AHRC SUFFOLK
2900 VETERANS MEMORIAL HIGHWAY, BOHEMIA, NY 11716

2023
QUALITY IMPROVEMENT PLAN

I. INTRODUCTION

AHRC Suffolk strives for excellence in management and in support services for all people with intellectual and other developmental disabilities. It is our goal to uphold common standards and expectations to promote the well-being of those we support and assure individuals and their families of our common commitment to the AHRC Suffolk mission.

AHRC Suffolk's mission is to support and advocate with individuals of all ages with unique abilities and challenges. Our commitment is to provide individualized, high-quality services, utilizing person-centered approaches to discover and define their quality of life. Our vision includes fulfilling the promise to support individuals with discovering opportunities and choices for realizing a meaningful quality of life. AHRC Suffolk achieved Person Centered Excellence Accreditation from the Council on Quality and Leadership on September 23, 2016, and reaccreditation of Person Centered Excellence for a four year term from October 9, 2020 – October 9, 2024.

The Quality Standards Oversight Committee (QSOC) at The Arc New York has drafted quality benchmarks and quality improvement practices applicable to all of its Chapters. At its April 2012 Board of Governors meeting, The Arc New York QSOC instituted reporting requirements for each Chapter on a regular basis, recognizing that the results of this reporting requirement will enable The Arc New York to benchmark a framework of quality in the field of Developmental Disabilities for New York State and beyond, driving continuous improvement and reaffirming its commitment to excellence.

AHRC Suffolk's governing body will ensure there is a robust plan for quality oversight and improvement. A Quality Improvement Plan is required and there must be Board review/approval of the plan noted in the minutes of a Board meeting. A copy of the plan and the Board minutes will be forwarded to The Arc New York's state office.

The Quality Improvement Plan will include a requirement concerning the annual collection and review of data along with identifying areas for improvement. An annual analysis of the data will determine if revision of the Plan is necessary. The Plan itself should be updated at least every three years with Board review. AHRC Suffolk's Quality Improvement Plan reflects consideration for achieving the following outcomes consistent with The Arc New York's Quality Improvement Standards:

- Individualized supports, planning and service delivery
- Protections, health and safety, rights and environmental supports
- Support of family/natural supports and community connections/inclusion
- Workforce performance
- Continuous quality improvement
- Governance and leadership

II. KEY QUALITY INDICATORS

As part of the improvement process AHRC Suffolk focuses on nine areas listed below that require immediate focus and attention to achieve improvement. Key Indicators, which relate to current mission statement of AHRC Suffolk, include the following items:

1. Bureau of Program Certification Reviews (including the number of reviews and the number of deficiencies)
    - Statements of Deficiency
    - Exit Conference Deficiencies
    - Recommendations
    - Best Practices
    - Plans of Corrective Action
    - Report on plan approval and need for additional improvement

2. Special Review Committee Annual Report
    - Trends (include proactive measures as part of this process)
    - Recommendations for action and plan of correction

3. Quality Improvement Reviews by Non-regulatory Agencies (such as Accreditation Reviews)

4. Self-Audits, Compliance Reviews, and Peer Reviews:
Based on assessment of risk and need, agency personnel shall conduct audits on a sample of programs identified as high risk using OPWDD re-certification checklists and related guidance. Self-survey information will be reported to senior management and summaries of findings reviewed regularly with the Board. Agencies have discretion in developing auditing schedules, identifying risk, sampling, and protocols but such procedures will be outlined in the agency's Quality Improvement Plan.

5. Satisfaction Levels of the People We Support
Questionnaires/surveys with results compiled will be reviewed and utilized for improvement. People we support, their family members and advocates will be provided with contact information on appropriate agency staff/board members for conveying complaints and/or concerns.

6. Satisfaction Levels of our Staff Members.
Questionnaires/surveys with results compiled will be reviewed and utilized for improvement.

7. An Assessment of the Quality of Life of the People We Support
More in depth than a satisfaction survey and emphasizing the CQL Personal Outcome Measures (POM's). Description of how the needs, strengths, interests and aspirations of the person are being met through individualized supports, as well as individual satisfaction with services. The person's input will be included in the self-survey process.

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

9. Board governance and review with attestation of Quality Improvement Plan:

- Review of the agencies programs and services to ensure conformity with the agency's mission
- Participation on the standing committee for incident review
- Visits to program sites (Agency will provide guidelines for visits)
- Awareness of agency self-surveys and regulatory surveys to identify agency or program specific trends.
- Awareness of State or Federal regulatory authorities communications regarding deficiencies in any agency program or operation
- 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
- Assurance that the agency has a plan for ongoing staff development and training
- Assurance that expectations for ethical conduct be communicated and reinforced for all agency employees, volunteers and Board members
- Assurance that agency 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 to provide input to agency practices and governance.

III. ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS

1. Bureau of Program Certification Reviews

Statements of Deficiency (often referred to as SOD) are issued by OPWDD's Department of Quality Improvement (DQI) 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 individuals supported. These "letters", which are also sent by OPWDD to each member of the Board of Directors, require 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.

The Program Vice President and Vice President of Quality Improvement, along with oversight from the Chief Executive Officer (CEO) and Chief Operating Officer (COO) will oversee and coordinate all OPWDD Bureau of Program Certification 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 Vice President shall coordinate a Comprehensive Plan of Corrective Action (POCA) and communicate such findings to agency leadership. POCAS must be pre-approved by the Vice President of Quality Improvement or designee prior to sending it to the regulatory agency.
- Ensure that all SOD's that result in a 45/60 day letter are promptly communicated to The Arc New York's State Office.
- Maintain, aggregate and analyze data on OPWDD surveys.

- Share survey data with leadership and The Arc New York annually as outlined in The Arc New York Quality Data Reporting Form.

2. Incident Review Committee Annual Report

AHRC Suffolk takes the issue of reporting and investigating incidents as defined by OPWDD in the Part 624 regulations very seriously. All staff, regardless of position, are provided with training and information on incidents and allegations of abuse, as well as promoting positive relationships with individuals supported. 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 specific information to ensure 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 (within 5 business days for the ICF program and 30 days for the IRA program). This investigation report is carefully reviewed by supervisory staff. Once approved, it is submitted to the Incident Review Committee (IRC). At each meeting, the initial incident(s), investigation(s), and incident follow-up 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 in nature are also closely examined. The committee may request additional information and/or recommendations. Once the committee feels that the program has fulfilled its responsibilities, they will close the case. The program must complete all of the recommendations and document actions taken. This provides information to the Committee that the program followed through on the recommendations that will be periodically checked during the agency self-survey process. 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.

On an annual basis, Quality Improvement staff will compile data and develop an Annual Incident Trend Report as 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. This report will be shared with the IRC, leadership and the Board of Directors.

The Vice President of Quality Improvement will oversee and coordinate all incident activities and reporting, including:

- The Vice President of Quality Improvement will present the Annual Incident Trend report to the CEO & COO, IRC, leadership, and the Board of Directors.
- The Vice President of Quality Improvement will provide on an annual basis a summary of The Arc New York incident indicators to The Arc New York State Office.

Part 625 Incidents

A. Situations that occur off site while a Person We Support is not under the auspices of the Agency are required to be reported as a Part 625 Event/Situation and reported through IRMA with the actions taken. In cases when a 625 incident is filed, the Agency is responsible for conducting a follow-up incident to the best degree possible and to document actions taken. It is a summary memo of what occurred with the follow-up (completing OPWDD Form 150). As a best

practice, AHRC Suffolk will present all Part 625 Event/Situations to the Incident Review Committee.

3. Quality Improvement reviews by non-regulatory agencies (such as accreditation reviews)
There are a number of external bodies that may also conduct quality related reviews. AHRC Suffolk achieved Person Centered Excellence Accreditation from the Council on Quality and Leadership (CQL) on September 23, 2016, and reaccreditation of Person Centered Excellence for a four year term from October 9, 2020 – October 9, 2024.

The Vice President and Director of Quality Improvement will oversee and coordinate all CQL related activities and responses, including:

- Ensure that CQL 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 Vice President and Director of Quality Improvement shall coordinate any written response and communicate such findings and responses to leadership.

4. Self-Audits:
AHRC Suffolk's Quality and Compliance Department completes self-surveys for all programs/sites at least one time each calendar year, with self-survey information/results reported to leadership and the Board of Directors.

The self-survey process has been in place and consists of OPWDD's site review and person-centered review. Summaries of the internal self-survey findings may be reviewed with the Corporate Compliance Committee, with the Board of Directors and monthly Operations meetings. Additionally, based upon assessment of risk and need, more frequent reviews are completed.

In 2019 the Agency Review Committee was formed to review OPWDD's Agency Review Manual and prepare for future agency review surveys, review/revise/create policies and procedures and best practices agency wide.

The Vice President of Quality Improvement will oversee and coordinate the self-audit process, including:

- Initial memo sent to the program administrator/management prior to the review, noting the areas of review and documentation required
- Observations and interviews to ensure satisfaction
- Record and documentation reviews
- Environmental/Physical Plant reviews
- Exit Conferences to discuss findings, concerns and good practices, as well as recommendations
- Distribution of the findings
- Plan of Correction should be submitted to the Quality/Compliance Specialist
- Any concerns that require immediate attention are communicated with the program's administration during the survey process so immediate correction can be instituted.
- The Vice President of Quality Improvement will summarize the findings for leadership and review with the Chapter Board annually.

5. Satisfaction Levels of the People We Support:

AHRC Suffolk shall ascertain satisfaction with agency supports and services from the individuals supported, family members, guardians, and advocates through opinion questionnaires/surveys. The results of such surveys will be reviewed by leadership and the Board of Director's and used to enhance operations.

The Quality Improvement Department will gather information about the quality of the services, supports, and resources provided to individuals on an annual basis. The first method used to gather information on the quality of provider's actions is the completion of an Individual/Family Satisfaction Survey. Annually, the individual, along with their family if appropriate, are asked to complete the Satisfaction Survey and the Quality Improvement Department will summarize the information and report back to leadership and the Board of Director's. In 2022, the Quality Improvement Department implemented a streamlined process with the use of an electronic version of the survey.

The Vice President of Quality Improvement shall coordinate the following activities:

- Quality Improvement will develop a satisfaction survey for use throughout the agency to obtain feedback regarding satisfaction with agency supports and services.
- The Vice President of Quality Improvement will coordinate distribution of the surveys on an annual basis.
- The Vice President of Quality Improvement will review the survey results with leadership and the Board of Directors.
- People we support, their family members and advocates will be provided with contact information on appropriate agency staff and leadership for conveying complaints and/or concerns.
    - Agency-wide information sheet for people who receive supports and their family members/advocates on how to contact agency personnel will be individualized by program.
    - Contact information, the agency's Privacy Policy and contact page is also made available on the agency's website at ahrcsuffolk.org.
    - The agency will maintain a policy that requires the Admissions Coordinator to distribute the information sheet to new enrollees as they enter the agency.

6. Satisfaction Levels of our Staff Members:

AHRC Suffolk shall ascertain satisfaction from our employees through opinion questionnaires/surveys. An electronic survey is now used to collect such data. The results of such surveys will be reviewed by leadership and the Board and used to enhance operations.

The following activities will occur annually:

- The Vice President of Human Resources will develop an employee values survey for use throughout the agency to obtain feedback from its employees.
- The Vice President of Human Resources will distribute the values survey to staff every 12-18 months and review and document the results of the survey.
- The Vice President of Human Resources will review the survey outcome with leadership and the Board of Directors.
- As directed by management and the Board, any actions that result from the responses to the survey shall be implemented under the oversight of the Vice President of Human Resources.

7. An Assessment of the Quality of Life of the People We Support:

Description of how the needs, strengths, interests and aspirations of the person are being met through individualized supports, as well as, individual satisfaction with services. The person's input will be included in the self-survey process.

AHRC Suffolk has made a strategic decision to maintain accreditation with the Council on Quality and Leadership (CQL). This internationally recognized non-profit organization focuses on serving individuals with disabilities to enhance and provide a robust level of person centered supports that facilitate the achievement of their personal goals and aspirations. In addition, CQL assists organizations in conducting an intensive self-survey process that eventually leads to accreditation.

The CQL framework is an evidenced based system that includes an extensive data set of reliable and valid measurements of quality of life. This is most clearly demonstrated in the CQL Personal Outcome Measures (POM's), which are 21 areas that are determined by the individual as to whether they are achieving their desired goals and whether the organization is providing the necessary supports. OPWDD has announced its intention to use the 21 outcome measures as part of its analytics in measuring quality in the future.

The Personal Outcome Measures are categorized into five groups: My Human Security, My Community, My Relationships, My Choices, and My Goals.

- My Human Security focuses on safety, freedom from abuse and neglect, best possible health, continuity and security, exercising rights, treating people fairly, and respect.
- My Community focuses on areas such as people using their environments, living in integrated environments, interacting with members of the community, and participating in the life of the community.
- My Relationships focuses on connecting people to natural supports, friendships, intimate relationships, sharing of personal information, and social roles.
- My Choices focuses on where people live and work, as well as choosing services.
- My Goals focuses on choosing and realizing personal goals.

The Personal Outcome Measures are relatively simple and straightforward but contain the characteristics that are very relevant to AHRC Suffolk because:

- They are Personal. Each individual determines what quality means for him/her and the unique life that they lead.
- They are Outcome based. The work is guided by the individual and their expectations, and the results relate very much to what they want and desire.
- They are Measured Differently. The CQL approach addresses the questions of priority and relevance for each person, based on the person's priorities.

The information that is gathered is done so in a highly person-centric way in which a trained interviewer meets with the individual supported (sometimes several interviews are required). They engage in a semi-structured interview (or conversation) in order to make an assessment of the 21 data measures and to assist the person in developing focused priority goals. In addition, a person who is very familiar with the individual is also interviewed in order to gather additional information. This process then carefully ascertains what is critically important to the individual and that information is shared with the individual's team. Additional desired outcomes are integrated into the individual's plan, which is periodically reviewed at least on a semi-annual basis. This is a highly personal way to gather information and ensure that the individual is fully

heard and considered and the values and objectives that are most meaningful are included in their goals and plans.

As this process unfolds, AHRC Suffolk will obtain data on whether individuals served in our programs are reaching their aspired goals and if they have the necessary supports. The data gathered through the CQL POM interviews will be analyzed periodically and presented at least once a year to the Person Centered Planning Committee and Leadership meeting. When the information is aggregated, it will tell an organizational story as to what additional steps may be needed to improve the quality of services, whether it is in the area of training or supervision, access, actual services, etc.

The data will be collected, analyzed for trends and identify areas that require capacity building. Through these efforts, it is anticipated that the follow up will result in a higher level of individualized services, supports, and satisfaction. Some of this work will cause individual staff, various programs, and management to re-evaluate what services are provided, how they are provided, our expectations and assumptions, as well as our protocols and policies and procedures.

This major undertaking of CQL's Personal Outcome Measures will clearly hone our focus on individualized supports, each person's health and safety, their rights, the attainment of their choices and goals, and whether we have in place the appropriate degree of supports. As data will be collected in 21 outcome areas, AHRC Suffolk will begin to measure its progress to achieve the benchmarks set by CQL.

The Vice President and Director of Quality Improvement shall coordinate the following activities:

- Engage in POM training with staff.
- Utilize the work done in 2016 with the Basic Assurances to continue informing organizational transformation.
- Obtain trainings for POM Trainers to remain compliant with CQL Standards.
- Facilitate trainings for new POM interviewers, as needed, to meet organizational needs.
- Aggregate and analyze POM data. Develop and utilize Basic Assurances Monitoring System. Develop and update a policy to govern the use of Personal Outcome Measures.
- Teach providers, individuals, and families about the organization's journey with Personal Outcome Measures.

8. <u>Human Resource issues such as staff retention rates, OSHA reportable injuries, adequacy of staffing levels and staff development programs:</u>
Leadership at AHRC Suffolk 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 Agency will have a plan for ongoing staff development and training.

The Vice President of Human Resources shall coordinate the following activities:

- HR, along with leadership, will develop vacancy reports that provide information on staffing levels (staff vacancies by program site) and that is updated regularly.
- Provides data related to the number of injuries to staff while on the job. This data is analyzed by the Safety Committee and submitted annually to The Arc New York State

Office. This data will be analyzed by leadership and submitted to The Arc New York, Inc. annually.

- Maintenance of a staff vacancy report which is updated on an on-going basis.
- Ensures on-going staff development and training through in person training and/or Relias (online training platform) which meets OPWDD regulatory requirements of Part 633.8 and includes competency based training consistent with the Council on Quality and Leadership Basic Assurances.
- There is an established orientation process which provides new staff with information they need as Agency employees. Departments also have their own on-site procedures which are department and site specific.
    - Staff trainings includes:
        - Training on natural supports to support people to maintain and develop relationships;
        - To prohibit and prevent abuse, neglect, mistreatment and exploitation;
        - To recognize and respond to people experiencing medical emergencies,
        - First Aid, CPR and general medication training;
        - Mentoring, on the job support, management and personal development planning;
        - Training in skills and abilities needed to provide people with their individual supports and services;
        - Additional trainings as warranted based on internal and external reviews/findings.

9. <u>Board governance and review with attestation of Quality Improvement Plan</u>:
    - Review of the Agency's programs and services to ensure conformity with the Agency's mission
    - Board participation on the incident review committee
    - Visits to program sites
    - Analysis of the Agency's self-surveys and regulatory surveys to identify agency or program specific trends.
    - Awareness of State or Federal regulatory authorities communications regarding deficiencies in any program or operation
    - Assurance that leadership has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies
    - Assurance that the Agency has a plan for ongoing staff development and training
    - Assurance that expectations for ethical conduct be communicated and reinforced for all employees, volunteers and Board members
    - Assurance that Agency 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 to provide input to Agency practices and governance.

The Vice President of Quality Improvement shall coordinate the following activities:

- The Vice President of Quality Improvement will send a copy of the Quality Improvement Plan and Board Resolution adopting the plan to The Arc New York state office on an annual basis (by April 30th each year).
- The Agency shall have a mission statement. The Board shall review at least annually the performance of Agency programs and services to determine that there is congruence between the Agency mission statement, the Arc New York mission statement and Agency operations.

- Ensure that Board member participation on the Incident Review Committee, which is required by regulations, is completed. The Vice President of Quality Improvement will finalize draft incident management policies, specifically Incident Management Policy regarding Membership.
- Board members will have regular access to program sites and individuals served.
    - Visits to program sites will be mentioned at board meetings and include in board minutes.
    - The Board of Directors will develop a tentative schedule for at least one visit to a program site annually.
    - Special events at program sites or that include individuals supported will continue to be announced at board meetings and included in the minutes.
    - The Board of Directors shall be active in observing programs and residences in the Agency.
- Vice President of Corporate Compliance will update compliance policies to reflect current practice as it relates to surveys.
- The Vice President of Corporate Compliance and Quality Improvement will summarize for the Board of Directors the findings at least annually of the performance of all programs and services on internal audits and external surveys from regulatory agencies.
- The Vice President of Quality Improvement 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 Vice President of Human Resources shall provide an annual summary to the Board related to the adequacy of staffing levels, staff competence, and staff performance as outlined in #8.
- The Agency will specify the ways in which expectations for ethical conduct will be communicated and reinforced for all employees, volunteers, and Board members. The Vice President of Corporate Compliance will develop a procedure for each of the standards of conduct. Executive Staff shall provide an overview of the expectations and procedures to the Board on an annual basis.

III. The Arc New York Quality Indicators

To assess the quality of the entire organization, agencies must provide information to The Arc New York annually. This information, captured in three areas known as Indicators, are as follows: a) Statements of Deficiencies, b) Incidents, and c) General Programs. Using the Quality Indicators Reporting form, the Vice President of Quality Improvement will ensure the following reports have been made to assist with The Arc New York global quality initiative:

General Program and Operation:

P1. Total # of full/part time employees
P2. Total # of staff related injuries
P3. Total # of unduplicated individuals served in all programs
P4. Total # of unduplicated individuals served in OPWDD programs only
P5. Total # of unduplicated individuals ages 18-65 in all programs
P6. Total # of Individuals Residing in IRAs
P7. Total # of Individuals Residing in Certified ICF's
P8. Total # of participants gainfully/competitively employed due to agency supports
P9. Total # of full/part time employees that have exited employment in year
P10. Total # of vacant FTE DSP positions (CFR 200 codes)
P11. Total # of budgeted FTE DSP positions (CFR 200 codes)

P12. Total # of vacant Frontline Management positions
P13. Total # of budgeted Frontline Management positions
P14. Total # of Frontline Management employees
P15. Total # of Frontline Management employees that have exited the position
P16. Total # of Emergency Room (ER) Visits for individuals residing in IRAs
P17. Total # of Emergency Room (ER) Visits for individuals residing in ICFs
P20. Total # of Full-time and Part-time DSPs employed by the chapter.
P21. Total # of Full-time and Part-time DSPs who have exited the chapter.
P22. Total # of Full/Part-time DSPs that have exited employment within the first 180 days of employment
P23. Total # of Full/Part-time DSPs that have exited employment between 181-364 days of employment

Statements of Deficiency

S1. Total # of OPWDD Bureau of Program Certification (BPC) surveys
S2. Total # of OPWDD Bureau of Program Certification surveys resulting in a formal Plan of Corrective Action (POCA)
S3. Total # of Office of Fire Prevention and Control (OFPC) surveys
S4. Total # of Office of Fire Prevention and Control (OFPC) surveys resulting in a formal Plan of Corrective Action

Incidents

IN1. Total # of Reportable Incidents - Abuse & Neglect (14 NYCRR Part 624)
IN2. Total # of Reportable Incidents - Significant Incidents (14 NYCRR Part 624)
IN3. Total # of Substantiated investigations of Reportable Incidents-Abuse/Neglect
IN4. Total # of injuries to individuals (14 NYCRR Part 624)

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