Quality Improvement Plan 2025-2027

Amended March 2026

I. Introduction

Arc of Onondaga 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 Arc of Onondaga mission.

Arc of Onondaga's vision is for a society where all people are included, valued and have the support needed to achieve their dreams. It is our mission, through the supports and services of our agency, to support people with intellectual, developmental and other disabilities in leading meaningful lives in their community. Arc of Onondaga has served individuals and their families since 1951 and continues to provide supports in vocational, clinical, habilitative services and residential settings. The drive for excellence and continuous quality improvement is a part of all that we do.

The Quality Improvement Plan (QIP) is based on key areas that are aligned with the quality focus of Arc NY. These include but are not limited to; Bureau of Program Certification reviews; Incident Management Review; self-surveys/audits; quality of life and satisfaction levels of people supported and quality and satisfaction levels of staff.

In addition to the key areas of focus as outlined by Arc NY, the QIP identifies areas of focus specific to the Arc of Onondaga's mission. Focus areas of the QIP are determined by the Quality Improvement Committee and may be derived from multiple sources and factors, including but not limited to feedback from stakeholders; the agency's strategic plan; issues identified as opportunities for improvement through surveys and/or audits, etc. Input from stakeholders may be obtained through a variety of mechanisms such as satisfactions surveys; strategic planning surveys; self-advocacy meetings and/or other meetings held with stakeholders. Once approved, the Quality Improvement Plan will be made available to stakeholders on the Arc of Onondaga website.

Arc of Onondaga utilizes quality improvement reports that are submitted to a Quality Improvement Committee on a regular basis, typically monthly. The Committee members include Directors, Executive Management and Board Members. One of the tools used by Arc of Onondaga is a Continuous Quality Improvement (CQI) Indicator report, which includes details related to a specific area of focus, action steps/resources as well as ongoing measurement of data related to progress. As a CQI progresses, it may be necessary to revise the action steps or implement additional action steps to further the progress of a particular area.

Overall goals identified within the Quality Improvement Plan will be assessed on an annual basis and the QIP may be adjusted accordingly to current needs. A summary of the annual review will be addended to the document and made available stakeholders on the Arc of Onondaga website. Additionally, the Arc of Onondaga Board of Directors will review the summary report to complete an attestation for Arc NY.

II. Key Quality Areas of Focus

As part of the 2025-2027 improvement process Arc of Onondaga will be focusing on the following areas:

1. Bureau of Program Certification Reviews
2. Chapter Reportable and Significant Incidents
3. Self-Audits/Surveys
4. Quality of Life/Satisfaction of People Supported
5. Quality and Satisfaction Levels of our Staff Members.
6. Human Resource issues such as staff recruitment, staff retention rates, adequacy of staffing levels, etc.

1. Bureau of Program Certification Reviews

Statements of Deficiency (often referred to as SOD) are issued by OPWDD following a site survey in which there is at least one significant deficiency noted during the survey process. Items that may receive a SOD include but are not limited to; medication administration, health concerns, personal allowances, physical plant issues, fire safety and nutritional guidelines. At times, OPWDD will issue verbal recommendations or Exit Conference Deficiencies which will not rise to the level of a SOD. In other cases, when a more serious offence occurs that places individuals who receive services in imminent danger, a 45-day or 60-day letter will be issued. These letters are only issued by OPWDD when very serious site specific or system issues are identified in a survey and/or the services provided are unsatisfactory and may affect the health or safety of the program participants. In addition to the Executive Management at Arc of Onondaga, these 45- or 60-days letters will also be sent out to each member on the Board of Directors. These letters require an immediate Plan of Corrective Action be developed with includes immediate, monitoring and systematic responses that Arc of Onondaga leadership will put in place to ensure the health and safety of the individuals receiving services. This Plan of Corrective Action needs to be approved by OPWDD and if a satisfactory response is not received, OPWDD has the authority to close the program or transfer the auspices to another organization.

Ongoing Activities

- Program Directors will share results of BPC Surveys at Leadership and Quality Improvement Committee meetings in an effort to assist in the identification of emerging trends that may need to be addressed by other program areas.
- BPC Survey results are reported to the Board of Directors on a monthly basis by the Chief Compliance and Quality Officer.
- On an annual basis, the Chief Compliance and Quality Officer or designee will review the results of survey activity for the survey cycle year to identify trends and make recommendations for improvements. This information will be shared to Program Directors and the Quality Improvement Committee following the close of the annual survey cycle year in an effort to direct quality improvement activities.

2021-2024 Survey Cycle Years

Deficiencies by Protocol Standard

The chart below shows the number of deficiencies (ECF or SOD) received through BPC and OFPC surveys on specific portions of the Site Protocol. While other deficiencies were received, these were the most frequent. (Note all OFPC deficiencies fall into section 8 of the protocol)

- Section 2=focus is on Health Support and Medications
- Section 4=Individualize choice, Autonomy, Satisfaction
- Section 5-focus is on Delivery of Safeguards, Services and Supports
- Section 7=focus is on Site and Safety
- Section 8-focus is on Fire Safety; physical plant related to fire safety; inspections
- Section 10-focus is on specialized risk factors, mainly health and rights.

	Section 2	**Section 4**	**Section 5**	**Section 7**	**Section 8**	**Section 10**
10/2021-9/2022 Survey Cycle	23	3	11	4	25	9
10/2022-9/2023 Survey Cycle	8	11	11	10	17	9
10/2023-9/2024 Survey Cycle	19	4	21	8	26	10
Totals	50	18	43	22	68	28

The charts below identify specific deficiency areas that were identified as trends.

Section 2 and 10 (Health Supports/Meds and Specialized risk factors/rights)	**10/2021-9/2022**	**10/2022-9/2023**	**10/2023-9/2024**	**Totals**
Care plan/Dietary guideline issues (implementation or content)	5	5	4	**14**
BSP issues	2	4	5	**11**

Section 4: Individualize choice, Autonomy, Satisfaction	**10/2021-9/2022**	**10/2022-9/2023**	**10/2023-9/2024**	**Totals**
Lack of community integration opportunities	3	7	4	**14**

Section 5: Delivery of safeguards, services and supports	**10/2021-9/2022**	**10/2022-9/2023**	**10/2023-9/2024**	**Totals**
IPOP/Plan not implemented/updated	6	4	3	**13**
Dietary guidelines not implemented correctly	3	6	8	**17**
Dietary guideline in need of revision	1	0	0	**1**

Section 7 and 8 (site safety; fire safety/physical plant)	**10/2021-9/2022**	**10/2022-9/2023**	**10/2023-9/2024**	**Totals**
Issues related to fire system/emergency inspections	6	2	1	**9**

Fire drill remediation issues/fire evacuation plan issues	11	11	15	**37**

More detailed information and recommendations have been shared with Program Directors and the Quality Improvement Committee related to specific findings.

Goals

A. **Goal:** Improve completion of all fire drills, fire drill remediation and the accurate administrative review of fire drills records to ensure appropriate actions are being taken.
   i. **Action**: Implement a CQI indicator
   ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
   iii. **Responsible Party**: Director of Residential, the CPC Manager and the Transportation/Safety Specialist.

B. **Goal:** Improve staff's understanding and implementation of Dietary Guidelines:
   i. **Action:** Implement a Continuous Quality Indicator
   ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
   Responsible Party: Director of Residential, Director of Nursing, Director of Community Supports.

C. **Goal:** Increase the community inclusion and meaningful activity opportunities for those living in the Residential program based on their personalized desires.
   i. **Action:** Implement a Continuous Quality Indicator.
      i. **3/2026 Amendment:** Additional actions steps will be added to the indicator based on results of the 2025 Satisfaction Surveys.
   ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
   Responsible Party: Director of Residential

D. **Goal:** Increase the community inclusion and meaningful activity opportunities for those attending program through Community Supports based on their personalized desires.
   i. **Action:** Implement a Continuous Quality Indicator.
      i. **3/2026 Amendment:** Additional actions steps will be added to the indicator based on results of the 2025 Satisfaction Surveys.
   ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
   Responsible Party: Director of Community Supports

E. **Goal:** Improve education related to rights restrictions; the identification and prompt response to increased behavioral needs and supporting staff implementation and data collection.
   i. **Action:** Implement a Continuous Quality Indicator.
   ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
   Responsible Party: Horizon Clinic Director

2. Chapter Reportable and Significant Incidents

Arc of Onondaga takes very seriously the issue of reporting and investigating incidents as 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 our program participants. Following this initial training, all staff are given an annual refresher on these topics. Where necessary and sometimes following a specific incident, staff or groups of staff are provided focused information to ensure that all incidents are reported in a clear, concise, and timely manner.

Ongoing Activities

- After an incident or allegation of abuse is reported and investigated, an assigned agency investigator who has been trained and credentialed to perform investigations produces a written investigation report.
- Most incidents will include recommendations for the Division Director to implement to further safeguard the individuals' receiving services as well as the staff at Arc of Onondaga.
- Once the investigation is approved, it is submitted to the Division Director for them to review the incident and to provide a formal response to the recommendations made by the investigator.
- Any recommendations made by the IRC are responded to by the appropriate Division Director.

In 2024, 106 incidents were filed. 15 of those incidents were completed over the 30-day deadline with 11 of them being considered an unacceptable reason as to why it was late. For 2024, the completion of incidents within 30 calendar days was 90%. The agency should maintain this percentage as well as work to increase it.

In 2024, 63% of investigative reports were submitted on time to the Justice Center or IRMA. Those that were submitted late were due to supervisor review of an incident, IRC review of an incident, or if an investigation is late - due to varying reasons such as stated above.

Program Directors are responsible for providing a response to investigative reports and the recommendations made in each. Along with these responses, Directors are required to provide a target due date and have all verifications to the QA department by that target due date. It is best practice that these verifications be carried out as quickly as possible to hopefully aid in avoiding similar issues in the future, as well as help to continue to provide quality care to those

we support. Once verifications are submitted to QA, they must be reviewed for accuracy and completion and sometimes more information or verifications are required. This process can become time consuming. IRMA requires Corrective Action Plans to be submitted within 80 days from the date of the Letter of Determination and 90 days from date of incident for Non-JC reportable, significant incidents and Serious Notable Occurrences. In 2024, out of the 106 incidents that were filed, 44 have been closed late and 7 don't have CAP due dates yet. For 2024, the closure of incidents on time is 58%.

A. **Goal:** Meet regulatory requirements for completion and submission of Investigations and decrease the time it takes to carry out Incident recommendations, collect/review verifications, and close the CAP in IRMA.
    i. **Action:** Implement a Continuous Quality Indicator.
    ii. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
    Responsible Party: Director of Quality and Compliance

3. <u>Self-Surveys</u>

Based on ongoing assessments of program areas, program staff as well as members of the Arc of Onondaga Quality Assurance Department, or an appropriately trained designee may conduct audits, self-surveys, site visits, and/or meal observations based on programs that have either been identified as "high risk" from OPWDD, Arc of Onondaga personnel or related guidance. This level of risk can be based off prior survey results, observations or feedback by staff and management or a variety of other factors.

The goal in this area is to complete self-assessments for programs identified as high risk and to determine if those program areas have adequately implemented and maintained their past Plans of Corrective Actions. Site visits is one tool to assist with the achievement of decreased Statements of Deficiencies.

<u>Ongoing Activities</u>

- Site visits are completed monthly by members of the QA Department. The Chief Compliance and Quality Officer determines the schedule of the site visits based on a variety of factors including but not limited to the results of the last survey; date of last survey; issues identified through other activities (i.e. compliance issues; investigations, etc.).
- Site visit information is shared to the Division Director, the COO and the CEO. The Division Director is responsible to address issues identified and include actions taken in their Quality Improvement report.
- Programs (including the Centralized Services of Plan Coordination, Nursing and Behavioral Support) are expected to complete regular site observations including those focused on meals, implementation of program plans, implementation of Behavior Support plans and activity observations.

<u>Action Steps</u>

- Site Surveys and Observations will be reported to the Quality Improvement Committee and identified trends will be followed up with recommendations for improvements.
- Program Directors are responsible for following up and addressing any trends or notable issues.

A. **Goal:** To improve the safety of individuals supported by improving the performance of staff during meals/snacks to follow Dietary Guidelines as written.
    a. **Action:** Implement a Continuous Quality Indicator.
    b. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
    Responsible Party: Director of Nursing, Director of Community Supports and Director of Residential

B. **Goal:** To ensure individuals within the Residential program are receiving the appropriate medical and nursing services.
    a. Action: Monthly medical review audits will be completed by a member of the Quality Assurance Department as assigned.
    b. Data: Results of medical audits will be sent to the Director of Nursing, Director of Residential and shared to the PSO, COO and CEO for appropriate follow up. Results of audits are shared to the QI Committee.
        i. A new medical audit tool has been developed that will begin to capture error rate information. After enough data has been collected, it will be analyzed to establish a better understanding of opportunities for improvement.
    c. Responsible Party: QA Department, Director of Nursing and Director of Residential

4. Quality of Life/Satisfaction of the People We Support

Arc of Onondaga strives for excellence in management and in support services for people with intellectual and other developmental disabilities. Arc of Onondaga believes that people supported, their families and advocates must be involved in decisions about what supports will be provided.

Arc of Onondaga uses a person-centered planning (PCP) approach to supporting people with developmental disabilities. The process focuses on the person's unique preferences, needs, goals, and values, rather than fitting them into pre-existing programs or services.
The planning process typically involves the individual at the center, along with family members, friends, advocates, and professionals who know and care about them. Together, they explore the person's dreams, abilities, and support needs to create a plan that promotes inclusion, autonomy, and quality of life.

Key features of person-centered planning include:
- **Individual Empowerment**: The person with the disability leads or is meaningfully involved in directing the planning process.
- **Strengths and Interests Focus**: The plan highlights the individual's capabilities, interests, and what brings them joy.
- **Holistic and Flexible**: The planning process addresses all areas of life, including home, work, relationships, health, and recreation.

- **Community Involvement**: Emphasis is placed on building natural supports and facilitating community participation.
- **Action-Oriented Goals**: Clear, achievable steps are outlined to help the individual progress toward their personal goals.

Person-centered planning is not a one-time event; it is an ongoing, dynamic process that adapts as the individual's life and aspirations evolve. Ultimately, PCP aims to support people with developmental disabilities in living meaningful, self-determined lives within their communities.

Ongoing Activities

- Prior to each person's annual and semi-annual meeting, the person's Plan Coordinator meets individually with the person to have a conversation about things that are important to them; things they may want to learn or accomplish; their hopes and dreams; activities of interest; their opinions about their program and if they live in an Arc residence, specific questions their quality of life in their home. This information is used to help the Plan Coordinator and the person's team create program plans with the person that are based on what is important to them.
- On a yearly basis, a Family Satisfaction Survey is completed that offers family members and advocates an opportunity to report their satisfaction with the programs offered as well as the quality of service being provided. For the past several years, the SU Community Link program has been used to administer the survey to all family members and/or advocates of people supported through the different Arc of Onondaga programs. The SU student compiles information and completes a comparison of data based on prior year's survey results.
- **3/2026 Amendment:** In the Fall of 2025, the agency developed a new annual satisfaction survey designed specifically for the people supported that would provide information in the form of data. This survey was conducted with people supported in Residential and Community Services. Surveys for other areas such as supported employment and clinic services are conducted on their own. Further discussion to be had later in 2026 about the ability to combine and compare surveys and results.

Family Satisfaction Survey (Amended 3/2026)

In November ~~2024~~ 2025, the Family Satisfaction Survey was completed and utilized a Likert-Type scale for reporting satisfaction levels with different aspects of service at Arc of Onondaga. This scale consisted of 1 "strongly disagree", 2 "disagree", 3 "neutral", 4 "agree" and 5 "strongly agree. The survey was distributed both electronically and by mail to families and advocates of individuals receiving Arc of Onondaga services. Approximately 500 individuals comprised the sampling frame; 112 responses were received (estimated response rate ~22%).

Survey findings should be interpreted with consideration of limitations noted in the report, including uneven representation across service areas, possible duplication when respondents completed multiple surveys, and manual data transcription for mailed responses.

Participation varied by program area, with responses concentrated in Day Habilitation and Residential Services. Participation in the 2025 Family Satisfaction Survey included:

- 33% of the respondents received Residential services
- 39% of the respondents received Day Habilitation services
- 14% of the respondents received Community Habilitation or Respite Services
- 13% of the respondents received Vocational Services

Some of the results of the Family Satisfaction Survey were as follows:

- 88% say staff support, attentiveness, and respect is one of the most important survey areas.
- 42% say activities, outings, skills building & community participation are the best aspect while 41% say this is where improvement is most needed.
- 52% say they would not switch agencies and 36% report no suggestions or are fully satisfied with services.

It was also noted in the review of these survey results families feel that person-centered planning is evident in Service Programming with the majority of respondents in the largest service areas of Residential and Day Habilitation indicated their satisfaction with a (~~4.0~~4.1) and (4.2) respectively.

The Residential Department results indicated significant improvement in safety/cleanliness but declined in communication and issue resolution. Three areas of potential improvement include timely, proactive communication with families; consistency and follow through in resolving issues/concerns and more consistent person-centered engagement with community participation and individualized routines.

The Day Habilitation Program results remained very stable, with small gains in communication and issue resolution. Three areas identified for potential improvement include timely communication; strengthen responsiveness when concerns arise and increase structured engagement and meaningful activities.

The Vocational Program results showed improvement in safety and staff support, while most other areas remained steady. Three areas identified for potential improvement include timely communication, make person-centered planning more visible in vocational outcomes and improve issue resolution and coordination.

The Community Habilitation/Respite Program showed the strongest year-over-year improvement across nearly every category and led all services in 2025. Two areas of potential growth include expand access and flexibility of services and continue to grow community participation and individualized activity options.

Individual Satisfaction Survey (Amended 3/2026):

Participation in the individual satisfaction survey included 63 surveys completed in Residential and 71 surveys completed in Community Supports.

Some of the results of the Individual Satisfaction Survey were as follows:

- Residential had an overall 92.2% “yes” rate across the questions.
- Community Supports had an overall 90.4% “yes” rate across the questions.
- Residentials overall top 3 scores were *I have resources to meet my personal needs and desires, I have a staff person I can tell when I need help/resources, and I can make positive changes to my life* with scores between 96 and 98%.

- Residentials overall bottom 3 scores were *staff listen to me and my concerns, I have opportunities to make decisions and plan activities every day, and I can access community-based housing & work if desired* with scores between 82 and 86%.
- Community Supports overall top 3 scores were *Staff help/support me to meet my needs and goals*, *I have the people I want assisting in planning/decisions*, and *I can make positive changes to my life* with scores between 95 and 98%
- Community supports overall bottom 3 scores were *staff answer my questions quickly*, *opportunity to be a contributing, engaged member in the community*, and *go to places in the community that I find meaningful* with scores between 81 and 82%

A. **Goal:** To provide a range of high quality, individualized services and supports that meet the current and future needs and interests of the people we support, within the community as much as possible.
    a. **Actions:** One pillar of the agency's strategic plan focuses on this goal with the following objectives:
        i. Ensure services offered satisfy and are of interest to people supported.
        ii. Expand and develop services and supports geared towards older adults.
        iii. Improve ability to support people with complex needs.
        iv. Ensure staff have the resources and support needed to meet regulatory requirements and provide high quality services.
        v. Ensure that people have regular access to the community.
    b. **Data/Progress:** Results of activities will be documented through the ongoing work of the Strategic Plan Committee.
    c. **Responsible Party:** Pillar Team Leads-CCO, PSO, Director of QA/Compliance and Board member.

B. Goal: To provide more opportunities for people supported to achieve competitive employment.
    a. Actions: Implement a CQI Indicator focusing on increasing the number of people competitively employed; developing new work experiences for those in the Prevocational program and increasing communications to Care Managers about the opportunities available at the agency.
    b. Data/Progress: Results will be reported through the QI Committee.
    c. Responsible Party: Director of Employment Options.

C. Goal (new goal 3/2026): Improve timely communication and strengthen responsiveness when concerns arise within the Community Supports Department.
    a. Action: Implement a Continuous Quality Indicator
    b. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.
    Responsible Party: Director of Community Supports

D. **Goal (new goal 3/2026):** Improve timely communication and strengthen responsiveness when concerns arise within the Residential Services Department.
    a. Action: Implement a Continuous Quality Indicator
    b. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee. Additional review will occur at

the 6-month review of the Quality Improvement Plan and additional action steps implemented as necessary.

c. **Responsible Party**: Director of Residential

5. Satisfaction Levels of Employees (Amended 3/2026)

Arc of Onondaga shall ascertain feedback regarding satisfaction from our employees through opinion questionnaires/surveys. For the past several years, the SU Community Link program has been used to administer the survey to the employees of Arc of Onondaga. The SU student compiles information and completes a comparison of data based on prior year's survey results and provides this to the Chief Human Resources Officer.

These satisfaction surveys serve as a tool for HR and the Leadership Team to be able to assess the strengths and weaknesses of Arc of Onondaga as it relates to employee satisfaction, but these surveys also serve as an anonymous way of expressing potential concerns and dissatisfaction with aspects of being employed at Arc of Onondaga. This survey will be completed at minimum annually. The results of such surveys will be reviewed by Chapter management and Board of Directors and used to enhance operations.

In October 2025, the Staff Satisfaction Survey was completed. The majority of the questions utilized a Likert-Type scale for reporting satisfaction levels with different aspects of service at Arc of Onondaga. This scale consisted of 1 "strongly disagree", 2 "disagree", 3 "neutral", 4 "agree" and 5 "strongly agree. Sprinkled throughout the survey were ordinal questions designed to gather a more in depth understanding of some of the agency's current efforts as well as a few open-ended questions. All questions required a response.

The top 5 positive responses of the Staff Satisfaction Survey were as follows:

- 92% of respondents reported that they know where to go or whom to ask if they have questions.
- 92% of respondents reported that their work contributes to the overall success of Arc of Onondaga.
- 87% of respondents reported that their work environment is safe.
- 86% of respondents reported that that they are supported by their supervisor.
- 84% of respondents reported that they are part of a team.

The lowest scoring responses from the Staff Satisfaction Survey were noted in the following areas:

- 48% of respondents reported that the compensation system in the organization is fair.
- 51% of respondents reported that they are fairly compensated for their work.
- 51% of respondents reported that they could earn more in another organization.
- 53% of respondents reported that they are rewarded for innovative approaches.
- 60% of respondents reported that the communication in the organization is effective, informative, and timely.

The Chief Human Resources Officer is responsible to implement action-based activities based on the results of the satisfaction surveys. Some information is reported on to the Quality Improvement Committee on a monthly basis and some on a quarterly basis.

A. **Goal:** Improve the timely completion of Employee Performance Appraisals. In addition to feedback from the Employee Survey, this was also a deficient area in the most recent Agency Survey from DQI.
    a. **Action:** Implement a Continuous Quality Indicator.
    b. **Data** will be collected and assessed as determined in the CQI indicator and reported to the Quality Improvement Committee on a monthly basis.
    c. **Responsible Party:** Chief Human Resources Officer.

B. **Goal:** Address workforce challenges, some of which are consistent with the ~~2024~~ 2025 Satisfaction Survey results.
    a. **Action:** The current Strategic Plan includes a pillar specifically related to workforce. These include but are not limited to: formalize and publicize career ladders for Direct Support staff; review/revise and market the availability of the Tuition Assistance Program and Microcredentialing; Strengthen skills of Frontline Supervisors regarding communication, addressing performance, time management.
    b. **Data/Progress:** Results of activities will be documented through the ongoing work of the Strategic Plan Committee.
    c. **Responsible Party:** Pillar Team Leads-Chief Human Resources Officer; Chief Executive Officer and Board Member

C. **Goal:** Improve the communication within the agency; specifically that between supervisors and their employees. As indicated in the 2025 Satisfaction Survey results this is one of the lower scoring responses.
    a. Action: Report to the Quality improvement Committee on a quarterly basis the percentage of supervisors that have completed their supervision meetings.
    b. Data: It has been a long-standing expectation of the CEO that supervisors are meeting with their employees regularly. Supervisors will be required to report to the CHRO if they have held these meetings. This will be reported to the to the Quality Improvement Committee on a quarterly basis. Ultimately, progress towards this goal will be reviewed in the next annual satisfaction survey.
    c. Responsible Party: Agency supervisors facilitated by the Chief Human Resources Officer

D. **Goal:** Maintain/improve the sense of support from supervisors as expressed by employees in the satisfaction survey. As indicated in the 2025 Satisfaction Survey results, employees shared they largely feel supported by their supervisors. This is important to maintain.
    a. **Action:** The current Strategic Plan includes a pillar specifically related to workforce. The overarching goal of the workforce pillar is to attract and retain an invested, supported, caring and skilled workforce. Supervisors play a large role in ensuring employees are supported. Requiring supervisors to report on this should keep this in the front of their minds for continual consideration.
    b. **Data:** Supervisors will be required to report to the CHRO what they have done to support their staff on a monthly basis. This will be reported to the Quality Improvement Committee on a quarterly basis. Ultimately, progress towards this goal will be reviewed in the next annual satisfaction survey.
    c. Responsible Party: Agency supervisors facilitated by the Chief Human Resources Officer

6. Human Resources

Leadership at Arc of Onondaga shall have the means to continually assess the adequacy of staffing levels, staff competence, and staff performance and will have a mechanism to address deficiencies.

Human Resources has developed a number of ongoing activities regarding staffing and staff retention rate that is shared with the Quality Improvement Committee on a monthly basis.

Ongoing Activities

- Monitoring of applications and recruitment activities.
- Monitoring of turnover rates and reasons for turnover.
- Utilization of ApplicantPro and Docusign as tools to manage the hiring process.

Goals

A. **Goal:** To improve the retention of staff through strengthening their connection to the agency, promoting advancement and offering resources and services to employees.

   i. **Actions:** A variety of action steps have been outlined in the Arc of Onondaga Strategic Plan related to this goal. These include but are not limited to establishing an emergency fund for employees in critical need; providing information to staff on resources available to them in the community; formalizing and publicizing career ladders for DSP's.

   Additionally, several initiatives have been implemented in the effort to improve retention. This includes the development of a partnership with Bryant and Stratton to deliver a 5-week paid training program for new DSP's; the implementation of the NADSP eBadge Academy and the creation of a DSP Success Coach position. The goal for these initiatives is to improve the training of employees in an effort to retain them longer.

   ii. **Data:** As retention is a long-term goal, data for this area will be evaluated every 6 months to 1 year. Action steps are being monitored through the implementation of the Strategic Plan.

   Employees who have received DSP Success coaching, participated in the Bryant and Stratton program or who have completed minimally DSP 1 level certification through the eBadge Academy will be followed to determine if there is an increase in retention noted when compared to employees who did not participate in these initiatives.

   iii. **Responsible:** Chief Human Resources Officer

B. **Goal:** OPWDD has recently shared that the Centers for Medicare Services (CMS) will be requiring specific metrics to be met related to certain training requirements for providers. Although Arc of Onondaga did very well during the most recent Agency Review Survey, it is expected that this area will be assessed with additional scrutiny in upcoming years. In an effort to ensure that we are successfully meeting the expected metrics, additional

monitoring will be implemented related to specific training for new hires as well as annual training required for existing employees.

3/2026 Amendment: Completion of annual training requirements improved in 2025. The Contract Services department did extremely well in having their employees complete all required training. This was due to a significant amount of oversight by management. Other departments experienced struggles to have employees complete training in a timely manner and had to set a deadline in which employees would be suspended if training was not complete. This was effective overall. Multiple employees were suspended until training requirements were met.

In reviewing our results from 2025, we continue to struggle with the completion of agency orientation requirements within 90 days of hire. The CQI Indicator will include additional action steps related to communication to candidates related to orientation training requirements as well as retraining of Directors related to the policy and the need to either request an extension or to hold staff accountable for the 90 day requirement. Additionally, policies related to Training Plans for new employees will be reviewed, revised if needed and retrained on.

i. **Actions**: A review of the OPWDD/CMS required metrics will be completed to ensure current policies and training requirements are consistent with expectations and baseline data collected and analyzed based on 2024 training data.
    i. **3/2026 Amendment:** Additional action steps will be added to the CQI Indictor. New baseline data will be established based on 2025 results and new goals set.
ii. **Data:** Quarterly data results will be shared to QI Committee. Employees who are not completing training as required will be followed up with according to agency policies. Additional action steps may need to be developed after further analysis of ongoing data.
iii. **Responsible:** Director of Compliance and Quality

Prepared by Donna Loveland, Chief Compliance and Quality Officer
Approved by Arc of Onondaga Board of Directors 9/23/25

Amendments: March 2026
Approved by Arc of Onondaga Board of Directors 4/28/26

March 2026 Progress Summary:

Amendments have been added to the QIP to incorporate results of the 2025 Employee, Family and Individual Satisfaction Surveys. As a result of this information, additional goals will be developed related to timely communication and strengthening responsiveness to concerns with families and individuals; improving communication with employees and improving the sense of support from supervisors as expressed by employees.

Goal 6B: To improve completion of agency orientation requirements within 90 days as well as successful completion of all annual training has been assessed. Completion of annual training requirements improved in 2025. The Contract Services department did extremely well in having their employees complete all required training. This was due to

a significant amount of oversight by management. Other departments experienced struggles to have employees complete training in a timely manner and had to set a deadline in which employees would be suspended if training was not complete. This was effective overall. Multiple employees were suspended until training requirements were met.

In reviewing our results from 2025, we continue to struggle with the completion of agency orientation requirements within 90 days of hire. The CQI Indicator will include additional action steps related to communication to candidates related to orientation training requirements as well as retraining of Directors related to the policy and the need to either request an extension or to hold staff accountable for the 90 day requirement. Additionally, policies related to Training Plans for new employees will be reviewed, revised if needed and retrained on.

As this Quality Improvement Plan has only been in place for 6 months, additional time is required to implement and assess other goal areas. Goals will continue as written at this time with progress reported to the Quality Improvement Committee and/or Strategic Planning Committee as indicated in the plan.