2024 Quality Improvement Plan
The Arc of Monroe, A Chapter of The ArcNY

Mission: Empower people to live truly integrated lives and reach their full potential within a progressive community.

Vision: The Arc of Monroe is an inspiring organization supporting people who are living their lives with unprecedented focus on possibilities. We are broadly recognized as leaders who refuse to set limits and boundaries and believe in every person's ability.

Values: Camaraderie, Creativity, Empathy, Excellence, Integrity, and Perseverance

This Quality Improvement Plan fully supports and endorses the chapter's Mission, Vision and Values.

1. Person-centered Approaches:

   Service delivery is based on a person-centered planning methodology. This means that all service delivery and support begins with the person being supported. In collaboration with them, we design the type and scope of services and supports we will provide based on the person's individual preferences while focusing on skill development or reducing the likelihood that someone will lose skills already attained. Our goal is always to support people in being as independent as possible and in ways they prefer. This includes our support of individualized routines and person-centered utilization of community resources. Schedules are designed with both the person's interests and support needs in consideration. Public transportation, volunteers and/or natural supports are used as appropriate and available to help people establish and sustain community access. There is no "one-size-fits-all" approach. It should not be presumed that what works for one person will work for someone else. This approach speaks to our commitment to quality of care and support for the people we work with. We continue to strive to provide the best support possible.

2. OPWDD Bureau of Program Certification (BPC) Surveys:

   To effectively monitor and respond to BPC/OFPC survey activity and trends, we actively track the information listed below. This data is pulled for their survey cycle and not the calendar year (so for 2024, the data pulled will be from 10/1/23 through 9/30/23):
   - Total number of BPC surveys (including Person-centered Reviews (PCRs))
   - Total number of BPC surveys at certified sites
   - Percentage of BPC surveys that are deficiency-free
   - Percentage of BPC surveys that are SOD-free
   - Average number of deficiencies per survey
   - Total number of facilities-related deficiencies (and percentage of total deficiencies)
   - Total number of medically-related deficiencies (and percentage of total deficiencies)
   - Total number of behavior-related deficiencies (and percentage of total deficiencies)
   - Percentage of OFPC surveys that are deficiency-free
   - Percentage of OFPC surveys that are SOD-free

This information is shared with leadership on a quarterly basis. When/as appropriate or indicated, trends are discussed formally at our monthly leadership meetings. Otherwise, individual trends and results are discussed and addressed within departments.

In addition, on our leadership dashboard, we are formally tracking percentage of BPC surveys without a SOD and percentage of OFPC surveys without a SOD. The goals for these are: 91% of BPC surveys will result in no SOD; and 100% of OFPC surveys will result in no SOD. The dashboard is reviewed regularly at leadership meetings.

3. Chapter Reportable and Significant Incidents:

The Arc of Monroe has a robust Incident Management process, supporting the agency in creating a safe environment in which the people we support can thrive. In order to prevent recurrence of serious incidents and/or abuse/neglect, formal and detailed plans to prevent are required for each incident filed. These are reviewed and approved initially by Incident Department staff before being presented formally to the Special Review Committee for their review and approval. Cases are not closed without an effective plan to prevent in place.

Each year, annual incident reporting trends are compiled with prior year comparisons and presented to the Board of Directors. This report highlights both areas that have improved from prior years as well as areas where additional improvement is warranted. It also identifies system breakdowns and/or contributing factors, listing the top areas of concern and whether or not they are repeated from the prior year. While the Incident Department presents the incident-related data, the Vice Presidents over program operations along with the Chief Operating Officer present on the identified breakdowns and their plans to address them in the coming year. Our goal is always to reduce the number of substantiated allegations of abuse (see below) and to see the system breakdowns/contributing factors being repeated from year to year decline.

As part of our internal metrics list, we track the percentage of substantiated abuse per 100 people in OPWDD services. The target for this metric is 0.3 per 100 people. This data point (along with all metrics data – see later in the plan) is presented to the Internal Compliance Committee and agency leadership on a quarterly basis for review and, when needed, discussion.

Lastly, on our leadership dashboard, we are tracking reportable injuries per 100 people in OPWDD services. These are reported and discussed with leadership on a quarterly basis. The goal in this area is 0.5 per 100 people in OPWDD services.

4. Self-audits and Surveys:

Routine internal compliance audits are conducted on a monthly basis consistent with our audit plan. These focus on the regulatory requirements tied most closely to billing. Audit sample sizes are based on program census, with sample sizes ranging from 10-20% over the course of the calendar year.

Focused compliance audits can be (and have been in the past) initiated upon request based on emergent issues or concerns, or based on audit trends. An example of this has been auditing whether staff are completing agency work when not on the clock.

Due to an emergent trend, we have added to our leadership dashboard to monitor and report out on the distribution of Staff Action Plans (SAPs) within 60 days of the Life Plan meeting. The goal here is to have 98% of them sent out within required timelines. This data point, along with the following are also included on the 2024 Compliance Work Plan to be reviewed and presented on a quarterly basis to the Internal Compliance Committee: completion of monthly summaries by the end of the following month and completion of DDP-1s before beginning billing. These were also identified by trends.

In our Residential and Day Habilitation Programs, routine quality-related (survey-like) reviews are completed on a monthly basis. These focus more on quality-related aspects of our programs and are most closely aligned to BPC surveys. We hope this year to explore similar reviews within our community prevoc programs (staffing constraints have impeded this in the past).

As mentioned above, we have a list of metrics which we collect data on and trend on a quarterly basis. Specifically, these include:

- Rate of substantiated abuse/neglect per 100 people in OPWDD services: target is 0.3/100
- Percentage of nutrition/dietician encounters in our Article 16 clinic in which a BMI is documented: target is 98%
- Total average BMI score for everyone seen by the dietician in our Article 16 clinic: target is 37.1
- Total average BMI score for people in our residential program who are seen by the dietician in our Article 16 clinic: target is 36.8
- Total average BMI score for people outside our residential program who are seen by the dietician in our Article 16 clinic: target is 37.2
- Clinic enrollment cycle time: target is 14 days
- SEMP enrollment cycle time (measured from the date of referral to the date we reach out to initiate enrollment): target is 14 days
- Residential enrollment cycle time: target is 15 days
- Day Habilitation enrollment cycle time: target is 15 days
- Community Prevoc enrollment cycle time: target is 14 days
- Medication error rate per 100 people in residential: target is under review
- ED visit rate per 100 people in residential: target is 12/100
- Rate of aspiration pneumonia as a diagnosis for people in residential per 100: target is 1/100 per quarter
- Percentage of people in residential who received an annual flu vaccine: target is 90%

Some of the targets (such as those for enrollment cycle time) are derived from the SIP-PL document from a few years ago. Other targets are based on internal experience and, where available, industry standards although those are hard to come by.

Data is shared with the Internal Compliance Committee and agency leadership on a quarterly basis. Factors contributing to not reaching targets are discussed at leadership meetings to try

and improve results. As necessary, we also review assumptions around collecting these data to ensure that we are getting the information we hoped for.

5. Quality of Life/Satisfaction of the People we Support:

In 2024, we will implement a satisfaction survey for people we support in the following programs: Article 16 clinic, Self-direction, Supported Employment, Community Habilitation, Day Hab, Community Prevoc and Residential. In addition, we will implement a survey for our families. The goal for all of our surveys is to be in the 90th percentile of people satisfied. Surveys are set up with a program a month. Each survey includes ten questions. For the surveys of the people we support, the first five questions are the same for all programs so that we can obtain an agency-wide pulse on the overall satisfaction in these key areas. The other five questions are program-specific. Results are distributed to the leadership of the department. The agency-wide trends are shared with agency leadership once they are updated after new survey results come in. Programs are asked to review and respond within their programs to their individual findings.

Through discussion with executive leadership, in order to allow programs time to respond to survey results and effectively implement any follow-up actions, surveys for the people we support will be implemented every other year. Consequently, the next survey will occur in 2026.

6. Quality and Satisfaction Levels of the Chapter's Workforce:

The agency is committed to hearing from its workforce on areas that matter. In 2022, we implemented an Employee Engagement Survey. We had a 75% participation rate and an 81% overall employee satisfaction rate.

In 2023, the results were analyzed by employees in focus groups representing the different areas of the organization. They made suggestions for improvements in the areas of Communication, Retention and Recognition. We have developed plans and are in the implementation of the following strategies based on employee feedback:

- ArcSmart – *(Enhance Communication)* A clean, simple employee intranet system for tools and information pertinent to staff. It is a user-friendly site to share agency documents, news, events, and important reminders.
- Department of the Month – *(Enhance Communication and Recognition)* An annual calendar will be set up to recognize a department every other month. A gallery of photos will be developed; communication on what the department does, who is in the department and additional fun facts will be created. This information will be shared through an email, at managers meetings, Town Hall meetings and an ArcSmart department box will be created where employees can "click" to get all department information.
- DSP Success Coach – *(Employee Retention)* This position will assist manager onboarding, support DSP new hires with training for 3-6 months, act as a liaison between orientation/training and job location. The position will improve the onboarding experience and job satisfaction which will lead to overall retention.
- DSP Credentialing Program – *(Retention and Recognition)* This program professionalizes the work of a DSP through an e-badge academy online through NADSP. There are 3

levels of credentialing based on DSP competencies and code of ethics. There is a salary increase once each level of credentialing is accomplished.

In addition to the formal surveys, we hold quarterly Town Halls in which any agency employee can request topics or pose questions they may have to Executive Leadership. These include both an in-person and virtual option, with the in-person location occurring at a new location each quarter.

We will continue to assess the best method and frequency for obtaining important feedback from our workforce.

7. Governance Role in Quality Improvement:

The Board of Directors receives quarterly reports from the VP for Quality and Compliance covering compliance and some quality-related activities. There is discussion on actions being taken to prevent recurrence of issues and to improve quality moving forward. In addition, both the Board's Life Services Committee and the full Board of Directors receive the ArcNY Quality Metrics data, with chapter-specific comparisons. There is also discussion with the Board's Life Services Committee on BPC activity within the agency, including discussion on responses to identified issues. The Board receives an annual Compliance Report, which summarizes the Quality and Compliance Office activities for the prior year, and includes the next year's Compliance Work Plan and updates to the ArcNY Quality Improvement Plan. Lastly, the VP for Quality and Compliance holds a closed session with the board, during which time they can ask any questions they wish, including some of those suggested by The ArcNY.

Approved by The Arc of Monroe Board of Directors on 3/14/24
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