Quality Improvement Plan:

Revised date: 4/2025

Reviewed: 5/2026

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Part I. Introduction/Purpose of the Quality Improvement Plan

The purpose of this Quality Improvement Plan (hereinafter also referred to as Quality Plan, Plan, QIP or QP) is to manage and maintain agency compliance and to ensure quality of services. Develop protocols, and policies and procedures in an effort to enforce and enhance overall quality. Ensure continuous efforts from all agency personnel to prioritize supports that enhance quality of life.

a. Aspire of Western New York, Inc.'s Mission and Vision:

Aspire of Western New York, Inc.'s mission is to support children and adults with intellectual and developmental disabilities, helping them to live their lives to the fullest by providing individualized assistance based on personal choices.

Aspire of Western New York, Inc. is built upon a foundation that supports individuals in making their personal choices that determine their life path, actualize their dreams and help them achieve their own highest levels of independence. We believe that everything we do is an opportunity to have a positive, meaningful and lasting impact on our partners – the people we support and their personal support systems, employees, other care agencies, and our broader community. The future of Aspire of Western New York, Inc. is in our commitment to listen with a positive attitude, relentlessly pursue opportunities, work together as one, and be accessible to all.

b. Overview of organizational structure of agency and key aspects of agency programs and services:

Aspire of Western New York, Inc. (herein the "Agency", "Aspire of WNY" or "Aspire")) is an independent not-for-profit corporation serving the needs of individuals with intellectual and/or physical disabilities since 1947. It operates in more than 60 locations in Erie and Chautauqua counties. It is governed by a Board of Directors, a leadership team consisting of a President and Chief Executive Officer, a Chief Operating Officer, Chief Financial Officer and a Chief Human Resource Officer. The Agency is made of numerous program divisions and support departments including without limitation separate Compliance and Quality Assurance/Improvement departments and a number of internal committees and partnerships centered on service delivery and quality improvement.

Services provided involve programs certified by OPWDD and the NYSED in the following areas:

Residential Opportunities

Aspire of WNY offers a variety of living opportunities for you or your loved one throughout Erie and Chautauqua counties.

Day Habilitation Services (Day Services)

Day Services programs offer a comprehensive approach designed to provide individuals with opportunities for meaningful participation in daily life.

Community & Independent Living Support (CILS)

The CILS Division empowers individuals with developmental disabilities to live independently, prepare for and attain employment, self-direct their services, and provides respite for caregivers, all while offering meaningful, person-centered opportunities

Educational Services (Center for Learning)

The mission of Aspire's Educational Services is to enhance the lives of our students by providing the highest quality education and services for developmental disabilities.

Adult Therapy Services

Aspire of WNY, operates an Article 26 clinic located at 7 Community Drive in Cheektowaga, N.Y., offering a range of therapy services delivered by integrated clinical teams.

c. Core Values:

People – We put the personal needs and goals of those we support first. We recognize the value and the potential of every employee. We listen and learn from those around us, especially those for whom we provide services. We know that everyone can make a difference and act accordingly and recognize the dignity and unique rights of all those whom we encounter.

Performance – We give the best we can at all times, demonstrating compassion and passion. We strive for excellence in all that we do. We are honest, ethical, and accountable. We meet every challenge with professionalism and with heart. We meet change with innovation. We live up to our responsibilities and our commitment to those we support.

Partnership – We work together as a team, to make a positive impact in the lives of the people we support and in our own. We are responsive and responsible to our partners – employees, the families and personal support systems of those who receive our services, other care agencies, and our community.

Part II. Overview of Quality Improvement System

a. **Description of the key roles and responsibilities of staff that support the agency's Continuous Quality Improvement Program**

Aspire implements an ongoing Quality Improvement System that involves every department and every level within the organization. Assisting each person in living their best life is considered whenever developing quality improvement initiatives, person-centered activities, staff development plans, and program assessments, and it and is part of every department within the Aspire footprint. At Aspire of WNY all staff are responsible for conducting the plan of improvement throughout the agency as part of operations. General roles to support Quality improvement and person centered initiatives are as follows:

- Steering Committee. Made up of senior leadership members, the committee is tasked with among other things accumulating numerical information related to trends and deficiencies and assigning corrective directions as needed.
- Central Intake and Communications Departments. They design and, administer satisfaction surveys. This ensures an arm's-length separation from actual service providers to promote more effective levels of communication.
- Board of Directors – Those who sit on the Board are responsible for overseeing the agency's activities. Board members meet periodically to discuss and vote on the state of the agency in order to ensure we are maintaining our mission and vision, as well as progress and growth. The Board receives updates on Compliance, QA/QI, survey results, outside survey findings, the Compliance Workplan and other indicators of quality. The Board approves the Compliance Plan on an annual basis.
- Executive team (Leadership) – Ensures the agency remains focused on Mission and enhancing the quality of services of those we support.
- Fiscal – Ensures the agency's fiscal viability.
- Human Resources — Develops and manages agency culture and expectations for all staff levels, provides a robust training program, and takes actions to support staff longevity.
- People Receiving Services – By promoting active participation from those we support, we gain unique and timely insights into reporting issues, quality concerns, etc., and take an active role in their service plans and outcomes/goals.
- Quality Assurance/Improvement Department and Special Incident Review Committee ("SIRC")– Develop, support, and monitor strategies for improvement through recommendations in reports and trend analysis.
- Compliance- Ongoing support, investigations and monitoring of actions supporting quality.
- Division Leadership – Develop, monitor, and train strategies for improvement. Follows up on survey results.
- Mid-level Management – Implement, enforce, and monitor strategies for improvement.
- Direct Support Professionals – Implement strategies for improvement and follow plans to enhance the quality of life for those we support.
- Committees with roles and responsibilities that include quality include:

Special Incident Review Committee
Steering Committee
Rights/Behavior/Consents Committees
Workforce Development/CEUs
Quality Partnership on Transition
Agency Safety Committees (Lifting, Beds)
Policy & Procedure Sub-Committee
Individual & Agency Risk Management
Clinical Services QA/QI Committees
Quality Partnership Medical

Central Intake Committee Aspire Corporate Compliance Committee
Committee of Last Resort (Helping Hands)

b. **Key Quality Indicators**

As part of the continuous improvement process, Aspire places focus on the below areas and others that may arise to gather a comprehensive picture if Quality Improvement:

1. Regulator reviews (OPWDD, OCFS and NYSED) including without limitation Bureau of Program Certification Reviews
2. SIRC Incident Review findings including numbers of incidents and trends
3. Self-Audits and Third Party Audits
4. Satisfaction Levels of the People We Support
5. Satisfaction Levels of our Staff Members
6. Board of governance and review of Compliance Plan and related work plan and reports, review of the Quality plan, SIRC/QA reports
7. Ongoing operational ongoing review of life plan goals
8. Clinical Services Quality Assurance/Quality Improvement Plan
9. Special initiatives. Identified areas to improve service
    - Choking protocols and falls prevention.
    - Power Platform & App/Software Development initiatives
    - Emergency Department visits and Hospitalizations
    - Support for enhanced medical needs
    - Self-advocacy
    - Redesign of driver training
    - Safety initiative

1. **Regulator reviews (OPWDD, OCFS and NYSED) including without limitation Bureau of Program Certification Reviews** :

Surveys and reviews conducted by regulators are viewed as a highly beneficial process for capturing and remedying any shortfalls in care that inevitably impact the quality of care for those served. 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. This may relate to areas such as fire safety, medication administration, health services, nutrition, physical plant, personal allowance, habilitation, etc. In some cases, OPWDD will only make recommendations that do not rise to the level in which they issue an SOD. Other, more serious deficiencies will result in the issuance of a 45/60 day letter. These “letters” are 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. These “letters,” which are also sent by OPWDD to the CEO and then shared with the Board

of Directors, require immediate action and correction; without satisfactory response, OPWDD may close the program or transfer the auspices to another organization. When the organization receives the SOD, the appropriate program staff with assistance from other departments as deemed appropriate develops a Plan of Corrective Action (POCA). This plan addresses the specific matter identified by the citation, and incorporates a systemic correction that may be necessary within the site or related programs. POCA files are kept to ensure all supporting evidence is present. In addition, continuous monitoring occurs of the POCAs including documentation review and site visits to ensure all systemic changes have been implemented and are effective.

Assigned program leaders will oversee and coordinate all OPWDD BPC activities and responses, including:

- Ensure that OPWDD survey teams have access to the information and the sites that they need and will assist the survey team during its reviews.

- For all certification reviews that result in a statement of deficiencies, the assigned team shall coordinate a comprehensive Plan of Corrective Action (POCA); findings and drafted POCAs will, the extent time allows be shared with the Division leadership, the Steering Committee and Agency Leadership team. POCAS will be approved by the CEO prior to sending it to the regulatory agency.

- For all certification reviews that result in an exit conference deficiency, the assigned program staff shall coordinate an internal POCA. Program leadership is responsible for ensuring all corrective actions are completed and will monitor for completion and the effectiveness of systemic corrections.

- Maintain, aggregate and analyze data on the OPWDD surveys.

- Share survey data with the Steering Committee and Leadership

For similar types of survey action by the NYSED and OCFS related to the Center for Learning similar procedures apply.

2. SIRC Incident Review Findings

Aspire takes the issue of reporting and investigating incidents as defined by OPWDD in the Part 624 and Part 625 regulations very seriously. All staff required by regulation regardless of position are provided with training and information on reportable incidents and occurrences. Following this initial training, all staff members are given an annual refresher. 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.

After an incident or allegation of abuse is reported and investigated the investigation report is reviewed by the Vice President of Quality or an authorized delegate. Once approved, it is submitted to the agency SIRC. At each meeting, the initial incidents, final investigation reports, and addendums (to the

investigations) are carefully reviewed and discussed. Once the committee is comfortable that the report is acceptable and the program has fulfilled its responsibilities, they will close the case.

Each incident is treated as an opportunity to improve services and frequently, Agency-wide changes are implemented.

The minutes of each meeting are carefully documented and all of the information (e.g., initial report, investigation, addendum, minutes) is entered into the OPWDD IRMA (Incident Review Management Application) electronic record-keeping system. Any trends or significant issues will be identified and discussed; trend reports are completed and reviewed with the committee; these discussions are reflected in the minutes of each meeting. If there are trends or significant issues identified, the same will be forwarded to the Steering Committee or leadership for consideration and follow-up.

On an annual basis, staff develops an annual Incident Trend Report that is required by OPWDD Part 624 regulations. This report is an aggregate of the year's results, includes trends as compared to previous years and makes recommendations for training, policies, physical plant, clinical and program services, etc. This report will be shared with the SIRC and Program Leadership and the full Board of Directors as well as any other groups determined by the CEO.

3. Self-Audits and Third Party Audits

The Agency has a number of internal audit process including without limitation:

- Monthly reviews by staff and Environment and Safety Department
- Drop-in program: unannounced visits to houses by non-program staff (to avoid potential conflict of interest). Members use a checklist to capture conditions at the residence and submit through an electronic form which notifies the correct leadership teams and grades each checkpoint to indicate any unsatisfactory conditions.
- Quality Department will review
    - Physical Plant reviews/fire safety reviews,
    - Medical reviews,
    - Petty Cash and
    - Personal Allowance/clothing audits.
- Special identified areas of concern that may arise
- Compliance audits as established in Compliance Work Plan
- Behavior Rights Committee/Individual Rights Committee; Meets at minimum on a monthly basis to review and approve any behavior management and/or rights restrictions in place or being proposed for any individual. Discusses and provides alternate ideas regarding rights infringements
- Annual independent financial statement and cost report audits are performed by Certified Public Accounting firm.

4. Satisfaction Levels of the People We Support

The Agency uses a number of methods to gauge satisfaction levels or those we support.

a. Comprehensive Person Served Survey Process:

I. Survey Preparation and Design:

- Operational Services Input:
  - Operational services compile questions regarding participant satisfaction.
- Program-Specific Survey Creation:
  - Operational service questions are integrated into program-specific surveys.
- General Agency Survey Creation:
  - A general satisfaction survey for the entire agency is developed.
- Survey Updates:
  - Surveys are reviewed and updated annually or biannually to maintain relevance.

II. Survey Distribution and Access:

- Online Publication:
  - Surveys are published on the Aspire of WNY website under a designated "Satisfaction Survey" section.
  - Website availability: 24/7, 365 days a year.
- Alternative Access:
  - Individuals unable to complete the survey online can request a paper copy or assistance.
- Distribution Channels:
  - External newsletters (via MailChimp).
  - Event invitations.
  - Direct mail campaigns (1-2 times per year, with a target of 2 in 2025).
  - Email signatures.
  - Social Media Channels.

III. Survey Management and Response Handling:

- Survey Platform:
  - Surveys are managed using Microsoft Forms and Microsoft PowerApps.
- Notification System:
  - Upon survey submission, a notification is sent to the Vice President of Communications and Growth Opportunities, with backup from the Intake and Outreach team.
- Survey Review:
  - Submitted survey results are reviewed.
- Response Handling:
  - Anonymous Feedback:
    - Survey responses are recorded and stored for data analysis, even without contact information.

- Feedback requiring response:
  - If contact information is provided and a response is requested:
    - The Communications team drafts an email with suggested language for the program.
    - The team provides relevant background information to the program.
    - In some cases, the Communications team may gather additional information before connecting the individual with the program.
    - The program reaches out to the individual via their preferred method (email or phone).
    - The program then confirms that the response has been completed to the communications division.
- Data Storage:
- All survey responses are stored within the Microsoft Suite for data analysis.
- Response Tracking:
- The Communications team tracks and monitors completed responses.

IV. Reporting and Analysis:

- Annual Presentation:
  - The Vice President of Communications and Growth Opportunities prepares a presentation of survey results for the Vice President of Compliance and Quality Assurance.
  - The Vice president of compliance and quality assurance then presents the survey results to the Board as appropriate to summarize the previous year.

b. **Town Hall Meetings:**

- The President/CEO and Vice President of Communications hold Town Hall meetings with families and stakeholders.
- Feedback is analyzed, and individual follow-ups are conducted.
- Town Hall feedback is discussed with the Board.
- Outstanding concerns are followed up on until resolved as appropriate.

c. **Intake and Outreach Feedback:**

- An embedded survey in the Intake and Outreach team's email signature collects feedback.
- Responses are stored and managed in monday.com, a software platform utilized by the agency for project management, tracking, collaboration, and analysis.
- Notifications of responses are sent to the Vice President of Communications and Growth Opportunities and the Director of Intake and Outreach.

- Intake and Outreach maintains a contact log in monday.com for phone and email communications.
- Intake and Outreach forwards feedback to appropriate parties as needed.

d. **Continuous Improvement:**

- Aspire of WNY is committed to ongoing improvement of the survey process, including accessibility, response rates, workflow clarity, and data analysis.

e. **General Feedback Collection:**

I. Multiple Channels:
- Feedback is encouraged through various channels: email signatures, newsletters, website, social media, Town Halls, and phone calls.

II. Team Collaboration:
- Teams collaborate to ensure effective communication and resolution of feedback.
- Meetings are held to facilitate communication between families, individuals, and supporters.

5. Satisfaction Levels of our Staff Members

Aspire recognizes the vital role staff play in the quality of care provided. Retaining experienced and caring staff has proven to be a challenging task in this industry generally so Aspire is keenly interested in staff satisfaction and retention rates.

The Agency currently collaborates with an outside vendor, Amazing Workplaces, to design, implement and interpret satisfaction surveys from employees. This process is repeated every 6-8 months. This ensures that employees have many opportunities to voice their concerns. Each time new or amended questions are added to get deeper into specifically identified areas of concern.

The results of the survey are analyzed by the Human Resources department and Amazing Workplace and reported to senior leadership and discussed with the Board.

Where possible exit interviews are conducted to look for areas to improve.

To the extent possible areas of concern are identified and strategies are implemented to address them .

Additionally, a substantial proportion of the Agency workforce is represented by a union ensuring another method of voicing concerns.

We monitor staff retention rates, open positions, OSHA-reportable injuries, adequacy of staffing levels and staff development programs among others.

6. Board of governance and reviews of Compliance plan and related work plan and reports, review of the Quality plan, SIRC/QA reports

Outline of Board involvement in quality improvement such as approval of plans (Compliance Plan, and Quality plan) receipt of reports (see above) items such as (this is only for ideas we may do more or other things) :

- Board participation on the standing committee for incident review
- The Board has diversity including individual/s served
- Board visits to program sites
- Board awareness of State or Federal regulatory authorities' communications regarding deficiencies in any program or 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 expectations for ethical conduct be communicated and reinforced for all employees, volunteers, and Board members.
- Board assurance that practices will encourage development and expression of self-advocacy by the people receiving support and services; and assurance that a process is in place for self-advocates to practices and governance.
- The Board receives updates on Compliance, QA/QI, survey results, outside survey findings, the Compliance Workplan and other indicators of quality. The Board approves the Compliance Plan on an annual basis.

7. Operational ongoing review of life plan goals

On a monthly basis, in all OPWDD programs, managers or delegates review the notes from the person's record and compare them to the goals set forth in the life plan. Observations are made about progress toward goals or if no progress, recommendations are made to the team relative to supports for the person. Additionally, issues and suggestions are made at the annual and semi-annual life plan meeting, all of which is done to promote

8. Clinical Services Quality Assurance/Quality Improvement Plan;

Separate quality plan as required by applicable regulations monitors Article 16 services and certain types of clinical services and programs, See Appendix A.

9. Special initiatives. Identified areas to improve service

- Choking protocols and fall prevention. The agency recognized the issues and has developed a process for both choking and fall prevention initiatives.
- Power Platform & App/Software Development Initiatives. The Agency has begun a major investment into modernizing its data systems relative to both data entry and the interpretation and use of data to benefit those served in entirely new and innovative ways. By using and combining the functionality of a number of software

packages new ways are being found to expedite information entry and expand the interpretation of the data to include Artificial Intelligence. For example, the entire Therap database is being converted to allow for much more sophisticated analysis and trending. Incidents under 624 are also included in enhanced trending through this program

- Emergency Department visits and Hospitalizations. The Agency is analyzing ED visits and hospitalizations to determine whether alternatives or preventive measures can be implemented.

- Supports for enhanced medical needs. The Agency currently provides certain levels of medical care (i.e. G-tubes) and is looking at expanding care for those with unique medical issues to allow for more time in home for residents. As the population served by the Agency ages naturally occurring declines in health need to be addressed if possible.

- Self-advocacy. The agency currently runs self-advocacy initiatives designed to expand the voice of those we support and that program is being bolstered.
- Redesign of driver training. A new driver safety program has been implemented emphasizing the unique aspects of driving vans with wheelchairs.
- Safety Education. An Agency wide program to educate staff on safety related topics has been initiated and will be bolstered.

Part III. Goals and Objectives

The goals and objectives of the Quality Improvement Program for the current year:

- Enacting and implementing the new Strategic Plan, many initiatives therein forth address quality improvement, and where appropriate, will be outlined the next Quality Plan.
- Continued development under the Power Platform & App/Software Development Initiatives to improve efficiencies and trending capabilities. As the program delivers results, specific matrix will be developed for tracking specific improvement numbers.
- Reduce ED visits.
- Improve staff retention rates.
- Reduce 624 and 625 incidents.
- Improve external audit results.
- Develop matrix to measure compliance with life plans.
- Continue surveys of those served and employees.
- Enhance health and safety through trainings, communications, and reminders

Part IV. Approval and revision of the QIP

This plan will be evaluated at least annually by the Steering Committee, Agency Leadership group and the Board.

End

Appendix A

Clinical Services Quality Assurance/Quality Improvement Plan

PHILOSOPHY

Aspire of WNY will implement a planned and systemic process for monitoring and assessing the quality of programs and appropriateness of health services received, as well as the clinical performance of staff on an ongoing basis. The Quality Assurance/Quality Improvement Plan will implement outcome-oriented procedures for overseeing the effectiveness of programs, assessing the appropriateness of services and implementing improvement activities.

DEFINITION of the QA/QI PROGRAM

The Program is designed to enhance patient care through the ongoing and objective assessment of important aspects of patient care and the correction of identified problems.

The formalization of the Clinical Services Quality Assurance/Quality Improvement Program into a written plan enables the consistent and uniform application of policies and procedures.

The application of this plan is evidenced by:

1. The delivery of comprehensive care which includes good preventative care in order to achieve the best possible health outcomes for each patient;
2. The avoidance of preventable complications;
3. The recognition and preservation of the dignity and personal rights of each individual patient;
4. The provision of care in a compassionate and efficient manner;
5. The maintenance of a comprehensive record, documenting the care and teaching provided to the patient/caregiver;
6. The provision of instruction to the patient/caregiver, to ensure ongoing compliance with clinical recommendations that require follow up PROGRAM OBJECTIVES

The objectives of the Clinical Services Quality Assurance/Quality Improvement Plan are to monitor and assess the quality and appropriateness of patient care and services, as well as the clinical performance of providers based on acceptable professional standards.

Aspire of WNY has determined the following to be the objectives of its Clinical Services Quality Assurance/Quality Improvement Program:

1. To identify actual and potential problems regarding patient care and services;

2. To recommend and implement action plans, consistent with Quality Assurance/Quality Improvement procedures, aimed at resolving identified problems and developing preventative programs;
3. To review policy and procedures on patient care and services and to ensure appropriate staff credentials;
4. To identify opportunities to improve patient care and services;
5. To ensure that patients are satisfied with services they are receiving;
6. To check that billing is in compliance with services provided.

ORGANIZATION

The Aspire of WNY Quality Assurance Plan is addressed in the agency's strategic plans and consists of a series of quality assurance and improvement activities including the following:

Special Incident Review Committee
Complaints/Concerns Hotline Calls
Rights/Behavior/Consents Committees
QA Audits
Clinical Services QA/QI Committees
Policy & Procedure Sub-Committee
Individual & Agency Risk Management
Agency Safety Committees (Lifting, Beds)
Customer Satisfaction Surveys
Preventative Maintenance/Safety Surveys
Workforce Development/CEUs
Quality Partnership – Medical Committee
Reports to NYSED Misconduct enforcement
Regulatory Surveys (OPWDD, DOH, etc.)

These activities are designed to ensure the provision of quality care and services provided to Aspire of WNY service recipients and to implement continuous improvement practices throughout the Agency. The Director of Quality provides global oversight for all agency QA/QI activities and reports annually to the Aspire Board of Directors.

The Clinical Services QA/QI Plan includes

- Clinical Services QA/QI Committee
- Infection Control Committee
- Quality Partnership – Medical Committee
- QA Audit Process

The Clinical Services QA/QI Committee, chaired by the Executive Vice President of Clinical Services in conjunction with the Designated Practice Office Manager, assesses the effectiveness and quality of the Article 16 Clinic, OPWDD Nursing Services, and NYSED Clinical and Related Services. Designated clinicians and managers are responsible for the following assignments, reporting outcomes, and

developing a staff action plan, if needed, to the Clinical Services QA/QI Committee: Establishes review criteria based on professional standards of practice in order to assess the appropriateness of treatments provided and clinical performance

- Quality Assurance Audits – QA Audits re completed in the Article 16 clinic, OPWDD Nursing Services and NYSED Clinical and Related Services on a quarterly basis.
- Mandatory Staff Education – Ongoing DOH and OPWDD education is provided to all clinicians and staff to meet mandatory requirements.
- Patient Surveys and Comment Box – Article 16 surveys are sent out to patients on a yearly basis.
- Billing and Compliance – Quarterly audit of chart notes are compared to billing codes.
- Policy Manuals – Supervisors will ensure policies are current and up to date for their designated department.
- Care Management – Nurses ensure appropriate clinical follow-up for individuals with chronic medical conditions, report concerns identified and establish care plans based on medical provider recommendations.
- Incidents and Security Issues – Article 16 incidents, Justice Center Calls and Ambulance Transports are documented.
- Credentialing – Ensuring that all medical and providers are properly credentialed.
- Review of Satellite Offices – Review documentation, performance and billing/compliance of Agencies who operate under the Aspire of WNY's Clinic Operating Certificate.
- Falls – Report on patients who have fallen in their home environment and treatment and follow up.
- Medication Errors -a monthly report of medication errors that occurred within the IRAs, with trend analysis
- Number of ER/Urgent Care/In-Patient Admissions – A report categorized by individuals who received urgent medical care, who were sent for emergency care, and who were hospitalized.
- Skin Integrity Committee – to prevent, monitor and mitigate pressure wounds

Please see Clinical QA/QI Report and Minutes for specific Audits conducted and results. Audit results are reported annually to the Board of Directors by theVP of Quality through Compliance reports.

The Infection Control Committee, chaired by the Executive Vice President of Clinical Services, ensures that appropriate and effective infection control practices are in place in accordance with the standards and regulations of the New York State Department of Health, the Center for Disease Control, and the

Occupational Safety and Health Administration. The committee will meet at least quarterly to review policies and procedures relating to infection control and make recommendations to the Agency-Wide Administration Team and/or QA/QI Division. The committee recommends or provides in-service training for clinic staff on infection control practices and preventive measures.

RESPONSIBILITIES / SCOPE OF THE CLINICAL SERVICES QA/QI PROGRAM

The Executive Vice President of Clinical Services, in conjunction with the Clinical Supervisors, are responsible for the development, implementation and monitoring of a comprehensive quality assurance/quality improvement program. This includes review and monitoring reports on all clinic services and patient care issues, and oversight to ensure resolution of identified problems, as well as periodic assessment of results of action taken.

The overall coordination and integration of the quality assurance/quality improvement program includes:

1. Implementation of the quality assurance/quality improvement plan and development of necessary forms to document activities of the quality assurance/quality improvement program;
2. Provision of technical assistance to all departments;
3. Compilation of data to determine trends, implement necessary recommendations and monitor for compliance;
4. Awareness of the standards, rules and regulations of the medical/clinical staff;
5. Adherence to Aspire Agency-Wide policies and procedures regarding confidentiality;
6. Involvement of the Agency-wide Quality Assurance Department in the Clinical Services QA/QI process, to ensure accountability and integration across agency divisions.
7. Provision of administrative direction and support to the staff in carrying out the quality assurance program; and
8. Monitor corrective actions implemented for clinical services.

End