The Arc
Otsego
New York

2024 - 2025 Quality Improvement Plan

I. Introduction

The Arc Otsego was founded in 1965 and has established a comprehensive network of community-based programs and services that meet a wide array of individual and family needs.

Our vision is that all people with intellectual and other developmental disabilities will be afforded the same rights and opportunities as all citizens and will be accepted by and enjoy participating in the full spectrum of community life. It is our mission to provide supports, services and advocacy to assist individuals with intellectual and other developmental disabilities to live rich, fulfilling lives.

The Arc Otsego is committed to continuous quality improvement. The Quality Improvement Advisory Committee has been developed to manage and implement the Quality Improvement Plan. This Quality Improvement Plan includes consideration for achieving the key areas consistent with The Arc New York quality standards as well as current quality practices in place at The Arc Otsego.

II. Key Quality Indicators

As part of the improvement process The Arc Otsego focuses on five quality improvement key areas, which relate to the current mission and vision statements.

1. OPWDD Bureau of Program Certifications (BPC) Surveys
2. Chapter Reportable and Significant Incidents
3. Self-Audit/Surveys
4. Quality of Life/Satisfaction of People Supported
5. Quality and Satisfaction Levels of the Chapter's Workforce

III. Activities to Achieve the Quality Indicators

1. Bureau of Program Certification reviews
    - Statements of Deficiency (including 45 & 60 day letters)
    - Exit Conference Forms
    - Plans of Corrective Action
    - The Arc New York quarterly and annual data from Quality Metric Dashboards
    - The Arc New York quarterly Statements of Deficiency report on organization-wide trends

    Statements of Deficiency (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 President of the Board of Directors, requires immediate action and correction. Without a 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 with the site or related programs.

    The Leadership Team ensures that the OPWDD survey teams have access to information and access to the sites that they need and will assist the survey team during its reviews.

Information related to BPC reviews and the findings are shared at Leadership Meetings, to the Quality Improvement Advisory Committee and the Board of Directors on a regular basis.

The Chief Compliance and Quality Officer will ensure Plans of Corrective Action (POCA) are completed by a member of the Leadership team. The POCA must be approved by the Chief Executive Officer and the Chief Operating Officer prior to sending it to the regulatory agency. POCAs will be housed in one location for the Leadership team and Quality Improvement Advisory Committee to review. Reviews of these POCAs will be completed to ensure implementation occurs at dates specified and then at the six-month time frame.

The Chief Compliance and Quality Officer will share the survey data with The Arc New York as outlined in The Arc New York Quality Data Reporting system.

Goal: To decrease the overall number of Statements of Deficiencies received as well as to decrease the number of deficiencies received on Exit Conference Forms. The Arc Otsego received two SODs in the 2023 calendar year. These are the first SODs received in several years. Issues consisted primarily in mealtimes, medication storage and access to the home.

Measurable Action: All Statements of Deficiencies and deficiencies received on Exit Conference Forms are recorded on a spreadsheet for review. A member of the Quality Improvement Advisory Committee will complete an internal review to ensure monitoring plans are occurring. If a plan is not in place, then the committee will take immediate action with the director of the program to correct.

2. Chapter Reportable and Significant Incidents

- Annual Incident Review Committee Report - Trends
- Incident Review Committee meeting minutes
- Corrective Action Plans
- The Arc New York quarterly and annual data from Quality Metric Dashboards

All persons receiving services from The Arc Otsego have the right to be free from abuse, neglect, mistreatment, and/or exploitation. Abuse, neglect, mistreatment, and exploitation of people is expressly prohibited. Procedures have been established for reporting, investigating, reviewing, correcting, and/or monitoring certain events or situations in order to enhance the quality of care provided to persons with intellectual and other developmental disabilities and to protect them to the extent possible from harm.

The Arc Otsego takes very seriously the issue of reporting and investigating incidents as defined by OPWDD in the Part 624 regulations. All staff, regardless of position are provided with training and information on incidents and allegations of abuse, 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 and credentialed to perform investigations produces a written investigation report. This investigation report is carefully reviewed by supervisory staff. Once approved, it is submitted to the agency Incident Review Committee (IRC). At each meeting, the initial incidents, investigations, and 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. Once the committee feels that the program has fulfilled its responsibilities, they will close the case. The minutes of each meeting are documented, and all of the information is entered into the OPWDD IRMA (Incident Review Management Application) electronic record keeping system.

On an annual basis, the Chief Compliance and Quality Officer develops an Annual Incident 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 service, etc. This report will be shared with the IRC, Board of Directors and available for all staff to review. The Chief Compliance and Quality Officer will share the incident indicators with The Arc New York as outlined in The Arc New York Quality Data Reporting system.

At times IRC will have agency wide recommendations. A log will be kept and shared for review.

Goal: To improve training and understanding of the Direct Support Professionals, House Managers, Site Coordinators on prevention of abuse and neglect to decrease reportable incidents. There were no trends noted in the 2023 Annual Incident Review Committee Report. Two out of four incidents were substantiated cases.

Measurable Action: The Incident Review Committee will review all reportable incidents and require documentation of corrective actions. The Quality Improvement Advisory Committee will also review The Arc New York quarterly and annual data from Quality Metric Dashboards.

3. Self-Audits/Surveys

Based on ongoing assessments of program areas the Quality Assurance Specialist (or designee) shall conduct audits on a sample of programs identified as high risk from OPWDD, management or related guidance. This level of risk can be based off prior survey results, observations or feedback by staff and management or a variety of other factors.

Self-audit/survey information and summaries of findings will be reported to senior management immediately following the review and with the Corporate Compliance Committee. This information will be reviewed regularly with the Board of Directors.

- The Chief Compliance and Quality Officer provides copies of OPWDD guidance to division directors as they become available.
- Program directors are responsible for ensuring that their programs meet the criteria.
- The Compliance and Quality Department reserves discretion surrounding the audit schedule and audit tools to review risk areas. For other things, a probe sample using RAT-STATS is audited. If the results warrant it, a larger sample or full audit will be conducted.
- The results of each audit conducted by the Compliance and Quality Department are given to the division director, executive director, and assistant executive director.
- Program directors are responsible for putting plans of corrective action in place when the audit reveals issues.
- All audits conducted by the Compliance and Quality Department are summarized for the Corporate Compliance Committee and the Board of Directors.

Goal: To complete a self-audit/survey of each program identified as high risk using The Arc New York audit tools.

Measurable Action: The results of each self-audit/survey conducted will require a corrective action. These plans will be reviewed by the Corporate Compliance Committee and the Quality Improvement Advisory Committee. Trends will also be noted.

4. Quality of Life/Satisfaction of the People We Support

- Personal Outcome Measures
- Participant Satisfaction Surveys
- Information from an informal grievance process
- Results of Bureau of Program Certification Surveys

The Arc Otsego has a commitment to meet all conditions based on the needs and goals of individuals receiving services as identified in their person-centered service plan.

Personal Outcome Measures assessments are completed for people receiving services to evaluate people's satisfaction with services. This information is shared with individual teams to determine specific actions to be taken for each individual receiving service, as well as the Quality Improvement Advisory Committee to evaluate organizational processes. The people we support are provided with team members' names and contact information on a consistent basis. Individuals and their family/advocates are encouraged to contact agency staff/board members regarding complaints and/or concerns.

Participant Satisfaction Surveys are completed by people receiving services annually at LifePlan reviews. These surveys evaluate people's satisfaction with services and if changes are desired. The information collected is used to determine if supports and services provided are appropriate and desired for each individual receiving services, as well as the Quality Advisory Committee to evaluate organizational processes. Individuals are informed of their Rights and Responsibilities and are encouraged to contact agency staff/board members regarding complaints and/or concerns.

Goal: To increase satisfaction and a feeling of active involvement among the people we support.

Measurable Action: The results of outcome assessments and satisfaction surveys will be brought to the Quality Improvement Advisory Committee for review and discussion each quarter. Dissatisfaction will be discussed thoroughly, and options provided for improvement.

5. Quality and Satisfaction Levels of the Chapter's Workforce

- Reports capturing an assessment of staffing levels
- Staff surveys
- Information from any informal grievance process
- Log of employee injuries and illnesses
- Data from exit interviews

The Arc Otsego is committed to securing and retaining workforce members and ensuring safety in the work environment.

The information obtained through interviews with employees, evaluations of employees, staff surveys, etc. will be coordinated by the Chief Administrative Officer and the Chief Marketing Officer. Reports will be made for determination on what action should be taken organizationally and reported to the Quality Improvement Advisory Committee for approval of any action plan.

Senior management of The Arc Otsego 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. The Arc Otsego maintains a plan for ongoing staff development, training and a robust staff development program is maintained and includes items such as tuition assistance, newsletters, employee recognition awards, and service recognition/awards, etc. as well as generous benefits packet. The Arc Otsego also maintains a comprehensive training program which meets and exceeds regulatory requirements (Part 633.8 Training of Employees). All staff are required to attend an initial orientation training and annual refresher training.

Goal: To identify safety trends to minimize employee injuries and illnesses. To identify trends in the staff satisfaction survey and reduce/increase the frequencies of those trends noted.

Measurable Action: The results of satisfaction surveys will be brought to the Quality Improvement Advisory Committee for review and discussion each quarter. Dissatisfaction will be discussed thoroughly, and options provided for improvement.

IV. Governance Role in Quality Improvement

The Board of Directors has a role in the quality improvement process. The following tasks are part of this process.

- The Quality Improvement Program will be presented to the Board of Directors for approval. Documentation of this approval will be made in the Board of Directors meeting minutes.

- Board review of The Arc Otsego programs and services to ensure conformity with the mission.

- The Board of Directors reviews all external survey and audit findings, monthly Incident Review Committee meeting minutes, the Incident Review Committee Annual Report, and quarterly Corporate Compliance Committee minutes.

- There is a board representative on The Arc Otsego Incident Review Committee. In addition, review of the Incident Review Committee monthly meeting minutes is a standing agenda item at each board meeting.

- Board visits to program sites. Board visits to program sites are documented in the Board of Directors meeting minutes. A form has been developed for board members to use in evaluating each site they visit. Guidelines for the visits will be reviewed with Board members as needed. Board members should review the evaluation form before each visit. Once at a site the member should introduce themselves and ask questions for information as they see fit.

- Board analysis of self-surveys and regulatory surveys to identify agency or program specific trends. Copies of exit forms for regulatory surveys as available are provided to the board and discussed at the board meeting following the survey. The results of internal audits and surveys are included in the Corporate Compliance Committee minutes that are given to the board and discussed by the board.

- Board awareness of State or Federal regulatory authorities' communications regarding deficiencies in any program or operation. The Board of Directors is provided copies of all external survey and audit findings, including deficiencies. Surveys and/or audits are a standing item on the board agenda.

- 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. The Board of Directors approves the annual budget and reviews the finances on a quarterly basis for allocation of resources. All information regarding staffing is supplied to the Board via an Executive Report. Items of importance are discussed and analyzed.

- Board assurance that The Arc Otsego has a plan for ongoing staff development and training. The Board of Directors is kept informed of major changes in the agencies ongoing staff development and training plan goals.

- Board assurance that expectations for ethical conduct be communicated and reinforced for all employees, volunteers, and Board members. The Board of Directors receives compliance training that includes the expectation for ethical conduct.

- Board assurance that The Arc Otsego practices will encourage the development and expression of self-advocacy by the people receiving supports and services; and assurance that a process is in place for self-advocates providing input to the agency, practices, and governance.

- Board approval of new policies. A procedure on how to write and update policies and procedures is available. All policies and procedures for each department will be in one location.

V. The Arc New York Quality Indicators

To assess quality of the entire organization, The Arc Otsego will periodically provide information to The Arc New York. This information, captured in three areas known as Indicators are as follows: a) Statements of Deficiencies, b) Incidents, and c) General Programs. The Chief Compliance and Quality Officer will ensure the following reports have been made to assist The Arc New York quality initiative.

<u>General Program and Operation</u>

1. Total number of full/part-time employees
2. Total number of staff related injuries (see OSHA Definition's)
3. Total number of unduplicated individuals served in all programs
4. Total number of unduplicated individuals served in OPWDD programs ONLY
5. Total number of unduplicated individuals ages 18-65 served in all programs
6. Total number of individuals residing in IRA's (Quarterly and Full Year)
7. Total number of individuals residing in ICFs
8. Total number of participants gainfully/competitively employed due to agency supports
9. Total number of full/part-time employees that have exited employment in year
10. Total number of vacant FTE DSP positions
11. Total number of budgeted FTE DSP positions
12. Total number of vacant Frontline Management positions
13. Total number of budgeted Frontline Management positions
14. Total number of Frontline Management employees

15. Total number of Frontline Management employees that have exited the position
16. Total number of Emergency Room Visits for individuals residing in IRAs
17. Total number of Emergency Room Visits for individuals residing in ICFs
18. Total number of full-time and part-time DSPs employed by the Chapter during a quarter
19. Total number of full-time and part-time DSPs who have exited the Chapter during a quarter
20. Total number of full/part-time DSPs that have exited employment within the first 180 days of employment
21. Total number of full/part-time DSPs that have exited employment between 181-364 of employment

Statements of Deficiency

1. Total number of OPWDD Bureau of Program Certification surveys
2. Total number of OPWDD Bureau of Program Certification Reviews resulting a formal Plan of Corrective Action (POCA)
3. Total number of Office of Fire Prevention and Control surveys
4. Total number of Office of Fire Prevention and Control surveys resulting in a formal Plan of Corrective Action

Incidents

1. Total number of substantiated investigations of Reportable Incidents - Abuse/Neglect

VI. QIP Annual Progress Summary and Review/Approval Process

An annual summary focused on the quality improvement actions taken and the effectiveness of the strategies will be completed. This summary will be used to look ahead to actions for the following year.

- Describe the implementation of goals/measurable actions and the summary analysis of the effects of the actions to bring about the desired and intended change/improvement.

- Include the significant and minor improvements/changes in quality and actions that appear to have had no impact.

On an annual basis, the QIP will be reviewed to include the Annual Progress Summary, revised as necessary and attest that the Chapter Board has examined the QIP. Board review/approval of the plan must be noted in the Board meeting minutes.

- These minutes should also clearly capture the discussion of targets for improvement.
- Upon request, a copy of the plan and the Board minutes must be provided to The Arc New York.
- At a minimum, QIPs must be submitted to The Arc New York for review every three years unless otherwise directed.