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. 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:

- Upon the arrival of Bureau of Program Certification (BPC) surveyors to any location, the program will notify the associated Quality Coordinator (QC). They will notify the CEO, COO, VP, Site manager, VP for Quality and Compliance, Director of Nursing, Quality Specialist RN, Sr. Dir of Facilities, Dir of Behavior Supports, HR manager, and residential administrative assistant.
- When possible, a QC will attend the exit conference.
- Copies of any exit conference forms and/or statements of deficiencies will be sent by the program to the VP for Quality and Compliance.
- If a plan of corrective action (POCA) is required by the BPC, the QC will facilitate the development of the plan along with program leaders. A copy will be maintained by the program and sent to the VP for Quality and Compliance.
- If any deficiencies are noted on either an exit conference form or a statement of deficiency, the identified concern must be corrected within 30 days. If for any reason, the program is unable to meet the plan, strategies must be written by the program to identify the root cause for the inability to make the correction.
- The QC will schedule a validation meeting in order to ensure corrective actions have been taken. A report will be completed and sent to the program manager, director, administrator, VP for Quality and Compliance, and CEO. The program administrator will follow-up on any unresolved issues after the validation visit.
- All BPC reports must be kept on file at the sites. All copies will be archived for future reference by the QC. This may be in an electronic format.
- The VP for Quality and Compliance will complete a monthly dashboard summarizing agency BPC reviews including the number of reviews and the number and type of deficiencies noted. These will be shared with agency leadership. From this, an annual report will be created and shared with agency leadership.

2. Chapter Special Review Committee Annual Report

Each year the Board of Directors and agency managers will 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.

3. Quality Improvement reviews by non-regulatory agencies

ArcWorks, vocational division of The Arc of Monroe County, is ISO certified. The general process is as follows.

ISO Certification provides your company with a set of principles that ensure a common sense approach to the management of your business activities to consistently achieve customer satisfaction.

Any organization can benefit from implementing ISO 9001:2008 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 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 9001:2008 - 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 three yearly re-certification audit.

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 manual conforms to the requirements of ISO 9001:2008
• 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 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 9001:2008 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 assessor identifies any major non-conformance, the organization cannot be certified until corrective action is taken and verified.

Certification Audits:

Checking that the system works is a vital part of ISO 9001:2008. An organization must perform internal audits to check how its quality management system is working. An organization may decide to invite an independent certification body to verify that it is in conformity to the standard, but there is no requirement for this. Alternatively, it might invite its clients to audit the quality system for themselves.

• The agency achieved Council of Quality and Leadership (CQL) accreditation in January 2015.
• The agency continues to implement the basic assurances plan, the plan for excellence and the POMs implementation plan.
• In August 2016, the agency had their 18 month check-in with CQL. They were exceptionally pleased with our progress.
• The agency is preparing for a full CQL recertification in May 2019.

4. QI / Compliance Engagement and Auditing:

• On-site and individualized quality- and compliance-focused auditing and support will be provided to 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.
• 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 and its management.
• On 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. The VP for Quality and Compliance is responsible for this task.
• We have created a Quality Management Systems (QMS) committee. Through this, we will develop an organizational framework for quality which will reduce redundancies, develop standardization in policy and procedure, and ensure alignment between organizational quality approaches and those within programs. Through this framework, staff will receive training and information on their role in quality, remaining person-centered in the work they do, and how quality operates within the organization. Please see attached charter for further details.

At the end of 2018, a Quality Management Systems committee was created. This consists of quality coordinators and comparable positions from across programs as well as representatives from support departments. During the first half of 2019, this committee developed a Quality Framework. This is designed to:

• Help staff understand why the work they do matters and how it ties to agency mission, vision and values (MVV)
• Ensure alignment between MVV, policies, procedures, work staff do, and the triple aim (to best position us for managed care and a value-based payment environment)
• Build in a continuous improvement cycle (PDCA)
• Establish a concise set of agency policies (which align with CQL’s basic assurances)
• Create a set procedural format, to be adopted agency-wide
• Establish a procedure on procedures which includes controls (to prohibit unapproved revisions) and processes for review and changes.

Graphically, the framework is represented below.
The framework was approved by agency leadership in July 2019. Target date for full implementation is January 2019. The second half of 2019 will be devoted to:

- Developing and implementing training curricula on the framework, with a focus on the “why” our work matters
- Migrating policies and procedures into the new format
- Continuing to look at agency metrics (separate workgroup) and pull metric data into the QMS committee review process as it becomes available
- Bring satisfaction survey data to the QMS committee (see references to satisfaction surveys below)
- Continue to complete internal audits, and develop a way to trend and review that information within the committee

5. **Satisfactions Levels of the People We Support**

   - The agency achieved Council of Quality and Leadership (CQL) accreditation in May 2019.
• Attached, please see our basic assurances plan and the plan for person-centered excellence.

• We continue to implement POMs, with an annual goal of at least 140 interviews. This includes a mix of people who have had interviews in the past and those who have never had one before. We also have a goal to ensure that at least 90% of POMs recommendations are addressed. There is a formal process to ensure that this is monitored consistently. POMs data is being used to improve the lives of individual people based on the information gleaned. In addition, we are looking at how results are trending to help us identify where we need to focus improvement efforts. This is an ongoing process.

• As part of the new Strategic Plan, we have developed and will be implementing satisfaction surveys with the people we support and their families. Satisfaction survey roll-out is to occur in 4th quarter 2019. See attached procedure and examples the satisfaction survey (English and Spanish).

• Satisfaction data will be collected, aggregated, presented to and reviewed by the Quality Management Systems committee. In addition, routine reports will be made to agency leadership and management teams. At least annually, all agency staff will be informed of the results of satisfaction surveys. As appropriate and based on identified trends, site or department-specific data/trends may be shared more frequently and specific to those locations.

6. **Satisfaction Levels of our Staff Members.**

• A component of the Agency 2018 Strategic Plan includes focus on the agency competitive edge and culture. Goals include:
  
  • Decrease in turnover rates
    
    ▪ Right Fit Hiring will be implemented as a strategy to increase effectiveness in employee selection and retention while giving employees a sense of ownership about the organization. This new selection process will focus on ensuring we have a good organizational fit, job fit and fit within the team.
    
    ▪ 30-90 Day Meetings with new staff concentrating on this critical time to encourage future communication, as well as, provide feedback that will improve the workplace and retention.
    
    ▪ Revamp on-boarding process to ensure we are positioning our employees for success which ties to lower turnover and increased retention rates.

  • Implementation of retention strategy
    
    ▪ Employee Engagement/Fun Committee
    
    ▪ Competitive Wages/Benefits
    
    ▪ Coordinated and focused marketing
    
    ▪ Right Fit Hiring
- 30-90 Day Meetings
  - Learning and development for managers
    - Front Line Leader Development Program
    - DSP Credentialing Program
    - Succession Planning
- An agency wide staff survey was implemented in the first quarter of 2019. We had a response rate of 75%. Results were favorable. The results were presented to staff via in-person presentations. Focus groups were developed to address key areas of improvement. From these, plans and action items were identified to improve in these areas.

7. 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.
- Attached, please see our basic assurances plan and the plan for person-centered excellence.
- Consistent with CQL ideals and guidelines, 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.
- We continue to implement POMs, with an annual goal of at least 140 interviews. This includes a mix of people who have had interviews in the past and those who have never had one before. We also have a goal to ensure that at least 90% of POMs recommendations are addressed. There is a formal process to ensure that this is monitored consistently. POMs data is being used to improve the lives of individual people based on the information gleaned. In addition, we are looking at how results are trending to help us identify where we need to focus improvement efforts. This is an ongoing process.
- As part of the new Strategic Plan, we have developing and will be implementing satisfaction surveys with the people we support and their families. Satisfaction survey roll-out is to occur in August 2019.
- Our approach toward habilitation and support always begin with the person. We utilize POMs data to inform areas of interest or focus. As part of our strategic plan, we measure the percent of POMs recommendations that are addressed. In addition, the current Life Plan process incorporates an I AM assessment, completed by the care coordinator. Through the life plan meeting, the support team (including Arc staff) use this and other information from the person to direct the services and supports they receive.

8. Human Resource issues such as staff retention rates, OSHA reportable injuries, adequacy of staffing levels and staff development programs.
• A component of the Agency 2018 Strategic Plan includes focus on the agency competitive edge and culture. Goals include:
  • Recruiting the right talent
  • Engaging employees in meaningful ways
  • Creating opportunities for growth and career development within the agency

• 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. Those with * are for Direct Support Professionals only:
  • Overview of Normal Growth and Development
  • Introduction to Intellectual & Development Disabilities
  • Professionalism at work
  • Corporate Compliance / HIPAA, Information security
  • Hazard Communication,
  • Universal Precautions
  • First Aid for Seizures and Head Injuries
  • Hepatitis B
  • Choking Prevention and Nutrition*
  • Activities of Daily Living Skills Practice*
• Psychology of Disability
• Introduction to Sexuality
• Event Reporting Process
• Promoting Positive Relationships & Safe Environments & Justice Center
• Performance Management
• Team Process
• CPR/First Aid
• Introduction to CQL/POMs
• Sensitivity to disability
• Strategies for Crisis Intervention & Prevention
• Van Training*
• We will be implementing a curriculum for new staff on understanding the rights of the people we support

• Each program does program/job specific Orientation at the work site.
• Managers attend Quest for Excellence Performance Management Training. All managers have also attended communication training and will be attending a reward and recognition training by the middle of 2016.
• The Residential employees attend two 3-hour sessions annually for refresher training and program specific training such as Prevention of Abuse, Leisure Time, Behavior Management.

9. 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.
• 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.
  • An annual self-assessment and regulatory survey trend report as well as the action plan developed in response to the trend report will be reviewed with the Life Services Board Committee.
  • Quarterly compliance reports are provided to the executive committee of the board. Once the formal Quality Framework is in place and formally implemented, quality reports will be presented to this group as well.
• An annual compliance year-in-review report is provided to the full board. Quality reports will be added as well once the quality framework has been implemented.

• Board is aware of State or Federal regulatory authorities communications regarding deficiencies in any Chapter program or operation

• The chairperson of the board receives copies of all BPC results. Information is relayed by him to the full board as appropriate.

• Board assurance 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

• Information related to HR topics 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

• 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 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 are 2 People Supported serving on the Board of Directors.