

2024

Quality Improvement Plan

YEAR END SUMMARY REPORT

QI PLAN Approved by the Board of Directors 4/8/2024

Reviewed by the Board of Directors: 2/10/2025

Position Statement

Saratoga Bridges maintains this quality improvement plan in keeping with the Board of Governors of The ARC NY established in 2014.

We strive to maintain the highest level of quality standards that are reflected in a continuum of services and support for the people we support daily, keeping in mind the essence of high satisfaction levels with our services and with all stakeholders. This is evidenced by measurable outcomes and a continuous improvement process. This includes Person-centered service planning and delivery, community inclusion, protection and safety from harm, abuse, and exploitation consistent with the ARC NY's values.

This quality improvement plan is consistent with OPWDD's Agency Protocol manual and is designed to uniquely fit with Saratoga Bridges' culture, mission, vision for the future of service delivery as well as being adaptive to the challenges and strengths in our field. This quality improvement plan:

- ❖ Supports our mission more than anything else, to empower individuals with intellectual disabilities and their families to identify and pursue their life goals through knowledge, collaboration, and experience.
- ❖ Supports our vision, enriching lives by providing opportunities and partnerships.
- ❖ Supports our values-Respect, Innovation, Teamwork and Excellence.
- ❖ Commits to a continuous quality improvement process supported by our agency policies and procedures.
- ❖ Is managed by key stakeholders, the People we Support, the Board of Directors, the CEO, COO and Director of QA as well as involvement with Human Resources, Finance, and all Program Directors.
- ❖ Outlines our systems for data collection, review and analysis for our goals and objectives.
- ❖ Includes objectives, measurable actions, and the expected outcomes.
- ❖ Identifies how the plan will be reviewed, revised, and approved annually.
- ❖ Identifies how this plan and progress with implementation will be shared with agency stakeholders.

The Key Areas for Quality Improvement based on the ARC NY QSOC revised standards, 10/26/2023

The ARC NY has identified five (5) key areas for quality improvement that each chapter must address within their QIP (Quality Improvement Plan).

The five (5) key areas are:

1. OPWDD Bureau of Program Certification (BPC) Survey Results.
2. Saratoga Bridges' Reportable and Significant Incident numbers, trends, outcomes, and effects on the people we support.
3. Self-Audits and Surveys / Peer Review Results.
4. Quality of Life and Satisfaction Survey Results.
5. Quality and Satisfaction Levels of Saratoga Bridges' workforce.

Aside from these five key areas this plan also addresses the Governance role in the Quality Improvement process and plan development, review, and approval.

This plan also includes the requirement for an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

This Quality Improvement Plan addresses the OPWDD "Topic 13" in the Agency Protocol Manual which outlines the following standards that must be met:

A. QI Plan Person-Centered Outcome Standards:

1. The quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals.

a) To meet this standard, there must be evidence to support that QI strategies include measurement and analysis of *individuals' quality of life outcomes*.

2. The quality improvement plan addresses *person-centered planning and service delivery*.

a) To meet this standard, the QIP must describe activities to address agency effectiveness in person-centered planning and service delivery.

B. QI Plan Health, Safety and Freedom from Abuse Standards:

3. The written quality improvement plan addresses *assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation*.

a) To meet this standard, the QIP must describe activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

C. QI Plan Compliance Standards:

4. The quality improvement plan includes objectives, and processes to address compliance with OPWDD, state and federal requirements.

a) To meet this standard, the QIP must include activities to address compliance with OPWDD, state and federal regulations. This includes strategies to assess and/or measure rates of compliance and/or factors influencing the compliance/non-compliance. Additionally, OBJECTIVE setting and systemic strategies related to maintaining or improving the level of agency compliance must be present.

D. QI Plan Satisfaction and Planning Standards:

The agency quality improvement plan addresses areas important to stakeholders based on their solicited input.

a) To meet this standard, the QIP must describe the way(s) in which stakeholder feedback is solicited and the process for review/analysis and consideration for inclusion in the QIP.

6. The quality improvement plan addresses findings from *satisfaction surveys*.

a) To meet this standard, the QIP must formally address findings from satisfaction surveys.

E. QI Plan Communication Standards:

1. The quality improvement plan is reviewed and approved by the board of directors annually.

a) To meet this standard, the agency must be able to show that review and approval of the QIP by the board of directors has occurred within the last year.

2. There is a mechanism for making the Quality Improvement plan known to the people supported, staff, agency stakeholders and other interested parties.

a) To meet this standard, the agency must be able to demonstrate that stakeholders have been informed of the agency QIP. This Plan has been posted to our agency website and our communications department has send out

F. QI Plan Annual and On-Going Effectiveness Standards:

1. The agency's QI plan identifies quality improvement actions to be taken during the year.

a) To meet this standard, the QIP must describe the quality improvement actions to be taken during the period of the plan. These actions must include measures, analysis, implementation, and review

2. The agency's quality improvement activities include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

a) To meet this standard, the agency must complete an annual summary of the QIP describing actions taken and the results of those actions. This includes reflection on the significant and minor improvements/changes in quality, as well as the actions that appear to have had no impact, if any.

Section 1: OPWDD Bureau of Program Certification (DQI)

In 2023 the total number of OPDDD surveys was 39 and 14 of these surveys resulted in a formal plan of corrective action, referred to as a "POCA" (36%).

Although citations can be given and not result in a formal POCA, these are non-systemic issues and not egregious enough to result in a POCA. Although they are still considered citations, they are corrected with administrative and programmatic review.

Both types of citations and corrections are listed below for reference for the Quality Improvement OBJECTIVES for 2024.

A review of the survey results of 2023 shows that there were two trending factors that needed improvement. Those were:

- 1) Health Support and Medications
- 2) HCBS Settings Rules, specifically privacy, locking mechanisms available on doors and access to the broader community in both the residential and day programs.

OBJECTIVE #1: Decrease the number of citations in the realm of Health Support and Medications in the 2024 and beyond survey cycle to zero citations.

MEASURES:

- 1) The agency will track recruitment of nursing vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.
This is to ensure that each person has adequate RN oversight. –

As of 12/31/24 the nursing department is fully staffed with the newest RN being onboarded in January 2025. Being down one FTE in nursing, with caseload coverage, has not proven to lead to lack of RN oversight contributing to RN and healthcare cites. In 2023, the average nursing openings per quarter were 3.25. The 1 opening at the end of 2025 was an improvement. We had not seen medical and health care citations in DQI surveys until the end of the year and those were attributed to lack of staffing and consistent staffing in the houses.

- 2) The Coordinator of Medical Services will train each RN that has a residential caseload in the OPWDD regulations and expectations for RN oversight to reduce the # of citations. This training will be conducted quarterly at RN meetings. Coordinator of Medical Services, by 12/31/24.
-Has been ongoing with success. Over the course of the year the Coordinator of Medical Services trained the nurses in blood thinners, Grab and Go books, Plan of Nursing Supports (PONS) and Sedation/MIPS plans, Therap access to IPOPS, comparing documentation with call out concerns of mobility fact sheets, dining fact sheets, and Behavior Plans. Also reviewed Life Plans and how to access them in Therap.
- 3) QA and Compliance will conduct quarterly mock DQI audits using the OPWDD protocols and will relay findings to program nursing and administration. Any deficient practice will require an immediate plan of correction. QA will conduct surveys quarterly. Dir QA by 12/31/24.

These were not conducted as there was an investigator vacancy in the unit until August 2024. Investigations took precedence over the mock surveys, however a review and monitoring by QA of the OPWDD survey activity

noted a decrease in citations related to health support and medications. Had there been no decrease in numbers QA would have intervened with reviews.

OBJECTIVE #2: Decrease the amount of HCBS settings citations to zero citations in 2024.

MEASURES:

- 1) QA will retrain all middle managers bi-annually on the HCBS settings policy and will work with Program Coordinators, Hab Coordinators, Res Managers and Assistant Directors to identify opportunities to implement ways to provide privacy, community opportunities and documentation that reflects our commitment to these standards. Director QA by 6/30/24 and 12/31/24.

These trainings were completed and a review of the occupancy agreement was conducted summer of 2024 as a result of language that was inserted into the document before OPWDD had sent out their template (the agreement was to be implemented by 2023 in federal regulation, and the agency in good faith effort created our own to comply however the surveyors did not like the language and we were unfortunately cited on this in 2024).

- 2) The Assistant Directors will review individual community participation monthly and problem-solve with administration on how to effectively implement strategies with limited resources (Staffing in particular). Monthly by Assistant Directors, by 12/31/24.

This was completed. The Program Coordinators have implemented ISP data points in Therap (our electronic record) that records individual community participation. This has not been cited in 2024.

This goal can be replaced in 2025 with *“the PC’s will continue to track community participation and note monthly in their reports.”*

- 3) The agency will track recruitment of DSP vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.

This is to ensure that each program is sufficiently staffed to provide the support needed for full implementation of the Settings Rule.

This was completed by HR. As of 11/14/24 the DSP turnover rate was at 6.3% (Q1-Q3) and a vacancy rate of 21.3%. The statewide ARC NY rate was at 20.7 for the first three quarters of 2024.

Although there have not been citations on this area, staffing is still a struggle for the agency and programs are doing their best to accommodate individual community participation. This shall remain a goal for 2025 as staffing is critical to much of this quality improvement plan and the agency's success.

Section 2: Reportable Incidents including Allegations of Abuse, Neglect and
Mistreatment
Injuries

SARATOGA BRIDGES aims to ensure that all individuals who receive services do so in a safe environment and are protected to the extent possible from any potential danger or abuse.

Incident management is the formal system established to do so.

Therefore, the process of reporting and reviewing of incidents must work to ensure that necessary and prompt steps are taken to protect these individuals and others. It must initiate a response to dangerous or abusive situations and try to eliminate the potential for future recurrences. We are committed to the enhancement of the quality of support.

Our incident management trend report for 2024 shows that we had 33 Allegations of abuse and neglect with seventeen (17) being substantiated. This figure is up from 27 reports in 2023 with only (4) substantiated cases. This gives us a 52% substantiation rate for 2024 compared to a 15% substantiation rate in 2023.

Staffing shortages, sub and relief staff deployment and lack of management at some sites were determined to be contributing factors to the rise in the neglect cases.

The two programs with the highest number of reports of abuse were Grooms Road IRA and Birchwood IRA. Both had lapses in management and sub/float staff, coupled with a higher acuity level.

We saw 16 Neglect substantiations and one psychological abuse substantiation this past year.

Although we strive for zero incidents, allegations and reports of staff misconduct we realize that situations do occur that require the agency to immediately protect people, conduct a thorough investigation and to have the special review committee (SRC) oversee this process to ensure transparency, adherence to the regulations and requirements pertaining to incident management and to ensure that our policies and procedures are always in place and updated to reduce and eliminate incidents.

Our Special Review Committee has been recruiting for required membership as specified in regulation and must be attested to annually with the ARC NY. We are down a family member, DSP and person supported as members of the committee. Although we are recruiting the pool of potential available members remains an issue.

OBJECTIVE #3: Reduce the number of *substantiated* reports of allegations of abuse, neglect, or mistreatment to zero percent by 12/31/24 and beyond.

MEASURES:

- 1) To maintain our workforce at 100% currently trained in rights, abuse, and incident reporting throughout the year. Staff Development will run reports quarterly to track our rates and reach out to managers who need to sign their staff up for training or retraining. Staff Development will also ensure that program management knows how to run the training reports and keep their staff fully trained.

Staff Development, quarterly by 12/31/24

At the time of this writing at year end there were 88 out of 360 staff required to have this training in this area. We did not meet our goal of keeping 100% of the workforce trained in Rights, Abuse, and IR. This goal will continue, however there will be an added training in 2025 geared at Abuse Prevention which will focus on intervention, abuse, and incident prevention and by nature, if successful will result in an overall drop in the numbers of reports for 2025. This will be created and managed by the Quality Assurance Department with the support of Staff Development. We will track attendance and success of this training program.

- 2) The agency will track recruitment of DSP vacancies quarterly and aggressively recruit to fill vacancies. HR by 12/31/24.

This is to ensure that each program is sufficiently staffed to provide the support needed to ensure consistency, familiarity with the individuals supported and less need to float, or sub staffing.

This was completed by HR. As of 12/31/24 the DSP turnover rate was at 5.725 %(Q1-Q4) and a vacancy rate of 22%. The statewide ARC NY rate was at 20.7 for the first three quarters of 2024. The year end rates are not out as of this writing.

- 3) The QA department will track all minor reports and all allegations and reportable incidents monthly and use the trending to provide immediate information, training, support, and action plans to reduce the number of reports.

QA Department, monthly by 12/31/24.

This has been completed, and incident review (internal review with program and clinical participation) occurred weekly. Feedback and recommendations have been made to reduce and hopefully eliminate incidents of a similar nature. We will continue to track incident trends. Please see the 2025 Incident Review Trend report for more information.

OBJECTIVE #4: Reduce the number of injuries (as defined in Part 624 as “Any injury that requires treatment above first aid”) to zero in 2024.

MEASURES:

- 1) To ensure that each person’s plan of protection is kept up to date with safeguards, correct level of supervision and other important medical safeguards well defined.

Program Coordinators, monthly and as needed, by 12/31/24.

This has been completed. The Program Coordinators have been updating the IPOPS at the semi-annual meetings and as changes in program planning occurred. We are also in the process of changing over to the IPOP

Assessment module in Therap with a new design and layout so the newer IPOPs have been moved over to that platform.

- 2) Residential Managers to keep staff trained in individual IPOPS and other important safety documents (Behavior Plans, Dining Fact Sheets, Mobility Fact Sheets) by reviewing them quarterly with staff at staff meetings. Residential Managers of ADRS, by 12/31/24.

This has been completed by the Program Coordinators sharing the information at the residences and attending staff meetings where possible. This is still an area to track for 2025 and will continue. We are discussing moving paper copies of essential information regarding the individuals to Therap in 2025 which will ensure that staff can easily acknowledge that they have read the documents for training and tracking purposes.

- 3) The QA department will track all minor reports as well as all allegations and reportable incidents monthly and use the trending to provide immediate information, training, support, and action plans to the programs to reduce the numbers of reports. QA Department, monthly by 12/31/24.

This has been successful for 2024. We have been trending the allegations of abuse and neglect and the significant incidents at our Special Review committee and have shared those incidents with patterns by house, involved staff and incident type. The minor reports have also been trended in the same fashion at the internal weekly incident review committee.

This written quality improvement plan addresses assurance of individuals' health, safety, rights, and freedom from abuse/neglect and exploitation and sets forth these activities to address individuals' health, safety, rights, and freedom from abuse/neglect and exploitation.

Section 3: Self-Audits, Surveys and Peer Review Results

This quality improvement plan includes objectives, and processes to address compliance with OPWDD, state and federal requirements.

This includes strategies to assess and/or measure rates of compliance and/or factors influencing the compliance/non-compliance. OBJECTIVE setting and systemic strategies related to maintaining or improving the level of agency compliance are represented here.

Saratoga Bridges is committed to fostering a culture of compliance through the implementation of a system for the routine identification of compliance risk areas to detect, correct and prevent non-compliance behaviors. Through the process of our corporate compliance reporting structure, the articulation of compliance-related roles and responsibilities at every level of the Saratoga Bridges' operations, and through the utilization of our organizational experience, detection and correction of problems is expedited. If an internal investigation substantiates a reported violation, then it is our policy to engage in a two-fold process:

- (1) to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary; and
- (2) implementing systemic changes to prevent a similar violation from recurring in the future.

Saratoga Bridges is committed to routinely conducting internal audits of compliance risk areas. Results of internal and external audits are shared at minimum with the CCC and Saratoga Bridges Board of Directors. Saratoga Bridges also conducts annual reviews of the compliance program to determine and evaluate the program's effectiveness and any need for correction or revision. The results of annual compliance program reviews are shared at minimum with the CEO, senior management, the CCC, and the Board of Directors.

Saratoga Bridges maintains a compliance workplan that describes the plan for routine auditing monitoring and compliance program review activities. This workplan is drafted and/or developed by the Compliance Officer and shared with the Corporate Compliance Committee for feedback. Revisions are made to the workplan as risk areas change and based on the outcomes of the auditing and monitoring activities and updates from OMIG.

Compliance conducted several audits and investigations in 2023 with Community Habilitation (aka “Comm Hab”) being the program at highest risk for staff misconduct and Medicaid billing issues. This is due to the nature of staff working independently without direct supervision and the possibility of staff not carrying out the comm hab plans but documenting that they had.

In 2023 we saw three different Community Hab cases that were investigated by Compliance where it was shown that staff were behaving in ways that overbilled Medicaid for time and services, which were all corrected with OMIG self-Disclosures. These were settled with the OMIG.

Our 2024 Compliance Work Plan has at the top of its audit risk area, Community Hab. We were fortunate to obtain the services of a Compliance Coordinator, Heather Franke, in 2024.

With Community Hab being such a substantial risk for the agency, we have an OBJECTIVE to maintain checks and balances on the staffing, billing, and payments to the Comm Hab Program in 2024 and have zero compliance issues.

OBJECTIVE # 5: Reduce the number of compliance related issues in the Community Habilitation /Family Support Program to zero by 12/31/24 as defined by the OMIG audit tool.

MEASURES:

- 1) The Compliance Coordinator will conduct a 100% audit on the Community Habilitation documentation, claims and billing for 2024 both in the

beginning and end of the year to ensure 100% compliance (as the life cycle for Life Plans is every six months).

Compliance Coordinator, biannually by 12/31/24.

This has been completed as per this plan and there have been no fiscal issues found. It was determined to be beneficial to ensure that the program was in fact in compliance with the billing requirements and the electronic visit verification (EVV) has been utilized per Medicaid and DOH requirements.

The Compliance Coordinator and the QA Department has completed a full review of the Community Habilitation department's billing and recordkeeping, including verification of the EVV (Electronic Verification Visit) login credentials (GPS) per Medicaid rules. We have not found any errors resulting in billing errors. Minor clerical findings were relayed back to the program for resolution.

There have not been any Community Hab corporate compliance billing or investigations in 2024.

As the Office of Medicaid Inspector General (OMIG) has placed Community Hab, Respite and EVV billing on their worklist for 2025 this shall remain an objective to carry over into the Quality Plan for 2025.

Section 4: Quality of Life and Satisfaction of the people we support

This quality improvement plan includes measurement, aggregation, and analysis of factors related to the outcomes and quality of life desired by individuals by examining satisfaction surveys, life plan and staff action plan reviews and documentation of monthly notes which indicate individual outcomes and satisfaction.

To meet this standard, there will be evidence to support that QI strategies include measurement and analysis of individuals' quality of life outcomes.

The quality improvement plan addresses person-centered planning and service delivery.

OBJECTIVE #6: Demonstrate that family input and satisfaction surveys impact person-centered planning and service delivery in at least 90% of response rate, as demonstrated by involvement in the Life Plan and Staff Action Planning process.

MEASURE: QA will review 100% of the response rate of surveys and compare it with the Life Plans and Staff Action Plans (with input from the Program Coordinators) to ensure that input is included in the plans to determine total percentage rate.

The Quality Assurance Department reviewed 100% of the response rate of all surveys conducted by individuals in residential and day programs and the result of this was that 100% of the program planning included input from the individuals and this was evident in their staff action plans and plans of protection.

OBJECTIVE #7: Demonstrate that 100% of individual input from satisfaction surveys are incorporated into the Life Planning process.

MEASURE: QA will review 100% of the response rates from individual satisfaction surveys (With input from the Program Coordinators) and ensure that 100% of the responses are included in the Life Planning process, and documentation exists to verify outcomes. Documentation may be in the form of the Life Plan, monthly notes, six-month habilitation summaries, or other forms of verification.

To meet this standard, the QIP has described activities to address agency effectiveness in person-centered planning and service delivery.

This quality improvement plan supports our mission more than anything else, to empower individuals with intellectual disabilities and their families to identify and pursue their life goals through knowledge, collaboration, and experience.

OBJECTIVE #8: Demonstrate that the Mission of Saratoga Bridges is fulfilled by staff for all individuals served in 100% of plans sampled.

MEASURE: The QA Department will review Life Plans, Staff Action Plans and Community Outing ISP data in Therap for a 10% sample in each program area quarterly to determine if the mission of pursuing life goals is evident.

QA Department, quarterly.

QA completed reviews of life plan meetings, staff action plans and compared to those surveys that were completed by individuals and their families, and we found that 100% of the individuals were actively engaged in determining their services and were participating in life goals with a high level of satisfaction.

This goal will continue in 2025, but we recommend that the Program Coordinators revise the survey tools to better gauge what people really want in life and measure other satisfaction determinants.

OBJECTIVE #9: Demonstrate that the Vision of Saratoga Bridges is fulfilled by staff for all individuals served in 100% of plans sampled.

MEASURE: The QA Department will review Life Plans, Staff Action Plans and Community Outing ISP data in Therap for a 10% sample in each program area quarterly to determine if the Vision of enriching lives by providing opportunities and partnerships.

QA Department, quarterly.

QA completed reviews of life plan meetings, staff action plans and compared to those surveys that were completed by individuals and their families, and we found that 100% of the individuals were actively engaged in determining their services and were participating in life goals with a high level of satisfaction.

This goal will continue in 2025, but we recommend that the Program Coordinators revise the survey tools to better gauge what people really want in life and measure other satisfaction determinants.

Section 5: Quality and Satisfaction Levels of the Chapter's Workforce

To offer an Array of Support, Learning, and Growth Opportunities that Assist and Engage Employees

OBJECTIVE #10: Conduct an employee survey that focuses on employee interests in training/educational opportunities so staff may advance in their careers

	<input type="checkbox"/>	
Review by training department of current curriculum and courses to identify opportunities for updates or improvement	HRD	ongoing
Survey employee population for educational opportunities desired	HRD	August 2024

Identify talent within the Agency and provide mentorship & development for succession planning.

HR Director, Annually or more as determined by HR

These were both completed in 2024.

The updates to the training have happened as needed and will continue. Aside from regulatory changes that occur, there are updates that take place because of incidents.

As far as asking employees what training they desire this happens in the review process and we have instituted 30/60/90 check-ins with new hires to see what they feel they need more training in.

These will continue in the 2025 Quality Improvement Plan.

Section 6: Review, Revision and Approval of this QIP

- ❖ Identifies how the plan will be reviewed, revised, and approved on an annual basis:

This quality improvement plan will be reviewed by QA at least quarterly to determine if the measures and objectives are being implemented and remain appropriate. QA will document reviews on the plan.

This plan will be reviewed annually by the Board of Directors for their input, direction, and approval. The resolution to approve the plan will be included in the Board of Directors meeting minutes. The date of 2024 review was in April of 2024 and a resolution to approve the report was made.

This plan will be submitted to the ARC NY annually, post Board approval with the attestation of review by the Board. QA shall keep a copy of this attestation with the plan on file.

- ❖ Identifies how this plan and progress with implementation will be shared with agency stakeholders.

This quality improvement plan shall be available on the agency website and when conducting family and individual surveys, we will provide information on how to access it. We shall direct all stakeholders to contact the QA Department with any questions, concerns, or additional information they would like to see measured in future revisions of the plan.

- ❖ Is managed by key stakeholders, the People we Support, the Board of Directors, the CEO, COO and Director of QA as well as involvement with Human Resources, Finance, and all Program Directors.

This plan will be reviewed with the Board of Directors, Senior and Middle Management and will have input across agency-wide departments annually post Board approval. Meeting minutes shall reflect this review.

Section 7: Annual Progress Summary

The agency's quality improvement activities shall include an annual progress summary that identifies the quality improvement actions taken and the results/effectiveness.

This annual summary shall be reviewed by Senior Leadership and Middle Management and annually by the Board of Directors.

Quality Assurance will complete an annual summary of the QIP describing actions taken and the results of those actions. This includes reflection on the significant and minor improvements/changes in quality, as well as the actions that appear to have had no impact, if any.

Other ARC NY Quality Metrics that are tracked and entered into the Chapter Information System (CIS) on a quarterly basis with some annual numbers as well. These are:

Annual Quality Scores

Employee Injury Not tracked by ARC NY

Annual # of injuries to employees (per 100 employees)

Employment Rate % 19.2

Annual % of individuals competitively employed

Staff Turnover 25.3

Annual % of full/part time employees who exited employment

DSP Vacancy % 22.3

Annual % of DSP positions that were vacant

DSP Turnover % 23.7

Annual % of DSP positions that turned over

BPC SOD % 11.1

Annual % of BPC surveys that resulted in an SOD

OFPC SOD % 38.5

Annual % of OFPC surveys that resulted in an SOD

OFPC SOD not FSES % not tracked

Annual % of OFPC surveys not met by FSES

Abuse Allegations 1.7

Annual # of abuse/neglect allegations (per 100 individuals)

Substantiated Abuse 2.7

Annual # of substantiated abuse/neglect cases (per 100 individuals)

Injuries per Individual 0.2

Annual # of injuries to individuals (per 100 individuals)

Frontline Management Vacancy % 35.2

Frontline Management Turnover % 51.2

ICF ER Visit % 18.2

IRA ER Visit % 11.6

By:

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1/14/2025