Process

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 Quality & Compliance Director 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.