QUALITY ASSESSMENT AND IMPROVEMENT: COMPREHENSIVE REPORT

Pennsylvania Office of Developmental Programs

The Arc of Lehigh and Northampton Counties

November 8, 2017

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Introduction

The mission of ODP is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice, and opportunity in their lives. ODP's Quality Assessment and Improvement (QA&I) process is designed to conduct a comprehensive quality management review of county programs, Administrative Entities (AE), Supports Coordination Organizations (SCO) and Providers delivering services and supports to individuals with intellectual disabilities and autism spectrum disorders. As part of ODP's quality management strategy, this QA&I process has been designed to be comprehensive, standardized, and measurable. The QA& I process is intended to:

- Follow an individual's experience throughout the system;
- Measure progress toward implementing "*Everyday Lives: Values in Action*;"
- Gather timely and usable data to manage system performance; and
- Use data to manage the service delivery system with a continuous quality improvement approach.

The purpose of the QA&I Comprehensive Report is to compile the findings from the desk review and onsite review, face-to-face interviews, and self-assessments, as applicable. Each provider entity then is able to utilize the data to continuously improve quality for ODP's vision of an effective system of accessible services and supports that are flexible, innovative, and person-centered. For each entity, the QA&I Comprehensive Report will:

- Highlight those areas where the provider is doing well related to person-centered services delivery and promising practices;
- Analyze performance in ODP's quality focus areas for the current QA&I cycle;
- Compare results of the desk and onsite reviews with the entity's self-assessment;
- Summarize those instances of non-compliance that were remediated during the onsite review;
- Outline issues of non-compliance expected to be remediated within 30 calendar days of report receipt;
- Recommend Plan to Prevent Recurrences (PPRs) where compliance is below the established thresholds of 86%; and
- Recommend improvement activities to be addressed during the remainder of the QA&I cycle, including systemic quality improvement projects to incorporate into QM plans.

ODP's quality management strategy is a comprehensive approach that includes quality planning, quality assurance, and quality improvement/enhancement. This QM strategy is developed and implemented to:

- Offer the highest quality services that promote choice and control in individuals' everyday lives.
- Safeguard the health and safety of individuals receiving services.
- Implement promising practices.
- Ensure program compliance with regulations.

ISAC recommendations for *Values in Action* are built on the values, goals, expectations, and aspirations of people with disabilities and their families. The recommendations are a guide for ODP to develop policy and design programs for people with disabilities, families, providers of service, and advocates who support people to have an everyday life. By utilizing the ISAC recommendations and data gathered from the QA&I process, providers are able to create systemic improvement projects and are able to incorporate improvement activities into their QM Plans. The current ISAC recommendations are as follows:

1. Assure Effective Communication
2. Promote Self-Direction, Choice, and Control
3. Increase employment
4. Support Families throughout the Lifespan
5. Promote Health, Wellness, and Safety
6. Support People with Complex Needs
7. Develop and Support Qualified Staff
8. Simplify the System
9. Improve Quality
10. Expand Options for Community Living
11. Increase Community Participation
12. Provide Community Services to Everyone
13. Evaluate Future Innovations Based on *Everyday Lives* Principles

The focus areas identified by ODP for this QA&I cycle are ensuring communication, employment, and quality management. Provider entity performance in these areas will be highlighted in this report.

QA&I Summary

The Arc of Lehigh and Northampton Counties, successfully submitted their QA&I Self-assessment on August 22, 2017. The self-assessment identified that the Provider's peer review process to review the quality of investigations was not completed and documented. All other questions within the self-assessment were in compliance. The Provider Checklist, Quality Management Plan, Restrictive Intervention Policy, and Annual Training plan were also submitted to the AE on August 22, 2017. The AE validated that all of the policies and procedures that were submitted with the provider checklist are in compliance with applicable regulations.

On September 27, 2017, the AE provided The Arc of Lehigh and Northampton Counties with a two-week notification email which included the provider's sample and a list of items that would be reviewed by the AE during the on-site review. The AE selected a sample of ten. Eight of the individuals in the sample are consolidated waiver participants receiving Community Participation Supports from this provider entity. The remaining two individuals in the sample are P/FDS waiver participants receiving Community Participation Supports from The Arc of Lehigh and Northampton Counties. The on-site review was

originally scheduled for Wednesday, October 11, 2017 at 10:00 am. Unfortunately, due to a change in the AE's schedule, the onsite review was then rescheduled for Tuesday, October 31, 2017.

The QA&I on-site review of The Arc of Lehigh and Northampton Counties occurred on October 31, 2017 at the provider's 2380 licensed service location in Bethlehem, Pennsylvania. The on-site review began with the entrance interview which was attended by Frank Barella (Director of Quality Improvement/Compliance) and Jessica Pahountis (Lehigh County AE QA&I Lead). During the entrance interview, the AE provided an overview of the QA&I process and answered any provider questions in regards to the QA&I process. Mr. Barella provided the AE with a brief description of the Arc's vision and mission, highlighted their quality improvement priorities (incident management, participant satisfaction, outcomes, staff training, and self-advocacy). Mr. Barella also discussed the new peer review process for certified investigations that has been implemented, as well as some issues with utilizing the current MCI Tracker tool. At the conclusion of the entrance interview, Mr. Barella provided the AE with several binders containing all of The Arc's policies, procedures, and other supporting documentation that was utilized when completing the self-assessment, as well as the ten records for the individuals in the sample. The AE began the on-site review process by reviewing all of the documentation required to answer the questions in the QA&I On-site Questions Tool for Providers.

Upon completing the QA&I On-site Questions Tool for Providers, the AE conducted five staff and five individual interviews. Staff interviews were conducted with the following staff members who were providing Community Participation Supports: Robin Sweeny, Tiffany Bentson, Trish Osorto, and Dean Valezquez (interviewed for two different individuals in the sample). All of the interviews occurred within the 2380 licensed program building. The AE's overall impression of the Arc's staff following the completion of the interviews was that staff are well trained on the ISPs (including risk mitigation factors), have a clear understanding of the services they are providing, and are finding creative ways to incorporate preferred activities and other individual preferences into their delivery of services.

The AE also conducted interviews with the following individuals receiving services: MCI#001922906 (Consolidated), MCI#950178391 (P/FDS), MCI#600143473 (Consolidated), MCI#070001992 (Consolidated), MCI#900100562 (Consolidated). Two out of five of the individuals interviewed were able to clearly communicate their responses to the interview questions. Individuals receiving services had reported that they are "very satisfied" or "satisfied" with the services that they are receiving with The Arc of Lehigh and Northampton Counties. Individuals receiving services also reported that their staff listen to them and make them feel understood. Additionally, MCI#001922906 reported that she enjoys sewing, needlepoint, shopping, jewelry and accessories and her staff at the Arc ensure that she is able to participate in her preferred activities while receiving services.

Upon completing the on-site review questions tool, five staff interviews, and five individual interviews, the exit interview was conducted on October 31, 2017 with the following parties in attendance: Frank Barella (Director of Quality Improvement/Compliance), Julie Love (Program Specialist), and Jessica

Pahountis (Lehigh County AE QA&I Lead). The AE noted that The Arc of Lehigh and Northampton Counties has an extensive Quality Management Plan which utilized findings from previous Provider Monitoring on-sites to update their Quality Management plan and improve service provision. The provider also had a strong annual training curriculum for staff which extends beyond the minimum regulatory requirements. Additionally, the AE noted that the provider was very organized in their preparation for the QA&I on-site process. The AE discussed with The Arc of Lehigh and Northampton Counites, areas in which they are showing promising practices, which are detailed further in this report. The AE then informed The Arc of Lehigh and Northampton Counties that they would not be required to complete any remediation at this time due to having no areas of non-compliance. The next steps in the QA&I process were then discussed and additional provider questions were answered by the AE.

Data Analysis and Performance Evaluation

The Arc of Lehigh and Northampton Counties had no areas of non-compliance and are not required to make any remediation at this time. Data for every QA&I question can be located in Appendix A of this document. While completing the QA&I on-site, the AE noted that the provider does indicate what actions are being taken when there is a lack of progress, however, the staff's response is to continually increase prompting. This was the case for 3 months in a row for one individual in the sample (MCI#950178391). The AE is suggesting that the provider work to improve their practices in this area by requesting team meetings with the Supports Coordinators to explore new strategies/discuss the outcome when an individual continues to lack progress when the initial actions to respond to the lack of progress are ineffective. The AE does not have any further recommendations for the entity's system improvement, as The Arc of Lehigh and Northampton Counties appears to be providing quality services to individuals with an intellectual disability and/or autism spectrum disorders.

The entity has policies and procedures which meet all 55 Pa Code Chapter 51 waiver regulations, as well as requirements established by ODP. As mentioned previously, The Arc of Lehigh and Northampton Counties has a staff training curriculum that extends well beyond the minimum requirements. Additionally, The Arc of Lehigh and Northampton Counties has an extensive quality management plan which is reflective of ISAC recommendations for *Values in Action.* It is important to note that when updating the Quality Management Plan, the provider utilized data from previous Provider Monitoring on-site reviews to improve upon their service provision. The Arc of Lehigh and Northampton Counties is creating systemic improvement within their provider entity through their quality management plan data collection and analysis. In addition, the provider has made large improvements to their Incident Management Peer Review process. The Arc of Lehigh and Northampton Counties has created an incident management committee in which all incidents are discussed and reviews of incident management reports and certified investigations are completed. This extends beyond what is required in terms of the peer review process. Having well-written policies and procedures, a strong staff training curriculum, an extensive quality management plan, and newly created Incident Management committee are promising practices in which the entity excels.

As stated previously, The Arc of Lehigh and Northampton Counties had no areas of non-compliance for any of the focus areas (ensuring communication, employment, quality management) which were analyzed through the QA&I process. Data analysis of performance on focus areas is located in Appendix B of this document. The AE's onsite results and entity's self-assessment results did not report congruent findings on five different items. This was discussed with The Arc of Lehigh and Northampton Counties at the time of the on-site review. Some of the data was entered incorrectly as a result of some difficulties in utilizing the MCI Tracker. Analysis of this data is located in Appendix C of this document.

Appendix A

AE On-site Data: Questions Tool for Providers		
Question	**Findings**	**Comments**
Self-Assessment *The Provider completes an annual QA&I self-assessment*		
6. The provider completed its annual self-assessment using the ODP specified tool.	Yes	Completed 8/22/2017
Quality Management *There are systemic efforts to continuously improve quality*		
7. The Provider has a Quality Management Plan (QMP) that reflects ODP's Mission, Vision, and Values.	Yes	Effective 1/1/2017
8. The Provider reviews and evaluates performance data in selecting priorities for the QMP.	Yes	There is documentation to show that the provider reviewed and evaluated performance data in selecting priorities for the QMP.
9. The Provider analyzes and revises the QMP every 2 years.	Yes	There is documentation to show that the provider analyzes and revises the QMP every 2 years.
Person-Centered Planning, Service Delivery & Outcomes *The system of support is straightforward*		
10. The Provider implements a policy/procedure to screen employees and contractors.	Yes	The provider has a policy/procedure that meets all criteria established and there is evidence that it is being implemented.
11. The Provider documents grievances in accordance with regulation.	Yes	The grievances were completed in accordance with regulation.
12. The Provider has a policy that addresses restrictive interventions.	Yes	The provider has a policy that includes all required criteria.
13. In residential habilitation, the individual has a signed department-approved room and board contract.	NA	10/10 records reviewed. The individuals in the sample do not receive residential habilitation services from the Provider.
Qualified Providers *The individual's Provider(s) meet necessary training requirements*		
14. Staff receive training to meet the needs of the individual they support as identified in the current, approved Individual	Yes	8/8 records reviewed. Training records indicate that staff received training on the current, approved ISP prior to

Support Plan (ISP) before providing services.		beginning work with the individual.
15. If a provider has any new hire staff, the new hire staff received training to meet the needs of the individual they support as identified in the current, approved ISP before providing services to the individual.	Yes	4/4 records reviewed. Training records indicate that staff received training on the current, approved ISP for the person they support prior to beginning work with the individual.
16. The provider has an annual training plan that meets all requirements.	Yes	The provider has an annual training plan that meets all requirements.
17. The provider and the provider's staff completed all components of the Annual Training plan as required.	Yes	8/8 records reviewed were in compliance. The provider records indicate completion of the annual training plan.
18. Provider staff receive annual incident management training on preventing, recognizing, reporting, and responding to incidents and assuring a participant is safe.	Yes	8/8 records reviewed were in compliance. The provider records indicate completion of the annual incident management training.
19. The staff receive training on the Provider's policy/procedure on how to respond in cases of individual health, behavioral emergencies, and crises.	Yes	8/8 records reviewed were in compliance. The provider records indicate completion of the annual training on how to respond to individual health, behavioral emergencies and crises.
20. The staff receive training on the Provider's Emergency Disaster Response plan that addresses individual's safety and protection, communications and/or operational procedures.	Yes	8/8 records reviewed were in compliance. The provider records indicate that staff were trained on the Emergency Disaster Response plan.
Person-Centered Planning, Service Delivery & Outcomes *The individual is supported in developing their own ISP, including involvement of people chosen by the individual*		
21. The provider participates in the development of the ISP.	Yes	10/10 records reviewed. 10/10 records indicate ISP signature sheet indicates that a provider representative participated in the ISP Annual Meeting.
22. The provider documents delivery of services/supports in	Yes	10/10 records reviewed.

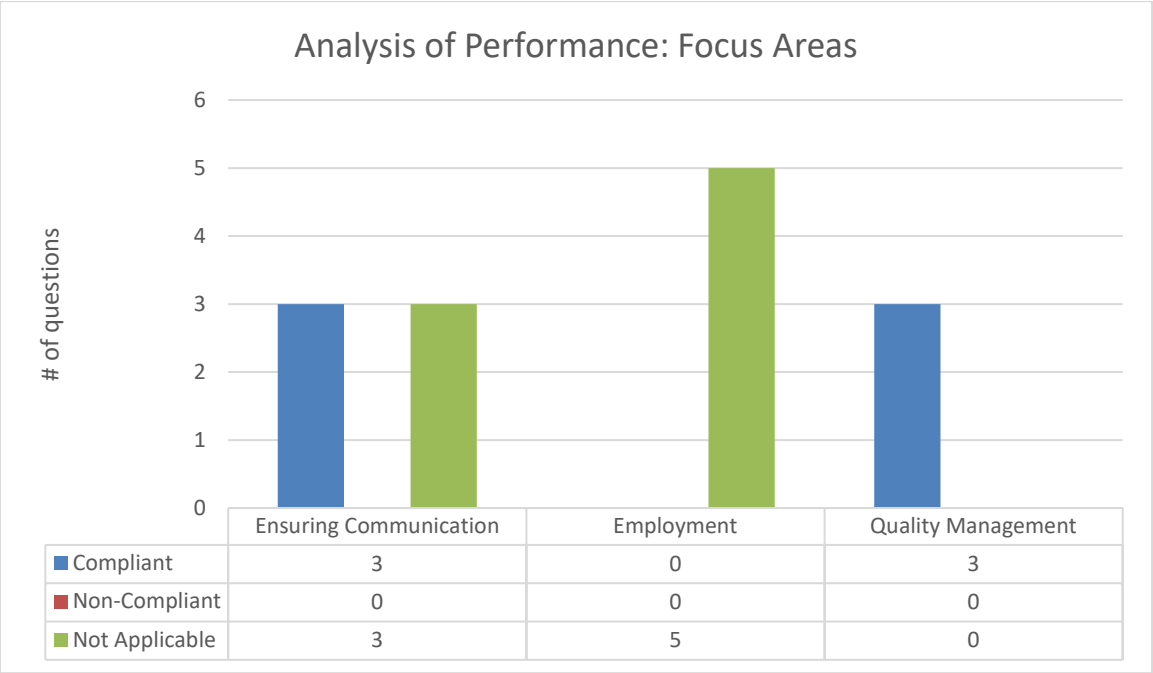
the type, scope, amount, frequency and duration specified in the ISP.		The daily documentation and progress notes reflect that services/supports were provided in accordance with the individual's ISP.
23. The Provider continued to provide the authorized services to ensure continuity of care during transition.	NA	0/0 records reviewed. The provider did not transition any individuals to a new provider for the previous year.
24. If a progress note indicates lack of progress in achieving an outcome, the provider progress note indicates what actions have been taken.	Yes	10/10 records reviewed. 7/10 records reviewed notated lack of progress in achieving an outcome. The progress notes reviewed indicate action taken to address lack of progress.
25. The individual receives employment supports from the provider.	NO	10/10 records reviewed. The individuals do not receive employment supports from the provider.
26. The individual is supported in exploring employment opportunities through job development and assessment.	NA	10/10 records reviewed. The individuals do not receive employment supports from this provider.
27. The employment provider supports the individual in obtaining employment through job interviewing.	NA	10/10 records reviewed. The individuals do not receive employment supports from this provider.
28. The employment provider supports the individual in maintaining employment through job support and follow-along services.	NA	10/10 records reviewed. The provider is not a provider of employment services.
29. The residential provider supports the individual to maintain employment by facilitating transportation.	NA	0/0 records reviewed. The Provider is not a provider of residential habilitation services.
<u>Person-Centered Planning, Service Delivery & Outcomes</u> *The individual is supported to communicate*		
30. Staff are trained on the person's communication plan and/or formal communication system.	NA	10/10 records reviewed. The individuals' ISPs did not have any communication supports and services identified.
31. The provider provides communication assistance as indicated in the ISP.	Yes	10/10 records reviewed. 1/10 of the individuals in the sample required communication assistance. The daily documentation and progress

		notes reflect how the provider implemented the communication assistance.
32. The provider has been entering the individual's progress related to their communication outcomes into the progress notes.	Yes	10/10 records reviewed. 1/10 individuals in the sample had an outcome related to communication. Daily documentation and progress notes show the progress or lack of progress has been documented as it related to the communication outcome.
33. The provider serves one or more Consolidated and/or P/FDS waiver participants who are deaf.	NO	10/10 records reviewed. The provider is not currently serving any individuals.
34. The provider ensures that one or more of the provider's administrative staff have viewed ODP's webinar.	Yes	3/3 records reviewed were in compliance. The training records indicate that two Program Specialists and the Quality Improvement/Compliance Director have completed the required ODP training.
35. The provider ensures that provider staff who serve a deaf waiver participant(s) have viewed ODP's webinar.	NA	10/10 records reviewed. The provider does not serve any individuals who are deaf.
<u>Health & Welfare</u> *The individual's health, safety, and rights are protected*		
36. The provider implements the individual's back-up plan as specified in the ISP.	NA	10/10 records reviewed. A back-up plan was not required for the service and there were no events that occurred which required the implementation of a back-up plan.
37. If an individual's back-up plan is not implemented as designed, an incident report of neglect was submitted.	NA	10/10 records reviewed. A back-up plan was not required for the service and there were no events that occurred which required the implementation of a back-up plan.
38. The provider ensures the replacement of an individual's lost or damaged property in accordance with regulation.	NA	10/10 records reviewed. The individuals did not have any lost or damaged property.

39. The provider finalizes incidents within 30 days.	Yes	2/2 records reviewed. 2 incidents were reported within the last 6 months but neither incident was for an individual in the sample. The incidents were finalized within 30 days.
40. The provider offered victim's assistance to the individual as appropriate.	NA	10/10 records reviewed. The Provider did not have any individuals in the sample with an incident for the timeframe reviewed.
41. The provider implemented the corrective action for each individual's incidents.	NA	10/10 records reviewed. The Provider did not have any individuals in the sample with an incident for the timeframe reviewed.
42. The provider reported all critical incidents.	Yes	10/10 records reviewed. The provider reported all critical incidents for the individuals in the sample.
43. The provider reviews and analyzes incidents at least quarterly.	Yes	The provider's review and analysis was completed at least quarterly for the previous year and included a review of medication errors (0) and restraints (0).
44. The provider's peer review process to review the quality of investigations was completed and documented.	Yes	The provider completed all the requirements.
45. The provider implements follow-up recommendations from the Certified Investigation peer review process.	Yes	There is documentation of the recommendation from the incident review process.
46. The provider completes all health care appointments, screenings, and follow-ups as prescribed.	NA	10/10 records reviewed. The provider is not responsible for health care appointments for anyone in the sample.
47. All required investigations are completed by a Department certified incident investigator.	Yes	All investigators who conduct investigations were certified at the time of the investigation.
48. If the individual has a dual diagnosis, the individual is receiving needed mental health (MH) services.	NA	10/10 records reviewed. Provider is not responsible for ensuring MH services for anyone in the selected sample.
49. The provider promotes wellness.	NA	10/10 records reviewed.

		The provider is not responsible for providing health promotion options for anyone in the sample.

Appendix B



	Ensuring Communication	Employment	Quality Management
Compliant	3	0	3
Non-Compliant	0	0	0
Not Applicable	3	5	0

Appendix C

Question	Onsite Findings	Self-Assessment Findings
Quality Management *There are systemic efforts to continuously improve quality*		
The Provider has a Quality Management Plan (QMP) that reflects ODP's Mission, Vision, and Values.	Yes	Yes
The Provider reviews and evaluates performance data in selecting priorities for the QMP.	Yes	Yes
The Provider analyzes and revises the QMP every 2 years.	Yes	Yes
Person-Centered Planning, Service Delivery & Outcomes *The system of support is straightforward*		
The Provider implements a policy/procedure to screen employees and contractors.	Yes	Yes
The Provider documents grievances in accordance with regulation.	Yes	Yes
The Provider has a policy that addresses restrictive interventions.	Yes	Yes
In residential habilitation, the individual has a signed department-approved room and board contract.	NA	NA
Qualified Providers *The individual's Provider(s) meet necessary training requirements*		
Staff receive training to meet the needs of the individual they support as identified in the current, approved Individual Support Plan (ISP) before providing services.	Yes	Yes
If a provider has any new hire staff, the new hire staff received training to meet the needs of the individual they support as identified in the current, approved ISP before providing services to the individual.	Yes	Yes
The provider has an annual training plan that meets all requirements.	Yes	NO

The provider and the provider's staff completed all components of the Annual Training plan as required.	Yes	Yes
Provider staff receive annual incident management training on preventing, recognizing, reporting, and responding to incidents and assuring a participant is safe.	Yes	Yes
The staff receive training on the Provider's policy/procedure on how to respond in cases of individual health, behavioral emergencies, and crises.	Yes	Yes
The staff receive training on the Provider's Emergency Disaster Response plan that addresses individual's safety and protection, communications and/or operational procedures.	Yes	NO
Person-Centered Planning, Service Delivery & Outcomes *The individual is supported in developing their own ISP, including involvement of people chosen by the individual*		
The provider participates in the development of the ISP.	Yes	Yes
The provider documents delivery of services/supports in the type, scope, amount, frequency and duration specified in the ISP.	Yes	Yes
The Provider continued to provide the authorized services to ensure continuity of care during transition.	NA	NO
If a progress note indicates lack of progress in achieving an outcome, the provider progress note indicates what actions have been taken.	Yes	NA
The individual receives employment supports from the provider.	NA	NA
The individual is supported in exploring employment opportunities through job development and assessment.	NA	NA

The employment provider supports the individual in obtaining employment through job interviewing.	NA	NA
The employment provider supports the individual in maintaining employment through job support and follow-along services.	NA	NA
The residential provider supports the individual to maintain employment by facilitating transportation.	NA	NA
<u>Person-Centered Planning, Service Delivery & Outcomes</u> *The individual is supported to communicate*		
Staff are trained on the person's communication plan and/or formal communication system.	Yes	NA
The provider provides communication assistance as indicated in the ISP.	Yes	NA
The provider has been entering the individual's progress related to their communication outcomes into the progress notes.	Yes	NA
The provider serves one or more Consolidated and/or P/FDS waiver participants who are deaf.	NA	NA
The provider ensures that one or more of the provider's administrative staff have viewed ODP's webinar.	Yes	Yes
The provider ensures that provider staff who serve a deaf waiver participant(s) have viewed ODP's webinar.	NA	NA
<u>Health & Welfare</u> *The individual's health, safety, and rights are protected*		
The provider implements the individual's back-up plan as specified in the ISP.	NA	NA
If an individual's back-up plan is not implemented as designed, an incident report of neglect was submitted.	NA	NA

The provider ensures the replacement of an individual's lost or damaged property in accordance with regulation.	NA	NA
The provider finalizes incidents within 30 days.	Yes	NO
The provider offered victim's assistance to the individual as appropriate.	NA	NA
The provider implemented the corrective action for each individual's incidents.	NA	NA
The provider reported all critical incidents.	Yes	NA
The provider reviews and analyzes incidents at least quarterly.	Yes	Yes
The provider's peer review process to review the quality of investigations was completed and documented.	Yes	Yes
The provider implements follow-up recommendations from the Certified Investigation peer review process.	Yes	Yes
The provider completes all health care appointments, screenings, and follow-ups as prescribed.	NA	NA
All required investigations are completed by a Department certified incident investigator.	Yes	Yes
If the individual has a dual diagnosis, the individual is receiving needed Mental Health (MH) services.	NA	NA