



THE ARC OF MONROE

QUALITY IMPROVEMENT PLAN

FOR 2023

I. INTRODUCTION

ArcNY strives for excellence in management and in support services for people with intellectual and other developmental disabilities and upholds common standards and expectations to promote the well-being of those we support to assure those individuals and their families of our common commitment to the ARCNY mission.

The ArcNY Mission is to improve the quality of life of persons with developmental disabilities by: being the preferred place of support, information, direction, and services for people with developmental disabilities; providing the best in service delivery; speaking with one clear voice in all matters; and becoming a learning organization by building training and educational opportunities into all aspects of ARCNY operations.

ArcNY's Quality Standards Oversight Committee (QSOC) has drafted quality benchmarks and quality improvement practices applicable to all of its Chapters. At its April 2012 Board of Governors meeting, the ArcNY QSOC instituted reporting requirements for each Chapter on a regular basis, recognizing that the results of this reporting requirement will enable ArcNY 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.

Each Chapter's governing body must ensure that there is a robust plan for quality oversight and improvement. A Quality Improvement Plan is required for each Chapter, 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 must be forwarded to the ArcNY state office.

The Quality Improvement Plan must 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 by the Chapter at least every three years with Board review. Chapter Quality Improvement Plans must reflect consideration for achieving the following outcomes:

- 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

1. Individualized supports, planning and service delivery:

The Arc of Monroe is committed to beginning with the person, and working with them to develop an individualized plan of service that is unique to them and supports their wishes and preferences.

2. Bureau of Program Certification Reviews:

The Arc of Monroe is committed to complying with OPWDD, NYS and federal regulations, laws and requirements.

Bureau of Program Certification Visits:

- Please see attached for our procedure on responding to BPC surveys and deficiencies, including the new stratified survey approach.

3. Chapter Special Review Committee Annual Report

Each year the Board of Directors and agency managers receive an annual Special Review Committee Report. The report will include current data, comparison data, and action items that are planned for improvements in program and service areas.

4. Quality Improvement reviews by non-regulatory agencies

ARCWORKS, A VOCATIONAL DIVISION OF THE ARC OF MONROE COUNTY, IS ISO CERTIFIED. THE GENERAL PROCESS IS AS FOLLOWS.

•ISO 9001:2015 IS THE INTERNATIONAL STANDARD FOR THE QUALITY MANAGEMENT SYSTEM (QMS).

•ISO CERTIFICATION PROVIDES ARCWORKS WITH A SET OF PRINCIPLES THAT ENSURES A COMMON-SENSE APPROACH TO THE MANAGEMENT OF BUSINESS ACTIVITIES AND CONSISTENT ACHIEVEMENT OF CUSTOMER SATISFACTION.

•THE ORGANIZATIONAL BENEFITS FROM IMPLEMENTING ISO 9001:2015 AS ITS REQUIREMENTS ARE UNDERPINNED BY EIGHT MANAGEMENT PRINCIPLES:

- A CUSTOMER FOCUSED ORGANIZATION
- LEADERSHIP
- THE INVOLVEMENT OF PEOPLE
- ENSURING A PROCESS APPROACH
- A SYSTEMATIC APPROACH TO MANAGEMENT
- A FACTUAL APPROACH TO DECISION MAKING
- MUTUALLY BENEFICIAL SUPPLIER RELATIONS
- CONTINUOUS IMPROVEMENT

BENEFITS OF CERTIFICATION/REGISTRATION:

•CUSTOMER SATISFACTION - THROUGH DELIVERY OF PRODUCTS THAT CONSISTENTLY MEET CUSTOMER REQUIREMENTS

- REDUCED OPERATING COSTS - THROUGH CONTINUAL IMPROVEMENT OF PROCESSES AND RESULTING OPERATIONAL EFFICIENCIES
- IMPROVED STAKEHOLDER RELATIONSHIPS - INCLUDING STAFF, CUSTOMERS AND SUPPLIERS
- LEGAL COMPLIANCE - BY UNDERSTANDING HOW STATUTORY AND REGULATORY REQUIREMENTS IMPACT ON THE ORGANIZATION AND ITS YOUR CUSTOMERS
- IMPROVED RISK MANAGEMENT - THROUGH GREATER CONSISTENCY AND TRACEABILITY OF PRODUCTS AND SERVICES
- PROVEN BUSINESS CREDENTIALS - THROUGH INDEPENDENT VERIFICATION AGAINST RECOGNIZED STANDARDS
- ABILITY TO WIN MORE BUSINESS - PARTICULARLY WHERE PROCUREMENT SPECIFICATIONS REQUIRE CERTIFICATION AS A CONDITION TO SUPPLY

THE PROCESS OF REGISTRATION FOLLOWS THREE SIMPLE STEPS:

- APPLICATION FOR REGISTRATION IS MADE BY COMPLETING THE QMS QUESTIONNAIRE
- ASSESSMENT TO ISO 9001:2015 STANDARD - THE ORGANIZATION MUST BE ABLE TO DEMONSTRATE THAT ITS QUALITY MANAGEMENT SYSTEM HAS BEEN FULLY OPERATIVE FOR A MINIMUM OF THREE MONTHS AND HAS BEEN SUBJECT OF A FULL CYCLE OF INTERNAL AUDITS
- REGISTRATION IS GRANTED AND MAINTAINED BY THE ORGANIZATION. MAINTENANCE IS CONFIRMED THROUGH A PROGRAM OF ANNUAL SURVEILLANCE VISITS AND A RE-CERTIFICATION AUDIT EVERY THREE YEARS.

INITIAL CERTIFICATION AUDIT

THE ASSESSMENT PROCESS FOR ACHIEVING CERTIFICATION CONSISTS OF A TWO STAGE INITIAL CERTIFICATION AUDIT AS FOLLOWS:

STAGE 1 - THE PURPOSE OF THIS VISIT IS TO CONFIRM THE READINESS OF THE ORGANIZATION FOR FULL ASSESSMENT. THE ASSESSOR WILL:

- CONFIRM THAT THE QUALITY MANAGEMENT SYSTEM CONFORMS TO THE REQUIREMENTS OF ISO 9001:2015
- CONFIRM ITS IMPLEMENTATION STATUS
- CONFIRM THE SCOPE OF CERTIFICATION
- CHECK LEGISLATIVE COMPLIANCE
- PRODUCE A REPORT THAT IDENTIFIES ANY NON-COMPLIANCE OR POTENTIAL FOR NON-COMPLIANCE AND AGREE ON A CORRECTIVE ACTION PLAN, IF REQUIRED.
- PRODUCE AN ASSESSMENT PLAN AND CONFIRM A DATE FOR THE STAGE 2 ASSESSMENT VISIT.

STAGE 2 - THE PURPOSE OF THIS VISIT IS TO CONFIRM THAT THE QUALITY MANAGEMENT SYSTEM FULLY CONFORMS TO THE REQUIREMENTS OF ISO 9001:2015 IN PRACTICE. THE ASSESSOR WILL:

- **UNDERTAKE SAMPLE AUDITS OF THE PROCESSES AND ACTIVITIES DEFINED IN THE SCOPE OF ASSESSMENT**
- **DOCUMENT HOW THE SYSTEM COMPLIES WITH THE STANDARD**
- **REPORT ANY NON-COMPLIANCES OR POTENTIAL FOR NON-COMPLIANCE**
- **PRODUCE A SURVEILLANCE PLAN AND CONFIRM A DATE FOR THE FIRST SURVEILLANCE VISIT**
- **IF THE AUDITOR IDENTIFIES ANY MAJOR NON-CONFORMANCE, THE ORGANIZATION CANNOT BE CERTIFIED UNTIL CORRECTIVE ACTION IS TAKEN AND VERIFIED.**

CERTIFICATION AUDITS:

CHECKING THAT OUR QUALITY MANAGEMENT SYSTEM IS COMPLIANT IS A VITAL PART OF ISO 9001:2015. OUR ORGANIZATION MUST PERFORM INTERNAL AUDITS TO CHECK HOW OUR QUALITY MANAGEMENT SYSTEM IS WORKING. AN INDEPENDENT CERTIFICATION IS COMPLETED YEARLY TO VERIFY THAT OUR QMS IS IN CONFORMITY TO THE STANDARD.

5. QI / Compliance Engagement and Auditing:

- On-site and individualized quality- and/or compliance-focused auditing and support will be provided within each program area.
- Frequency and focus of auditing and support will be determined in consultation with the program's management and based on areas of need identified via BPC findings and/or regulatory changes. Sample sizes will be consistent with census.
- On-going communication with program administration will allow for feedback and focus adjustment.
- Programs may also opt to audit a specific area or process as needed based upon consultation with administration.
- A review of compliance-related elements occurs in each program area throughout the course of the year.
- Results are forwarded to the program, its management and leadership.
- Quarterly compliance and quality data is presented to the internal compliance committee.
- On an annual basis, a comprehensive compliance risk assessment is completed. This includes review of compliance issues, BPC survey results, outside audit results (i.e., OMIG), information from government regulatory agencies on trends and areas of focus, and discussions with HR and senior leadership. Risks are mapped on a matrix, looking at likelihood and impact to identify priority areas. From this, a compliance work plan is developed and reviewed by the compliance committee. The VP for Quality and Compliance is responsible for this task.
- We seek to operate within an organizational framework for quality, the goal of which is to reduce redundancies, develop standardization in policy and procedure, and ensure alignment between organizational quality approaches and those within programs.

Other framework-related tasks:

- We have finalized a concise set of agency policies which have been presented to and approved by the Board of Directors. These policies are based on the CQL basic assurances.
- We are in the process of migrating procedures into the new format. All agency procedures must align with a policy on the approved list.
- Through our metrics workgroup, we identified a starting set of metrics we feel will position us for success in an outcomes-based environment. These include some based on I/DD CAGs, some that are HEDIS-related (more medical), some that are specific to our industry, clinical metrics (for our Article 16 clinic), and metrics related to enrollment cycle time.
- A subset of these metrics is included on our agency's operational goals and plan.
- Consistent with NYS SSL 363-d and 18 NYCRR 521, we have an internal compliance committee which reports to the CEO, who functions as the Chairperson. This group consists of members of senior and executive leadership representing program operations, nursing, IT, HR, finance, clinic, and governance. Their role is to support to the Compliance Officer, review and close compliance and HIPAA cases, review agency outcomes-based metrics, and review and approve compliance policies and procedures. A charter has been developed, consistent with state regulatory requirements.

6. Satisfaction Levels of the People We Support

- In q3 2022, we implemented a new satisfaction survey approach for the people we support and families. We identified 5 agency-wide questions that will be asked in all programs, and then programs identified an additional 5 questions that are program-specific. This will help us to identify any agency-wide trends around key areas, while still being able to assess discrete programmatic areas.
- Programs are surveyed during a given month on a schedule, with the survey frequency to be every 2 years.
- Families will be surveyed as well once every 2 years. This frequency allows the agency to review and respond to the results, and assess the impact of any changes made before surveying again. Family surveys address all programs except Supported Employment and Article 16 clinic, based on the nature of those services.
- Agency-wide results are aggregated and shared with our expanded leadership team (Executive Leadership, Senior Leadership, and Managers at the Senior Director level). Program-specific results are stratified and shared with the program's leadership.
- We are tracking satisfaction rates against established targets. We are also tracking participation rates, understanding that people have the right to refuse to complete a survey.

7. Satisfaction Levels of our Staff Members.

- An agency wide staff survey was implemented in April 2022. We had set goals of maintaining a 75% participation rate and a 78% overall satisfaction rate that we had achieved in our 2019 survey.

- We had a response rate of 75% and an overall satisfaction rate of 81%. We achieved both goals and based on market data which we received from the Greater Rochester Chamber of Commerce, these results were outstanding.
- The results were presented to staff via email message and on-lie presentations, and communication in department staff meetings. Focus groups were developed to address key areas of improvement.
- The focus groups suggested strategies to support employee communication, retention and recognition.
- From these, plans and action items were identified to improve in these areas. We have successfully developed and are in the implementation states to roll out the following to our employees:
- ArcSmart – (Enhance communication channels outside of emails): A clean, simple location (intranet) for tools and information. 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 along with communication on what the department does, who is in the department and additional fun facts. This information will be shared through 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 newly-created position will assist managers with on boarding, support DSP new hires with training for 3-6 months, and act as a liaison between orientation/training and their job location. The intent is to improve the onboarding experience and job satisfaction which will lead to retention.
- DSP Credentialing Program – (Retention and recognition): this program professionalizes the work of a DSP through an E-Badge Academy online through the 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.

8. An assessment of the Quality of Life of the People We Support

- The agency achieved Council of Quality and Leadership (CQL) accreditation in May 2019. We have decided not to re-accredit when this accreditation expires in May 2023. In its place, we will be looking to develop new and innovative strategies to enhance and sustain a person-centered culture agency-wide. This will include an agency-wide periodic self-assessment around key areas related to person-centeredness. This has yet to be developed; we anticipate implementing this in 2024.
- We are committed as an agency to ensure, to the best of our ability, that the people we support experience the best possible health they can, feel safe in all

the environments they visit, are able to identify and exercise their rights like any other citizen, and that they remain free from abuse and neglect.

- As we are stepping away from CQL, we have developed a person-centered interview process to hear from the people we support important aspects of their lives and areas where they may need additional support. Who participated in these interviews may be identified based on emergent issues noted with people we support.
- The agency has committed to trauma-informed care. We have provided training to agency managers and staff, identified measures around trauma, and used these concepts with/for staff as well. All residential staff have participated in this training and it is built into our new hire orientation. This includes recognition that trauma affects everyone, and the importance of self-care for staff in this field. There is an agency-wide work group that has been established to continue to implement trauma-informed concepts in the work we do.

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

- A component of the Agency 2020 Strategic Plan includes focus on the agency competitive edge and culture. Goals include:
 - Revisiting the 2 lowest areas on our employee survey to see if our strategies have impacted these positively
 - Classes are offered to prepare staff for promotion
- There is a process in place to monitor for and complete OSHA reportable injuries on an annual basis.
- There is an established orientation process which provides new staff with information they need as Arc employees. Departments also each have their own on-site orientation (onboarding) procedures which are department- and site-specific.
- In regards to day services staffing, the program reviews referrals and does trials to make sure the supervision level listed are accurate and that we have the staffing to meet the needs of the individual we are looking to take. Every day at each site, staffing is reviewed and a schedule is made for each room to ensure all levels of supervision will be met throughout the day. Adjustments are made in each room according to supervision level needs. Relief staff is used to supplement when there is a staffing shortage. Every year each site is reviewed to make sure staffing is adequate and adjustments are made at the end of the year.
- In Community Habilitation and Family Support Services adequate staffing patterns are determined based on the needs of the individuals that we serve (measured by approved service hours, family needs, grants) and FTE hours that we have available for each program. Budgetary restraints provide each of the programs with a framework from which to work with. To leverage these two components, administrative staff look to OPWDD standards as they provide a basis for minimum staffing ratios and generally accepted practices that our

department complies with. As a program we recognize the economic implications of staffing levels, a proactive approach that involves internal audits, staff supervision, individual's needs assessment and on-going program assessment allows us to readjust staffing levels and, if necessary, request additional funding for positions that will help support our programs and the individuals that we serve.

- All employees attend our Orientation group sessions which include the following:
 - Agency overview
 - HR Policies
 - Presentation by people we support
 - ID badge
 - Incident reporting, abuse prevention and the justice center
 - Benefits
 - Arc systems/Relias training system
 - IT Systems Overview
 - Safe transfer and mobility
 - On the job expectations
 - Trauma informed care
 - EHR overview
 - Rights and responsibilities for people we support
 - Workforce transformation
 - Introduction to DD
 - Sexuality
 - Behavior supports
 - Choking prevention
 - Driving safe
 - ADL training
 - SCIP
 - Wheelchair securement and van testing (if needed)
 - Aging and dementia
- Each program does program/job specific Orientation at the work site. On the job training includes the following:

- Tour location
- Introductions to people they will support
- Overview of mailbox, where to store personal items
- Relias assignments: technology overview, customer complaint process, blood-borne pathogens, sexual harassment training, hazardous chemicals, disaster preparedness, fire safety, preventing slips trips and falls, HIPAA, corporate compliance core training, guidelines for effective training, disabilities overview, human growth and development, workplace harassment, managing challenging behaviors
- Overview of typical day
- Review job description
- Review workplace expectations (cell phones, PTO submissions, breaks, dress code, attendance, etc.)
- Several weeks later, new employees come back for a “deeper dive day.” During this day, the following is covered:
 - Customer service
 - Workforce transformation/DSP competencies review
 - Understanding dual diagnosis
- New managers also participate in ArcWay Leadership training. This training covers:
 - Training on our time and attendance system for supervisors
 - Funding, purchasing and expense reporting overview
 - Overview of marketing and foundation
 - Interviewing, progressive discipline, hiring/termination process, and top 10 policies
 - Supervisor responsibilities in our EHR
 - Promoting employee wellness
 - FMLA FAQs
 - Incident reporting for supervisors
 - BPC surveys
 - Facilities and transportation
 - Billing, IPOP and plans
 - Ledgers, personal allowance, purchasing and spenddowns, vacation packets (residential staff only)

- Building a culture of appreciation
- The power of validation

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

- Board review of the Chapter's programs and services to ensure conformity with the Chapter's mission
 - Each year the Board of Directors will receive an annual Life Services Board Committee Report. The Life Services Committee membership is drawn from the Board of Directors, family members and agency senior program administrators. The charter of the Life Services Committee is to provide oversight and in-depth review of policies and design of all program areas of the agency including residential, day programs, clinical services, transportation, recreation, family support and community services. The Committee will assure that programs, services and supports are in conformance with the mission and core values of the agency and ArcNY.
- Board participation on the standing committee for incident review
 - At least one member of the Board of Directors is a member of the Special Review Committee.
- Currently, one member of the board sits on the Internal Compliance Committee.
- Board analysis of Chapter self-surveys and regulatory surveys to identify agency or program specific trends.
 - Program VPs and the COO will provide routine updates to the Life Services Board Committee regarding regulatory survey results within each program area.
 - Quarterly reports from the Internal Compliance Committee will be presented to the Executive Committee of the board and then brought to the full board.
 - An annual compliance year-in-review report is provided to the full board. Quality and metric-related information will be included as appropriate.
- The chairperson of the board receives copies of all BPC results. Information is relayed by them to the full board as appropriate.
- Information related to HR topics including staff development is presented to and reviewed by the HR/Finance committee of the board. As appropriate, information would be shared with the full board.
- Board assurance that the Chapter has a plan for ongoing staff development and training, and that senior leadership 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 expectations for ethical conduct be communicated and reinforced for all Chapter employees, volunteers and Board members
 - There is a conflict of interest process in place for both the board and key agency employees.
 - Said parties submit a conflict of interest disclosure form annually or if/as situations arise requiring one to be completed.

- The agency has implemented a Whistleblower Policy consistent with the Non-profit Revitalization Act. This is signed by all board members and all employees on an annual basis.
- Board assurance that Chapter 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 Chapter, practices and governance.
 - There has been at least 1 self-advocate on the agency's Board of Directors since July 2006.
 - Currently there is 1 person supported serving on the Board of Directors.