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Quality Improvement Plan

Mission Statement

SKHOV is a Brooklyn and Bronx based nonprofit that supports children and adults with autism, together with their families, in achieving greater independence, realizing their future potential, and contributing to their communities in a meaningful way by offering person-centered services.

Policy:

The Quality Improvement Plan will be utilized to measure, aggregate and analyze information gathered in order to assess/measure the following:

- Whether the individuals at SKHOV are experiencing the outcomes and quality of life they strive to achieve.
- Agency's effectiveness in planning and delivering person centered services.
- Assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.
- Goals, objectives and processes to address compliance with OPWDD, SED, state and federal requirements.

The analysis will also be used to determine appropriate improvements/revisions to SKHOV's systemic strategies to improve the individual's quality of life. The Quality Assurance Department, in conjunction with SKHOV management and employees, will identify quality of life issues, implement and monitor corrective actions and study their effectiveness in improving service delivery.

Areas of Emphasis:

The Quality Improvement Plan emphasizes three areas for continuous improvement:

1. **Quality of Services –** Services provided are given as prescribed under the SKHOV Mission Statement, New York State and Federal Regulations and Laws and SKHOV Policy & Procedures.
2. **Meeting of Desired Outcomes –** Person-centered services are provided to further each individual's ability to live the life they strive to achieve.
3. **Individual Satisfaction –** Agency is responsive to information collected from individuals and their family members/advocates.

Procedures:

1. At the beginning of the year, an internal QA audit schedule will be developed by the Assistant Director of Quality Assurance for internal audits to be conducted by staff from the QA Department. Internal audits will consist of a review of person centered plans, quality of life goals, medical services, health & safety, individual rights, behavior support plans, staff training, observations and interviews with individuals and staff.
    - At the conclusion of the internal QA audit, a report with all findings will be generated and provided to the program being audited.
    - The Assistant Director of Quality Assurance or designee will meet with the program team to review the findings.
    - Subsequent to the meeting, the program will submit a Plan of Corrective Actions (POCA) to the Assistant Director of Quality Assurance.
    - Assistant Director of Quality Assurance will create a response to the POCA to provide the program with weighted areas of concern and their corresponding regulations.
    - The QA Department will visit to the program to ensure implementation of actions indicated in the POCA.

- Designated QA staff will conduct a monthly review to ensure that Medicaid Exclusionary checks are performed as required for employees, volunteers, contractors, vendors and members of the Board of Directors.
- Designated QA staff will periodically conduct a review of Human Resource files, to ensure that staff credentials required for the job position are met.

2. During the year, external audits are conducted by OPWDD and other Governing Bodies to ensure site/agency is in compliance with State and Federal regulations.
   - At the conclusion of the audit, an Exit Conference Summary will be generated by the Governing Body.
   - If applicable, the program, in conjunction with the QA Department, will submit a Plan of Corrective Actions (POCA) in response to any issues identified.
   - Subsequently, a QA staff will visit the audited program to verify the accurate implementation of actions indicated in the POCA.
   - The Senior Director of Adult programs will review the Exit Conference Summary recommendations/ deficiencies and notify other locations/programs of the recommendations/deficiencies in order to ensure compliance program/agency wide.
   - If the review of the Exit Conference Summary recommendations/deficiencies determines that other locations/programs need to be notified of the recommendations/deficiencies, QA staff will conduct a sample audit of the locations/programs to ensure compliance related to the recommendation/identified area(s) of concern.
   - The QA Department will determine if the Exit Conference Summary recommendations/deficiencies need to be added to the QA internal audit tool in order to ensure future compliance.

3. During the year, SKHOV programs will conduct self-audits in order to ensure compliance and quality of care.
   - Results of self-audits will be copied to the Compliance and QI Plan Activities folder for review by QA staff.

4. Self-Advocacy Meetings will be conducted biweekly. After each meeting a summary report detailing group discussions and outcomes from previous meetings will be generated.
   - Summary reports will be copied to the Compliance and QI Plan Activities folder for review by QA staff.

5. On an annual basis, the SKHOV Strategic/Management Plan will be reviewed to ensure it corresponds to the QI Plan.

6. On a monthly basis, the SKHOV agency review committee will review incidents to ensure individuals are free from abuse/neglect and exploitation.

7. Family Satisfaction Surveys and Individual Satisfaction Surveys will be completed on an annual basis. Survey results will be reviewed and procedures will be put in place to address concerns. The team will make an effort to address all concerns and for those that are not immediately achievable, the team will assist in moving towards meeting the need(s) of the individual/family member.

Quality Improvement Actions:

1. At the end of the year, each department/area will ensure their internal auditing data is sent to the Compliance Officer consisting of aggregated outcome measurements regarding outcomes achieved, not achieved, trends noted, etc.

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Communication:

1. Annually, a progress summary will be generated that identifies the quality improvement actions taken and the results/effectiveness.

2. Annually, the Quality Improvement Plan will be reviewed and approved by the Board of Directors. Documentation of the Board's review and discussion is contained within the Board of Directors meeting minutes.

3. During the admission process, the individual's intake packet will include information for accessing either in electronic format, or, if requested, in paper copies, a copy of SKHOV's QI Plan to persons receiving services who have the capacity to understand the information and to their parents, guardians, correspondents or advocates. Annually thereafter, SKHOV shall inform these parties of the means to access this information.

4. Upon employment/commencement of service (i.e. vendor or contractor) and annually thereafter, SKHOV shall make SKHOV's QI Plan known to agency employees, interns, volunteers, consultants, and contractors.

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Quality of Services – Services provided are given as prescribed under the mission statement, policies & procedures and existing plans.	**Meeting of Desired Outcomes** – Person centered services are provided to further each individual's ability to live the life they want to live.	**Individual Satisfaction** – Agency is responsive to information collected from individuals or their relatives.
Policy & Procedures – all things done according to P & P and OPWDD (no violations)	Life Plans, SAPs, POMS – appropriate valued outcomes, individualization of plan (is it person centered)	Satisfaction Surveys – is the program meeting the needs of the individual; does the agency have a plan to address these findings
Existing Plans – Life Plans, SAPs – plan actionability	Goals/Objectives – were proper steps taken for the individual to attain their desired outcome(s); are goal(s) appropriate, individualized and contribute to a furtherance of desired outcomes and quality of life.	Self-Advocacy – group meets regularly to discuss issues
Health & Safety – environmental hazards, functional facility, HIPAA, OSHA, dietary needs, bathing, eating, choking hazards	Community Inclusion – are individuals engaging in activities of their choice, interacting with people in community that are non-disabled and going out	Individual Interviews – is the program meeting expectations/needs
Medical Services – medication errors, tx received as prescribed, PONS followed/in existence	BSP – do BSPs and other clinical plans decrease targeted behaviors and contribute to a furtherance of desired outcomes	
Individual Rights – choices given, freedom from abuse, confidentiality		
Incident Management – number of part 624 incidents reflective of service quality, incidents of mistx, allegation of abuse. See incident trends for more details		
Employees – code of conduct followed, conflict of interest		
Staffing – ratios met, training occurred		
Self-Assessments – are all departments checking for errors/trends via internal audits, observations, etc. (i.e. fiscal, etc.)		
Board of Directors – data submitted for review regularly, are they kept apprised of issues		
BSP – supervision maintained		