Coarc
Quality Improvement Plan (NYSARC)

Revised: September 2016

INTRODUCTION

Coarc is committed to quality services for individuals experiencing disabilities. This has been established over the course of many years and is reflected in Coarc's Mission and Vision statement. In all cases the term individual means the person receiving services and/or their guardian/advocates. Coarc's Mission is to "expand abilities, one person at a time, so individuals experiencing disabilities can achieve their individual goals". This Mission statement works in conjunction with a very clear Coarc Vision of "being an ethical organization that is part of a society that recognizes people with different degrees of abilities as full contributing members of their community". Coarc's goals are achieved through consistent standards and expectations for all Direct Support Professionals (DSPs), management staff and Board of Director members. Quality standards and expectations in carrying out the Mission and Vision towards Coarc's goals is a key focus in all operations.

In an effort to further this commitment, Coarc engaged with the Council on Quality and Leadership (CQL). CQL's identified goals include "working with human service organizations and systems to continuously define, measure and improve the quality of life of all people." CQL reviewed a number of Basic Assurance quality factors that are consistent with NYSARC's quality indicators and as of June 2014, Coarc achieved CQL accreditation (four year cycle). This accreditation reflects Coarc's current and on-going focus on quality of services. This relationship has enhanced Coarc's ability for improving the quality of life and the supports we provided to individuals experiencing intellectual and developmental disabilities.

This Quality Improvement Plan (QIP) intends to incorporate NYSARC's nine quality indicators identified by the Quality Standards Oversight Committee (QSOC).

Through Coarc-wide commitment to the Coarc Mission and Vision statement, the CQL Basic Assurances and the NYSARC Quality Indicators, quality can be maintained and improved. This plan is shared with all Coarc stakeholders including the individuals receiving services, their families, staff at all levels in the Agency, and the Board of Directors. Through continued commitment to monitoring the indicators in the QIP, in conjunction with CQL monitoring requirements, Coarc can continue as a model for quality and excellence in the Human Services field.

KEY QUALITY INDICATORS

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

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

3. **Quality Improvement reviews by non-regulatory agencies**

4. **Self-Audits**
   Based on assessment of risk and need, Coarc staff conducts audits on a sample of programs identified as high risk using OPWDD re-certification checklists and related guidance. The self-survey information is reported to Coarc's executive management staff and with Board members via review at the bimonthly Corporate Compliance Committee meetings. Meeting minutes are also provided to the full Board for review, further discussion and approval.

5. **Satisfaction Levels of the People We Support**
   Satisfaction levels are informally addressed via the "open door" policy and the grievance policy, which describes all the opportunities for individuals/families to express their levels of satisfaction. Additionally the Coarc MSCs note satisfaction about services and supports in their Monthly Note, when they have had an opportunity to speak with the individual/family. The individual/family also has the opportunity to discuss level of satisfaction at the ISP Review meetings which occur twice a year. All staff is expected to assist the individual/family with any dissatisfaction expressed and/or ensure that the issues are addressed by the appropriate program management staff.

KEY QUALITY INDICATORS *(cont.)*

6. **Satisfaction Levels of our Staff Members**
   Coarc encourages all staff to complete a "Satisfaction Survey" each year. The Chief Human Resources Office completes an analysis of the responses, with comparison to the prior year's findings, and the results are shared with all employees. The executive management staff discusses the results and develops responses to share with the employees as well as determines any other programmatic or strategic changes for the Agency.

7. **An assessment of the Quality of Life of the People We Support**
   Coarc uses the POM as the primary process to determine quality of life. A POM is completed for each individual receiving services, by the Coarc MSC or by trained program staff if the MSC is not a Coarc staff. The results of the POM are defined in the ISP Profile and become part of the ongoing discussion with the individual about supports and services to meet their stated valued outcomes. The plans prepared with the individual for each service or support also address the POMs information. The POM can be updated at any time and then shared with the staff in order to ensure that the individual's outcomes are current and being addressed.

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**
   The Board of Directors meets monthly and at least annually reviews the following:
   - Board review of Coarc's programs and services to ensure conformity with the Agency's mission
   - Board participation on the standing committee for incident review
   - Board visits to program sites both announced and unannounced
   - Board analysis of Coarc's self-surveys and regulatory surveys to identify agency or program specific trends
   - Board awareness of State or Federal regulatory authorities' communications regarding deficiencies in any program operation
   - Board assurance that senior management has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies
   - Board assurance that the Agency has a plan for ongoing staff development and training
   - Board assurance that expectations for ethical conduct be communicated and reinforced for all Agency employees, volunteers and Board members
   - Board assurance that the Agency's 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 the Agency, practices and governance.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS

1. Bureau of Program Certification Reviews

Oversight and coordination for Bureau of Program Certification activities and responses is the responsibility of the Chief Quality Officer (CQO) in conjunction with the specific program management staff and other quality staff positions, as follows:

- Ensuring that OPWDD survey teams have access to the information and access to the sites that they need and that staff are on site to assist the survey team during its reviews.
- For all certification reviews that result in a Statement of Deficiency (SOD), the Chief Quality Officer coordinates the completion of a Plan of Corrective Action (POCA) and ensures its transmittal to the Bureau of Program Certification staff per their procedures.
- The Chief Executive Officer (CEO) and President of the Board of Directors reviews, approves and signs all POCAs prior to submission to the state office. If the state office staff requires adjustments to a POCA, the Chief Quality Officer is the contact to ensure the adjustments are reviewed by Coarc staff and confirms the changes with the state office.
- The Board Ad Hoc Quality of Services Committee reviews all survey visit results and associated follow up activities at their quarterly meetings, regardless of the issuance of an SOD.
- The Chief Quality Officer ensures that all SODs that result in a 45 or 60 day letter are promptly communicated to the NYSARC State Office staff as required by NYSARC.
- The CQO ensures that survey data is maintained, aggregated and analyzed as part of the overall quality review by key management staff.

The following data is reported annually to NYSARC:

- *Number of OPWDD Bureau of Program Certification Surveys*
- *Number of OPWDD Bureau of Program Certification Reviews resulting in formal POCA*
- *Number of 45 or 60 day letters received*

This reporting is done by the Quality Services Director (QSD) using NYSARC's annual Quality Indicators Reporting Form

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

2. Chapter Incident Review Committee Annual Report

Coarc takes very seriously the issue of reporting and investigating incidents defined by OPWDD in the Part 624 regulations. All staff, regardless of position is provided with training and information on incidents and allegations of abuse, as well as promoting positive relationships with the individuals we support. Following this initial training, all staff is given an annual refresher on these topics.

On an annual basis the QSD and program management staff reviews the incidents by program or service and identifies trends. The QSD completes the Agency Incident Trend Analysis Report which is then reviewed with program management staff, the Incident Review Committee (IRC), the Board of Directors and the final report is submitted to OPWDD. This information is made available to other stakeholders as requested.

The following data is reported annually to NYSARC:

- *Number of Reportable Incidents - Abuse & Neglect*
- *Number of Reportable Incidents - Significant Incidents*
- *Number of Minor & Serious Notable Occurrences*
- *Number of Allegations of "Other Mistreatment"*
- *Number substantiated investigations of Reportable Incidents - Abuse/Neglect*
- *Number of confirmed/founded/substantiated investigations of "Other Mistreatment"*
- *Number of individual deaths*
- *Number of incidents/occurrences resulting in law enforcement notification*
- *Number of program participant injuries resulting in Notable Occurrences*

This reporting is done by the Quality Services Director (QSD) using NYSARC's annual Quality Indicators Reporting Form

3. Quality Improvement reviews by non-regulatory agencies (Example: accreditation reviews)

Coarc undergoes quality improvement reviews by a number of non-regulatory agencies including an annual financial audit occurring in April of each year. This is completed by an external accounting firm. This accounting firm also reviews the Corporate Compliance minutes and makes recommendations on risk associated with any items identified.

CQL accreditation activities include periodic review by CQL of the Basic Assurances Monitoring, including how the Agency is using the Personal Outcome Measures (POM) results to address quality, and monitoring of the progress on the Person-Centered Excellence Plan developed as part of the accreditation process. Coarc successfully completed the CQL reviews and is expected to self-monitor until the re-accreditation process begins in 2018.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

3. Quality Improvement reviews by non-regulatory agencies *(cont.)*

The CQO ensures that the results of all non-regulatory quality reviews and accompanying follow up activities are shared with the Board Ad Hoc Quality of Services Committee at their quarterly meetings. These meeting minutes are then distributed to the full Board for review, discussion and approval.

NYSARC has not requested that specific metric data be reported at this time.

4. Self-Audits

Coarc engages in the following activities as means of self-auditing; these activities are overseen by the QSD and the CQO:

- A self-audit on the status of completion of any POCA occurs by the Residential Auditor (for all Residential programs) and by the Compliance Specialist (for any non-Residential programs). Items that have not been addressed per the relevant POCA are forwarded to the applicable program management staff to address. The results of these self-audits are maintained in an electronic report each year.
- As noted earlier, the Board's Ad Hoc Quality of Services Committee reviews all surveys, Statements of Deficiencies and any associated POCAs at their quarterly meetings and makes any recommendations as necessary to the Board for further follow up by the program management staff.
- The Corporate Compliance Specialist audits the complete record for a set of randomly selected individuals each month, recording the results in an electronic report. Program management staff then reviews the results and notes any corrective actions they take to resolve the issue found upon audit.
- The results of the corporate compliance auditing process is reviewed with the Corporate Compliance Committee at their bimonthly meetings; including any necessary claims adjustments/voids related to the results of the audit. The Corporate Compliance Committee meeting minutes are distributed to the full Board for their review, discussion and approval.

NYSARC has not requested that specific metric data be reported at this time.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

5. Satisfactions Levels of the People We Support

In general, Coarc MSCs are required to assess satisfaction levels each month that they see the individual and to record the satisfaction level in the Monthly MSC Note. This provides an informal assessment that is ongoing and that the MSC can then use to facilitate discussions with provider staff about the individual's concerns.

Additionally all staff is expected to listen to concerns raised by individuals/families regarding satisfaction with services and to resolve concerns or ensure that program management staff and the MSC are informed so that a meeting or discussion can occur.

Each individual receiving Coarc services is offered a Personal Outcome Measure (POM) assessment. The POM provides some measure of the satisfaction level of the individual via interviewing the individual and/or other key members of their "circle of support".

Coarc does have a policy about grievances from individuals/families that defines all the avenues available to report a grievance and to have it addressed via informal or formal processes. This is in addition to the required "due process" procedures specific to changes in an individual's HCBS Waiver Services.

Formal processes include the ability to present concerns directly to executive management staff via their biweekly management meetings and required a written response if requested.

NYSARC has not requested that specific metric data be reported at this time.

6. Satisfaction Levels of our Staff Members

Coarc requests feedback regarding satisfaction from our employees through opinion questionnaires/surveys. Specific activities related to this indicator include:

- Updating and distributing an annual employee satisfaction survey, which can be completed electronically or by paper copy upon request
- Collection and analysis of responses by the Chief Human Resources Officer (CHRO) with comparison to the prior year's findings
- Sharing of results with all employees, with responses expected from management staff as needed or requested by Coarc's Leadership Team
- Overall progress, findings and trends are reviewed by the Leadership Team who then makes recommendations for changes or solutions to the program management staff

NYSARC has not requested that specific metric data be reported at this time.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

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

Coarc made a strategic decision to maintain accreditation with the Council on Quality and Leadership (CQL). This internationally recognized non-profit focuses organizations to enhance a robust level of person centered supports that facilitate the achievement of their personal goals and aspirations. The CQL framework is an evidenced based system that includes an extensive data set of reliable and valid measurements of quality of life which results in a higher level of both individualized services and individual satisfaction.

Medicaid Service Coordinators and other trained staff conduct interviews with individuals on their caseload. Interviews collect the individuals' view relative to "My Self, My World, My Dreams and My Focus". The POM interview relates to "quality of life" as follows:

- *It is personal*: each individual determines what quality means for him/her and the unique life that they lead.
- *It is outcome based*: the work is guided by the individual and their expectations and the results relate very much to what they want and desire.
- *It is measured differently*: the CQL approach addresses the questions of priority and relevance for each person, based on the person's priorities.

Based on Coarc's CQL Basic Assurances Self-Assessments the following actions are monitored on a regular basis to ensure quality of life is attended to:

- Annual POM completion with each individual
- Identification and inclusion of an individual receiving services as a member of the Coarc Human Rights Committee
- Annually reviewing with the individuals their rights and responsibilities
- Annually providing a review to the individual of the Coarc grievance and due process procedures
- Annually including a discussion with the individuals about the need/scope of guardianship/advocacy and alternatives
- Annually reviewing the list of each individual's contacts to verify accuracy of natural supports

NYSARC has not requested that specific metric data be reported at this time.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

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

- OSHA reportable injuries: on a quarterly basis the Coarc Safety Committee reviews staff related injuries and makes any recommendations to the program management staff regarding any progress, findings and trends.

- Staff Development Programs:
  - Coarc maintains a Training Department that monitors and implements OPWDD required initial and recertification trainings, in addition to providing targeted trainings designed with program management staff to address specific topics.
  - Coarc has recently instituted an electronic training system for most of the mandated trainings which also includes trainings to support development of the Core Competencies.
  - Coarc offers a mentoring program for all new supervisory staff.
  - Coarc continues to offer targeted trainings to enhance the supervisory skill set of new and emerging leaders.
  - Summary reports of completed trainings and overdue trainings are generated by the electronic training system and sent to all supervisors at the end of each month; additionally supervisors can view the training status for all employees assigned to them in the software program.

- Staff Retention Rates:
  - The Human Resources Department tracks the number of applications, separations and terminations and compiles the information in order to calculate a turnover rate for the year.
  - The turnover rate is shared with the management staff as needed, and with the Board Personnel Committee annually for review and recommendation. The report includes all prior year retention rates as well as a comparison against other NYSARC Chapters in the surrounding area who choose to respond to requests for information.
  - An annual summary report is shared with the Board on any factors that may have led to changes in staffing levels through analysis of the recruitment and retention summary.
  - The QSD and the Human Resource staff review the prior year rate and current rate annually and identify any causes for change. This is included in a summary report to the Board of Directors.

ACTIVITIES TO ACHIEVE THE KEY QUALITY INDICATORS *(cont.)*

8. Human Resource issues…*(cont.)*

- Adequacy of staffing levels:
  - Program management staff reviews the level of staffing on an on-going basis and makes recommendations when needed to the Leadership Team to adjust staff levels to meet emergent support requirements of the individuals.

The following data is reported annually to NYSARC:

- *Approximate # of FTE staff*
- *Staff related injuries (OSHA defined)*
- *The number of adjusted staff that have exited employment in the year*

This reporting is done by the Quality Services Director (QSD) using NYSARC's annual Quality Indicators Reporting Form

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

The following activities are conducted by the Board of Directors:

- Board participation on the standing committee for incident review
- Board visits to program sites
- Board analysis of Chapter self-surveys and regulatory surveys to identify agency or program specific trends
- Board awareness of State or Federal regulatory authorities communications regarding deficiencies in any Chapter program operation
- Board assurance that senior management has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies
- Board assurance that the Chapter has a plan for ongoing staff development and training
- Board assurance that expectations for ethical conduct be communicated and reinforced for all employees, volunteers and Board members
- Board assurance that Chapter practices will encourage the development and expression of self-advocates to provide input to the Chapter practices and governance.

NYSARC has not requested that specific metric data be reported at this time.

NYSARC QUALITY INDICATORS

To assess quality of the entire NYSARC organization, Chapters must periodically provide information to NYSARC. This information captured is in three categories (some of these were noted within the discussion of the specific Indicator previously):

General Program and Operation

- Approximate # of FTE Staff
- Staff related injuries (OSHA Defined)
- Approximate # of unduplicated individuals served in all programs
- Approximate # of unduplicated individuals ages 21-62 in all programs
- # of Individuals Residing in IRAs
- # of Individuals Residing in ICFs
- Number of unduplicated individuals in vocational programs
- Number of unduplicated participants in non-residential, non-vocational day activities
- Number of participants in certified residential programs
- Number of participants gainfully/competitively employed due to agency supports
- Number of adjusted staff that have exited employment in year

Statements of Deficiency

- Number of OPWDD Bureau of Program Certification Surveys
- Number of OPWDD Bureau of Program Certification Reviews resulting in formal Plan of Corrective Action (POCA)
- Number of 45 and 60 day letters received

Incidents

- Number of Reportable Incidents - Abuse & Neglect
- Number of Reportable Incidents - Significant Incidents
- Number of Serious Notable Occurrences
- Number of Minor Notable Occurrences
- Number substantiated investigations of Reportable Incidents - Abuse/Neglect
- Number of Allegations of “Other Mistreatment.”
- Number of confirmed/founded/substantiated investigations of “Other Mistreatment.”
- Number of individual deaths
- Number of incidents/occurrences resulting in law enforcement notification
- Number of program participant injuries resulting in Notable Occurrences

NYSARC QUALITY INDICATORS

The Quality Services Director ensures that the metrics are collected, reviewed and confirmed during the spring of the following year. The NYSARC required metrics reporting form is then shared with the Board and the Board completes an attestation regarding the metrics and the Quality Improvement Plan. This is submitted to NYSARC along with copies of the minutes of the Board meeting where that data was discussed and quality targets identified.