

MAKOR QI/QA MANAGEMENT PLAN

2026

TABLE OF CONTENTS

PART 1 BOARD AND MANAGEMENT COMMITMENT

Board and Management Commitment to Providing Quality Services

- 1.1 Reporting to the Board on Activities and Feedback
- 1.2 Board Meeting Minutes
- 1.3 Review of Mission Statement
- 1.4 Individuals' involvement in decision making
- 1.5 Commitment to inclusion of Natural Supports
- 1.6 Commitment to the diversity of the community served
- 1.7 Text of Current Mission Statement

PART 2 MANAGEMENT PLAN

Individual Input and Quality Assurance

- 2.9 Inclusion of Individuals' Input in the Self Survey Process

Empowerment through Learning

- 2.17 Coordination of Training
- 2.18 Role of QA in Monitoring Training
- 2.19 Enhancement Training for DSP Staff
- 2.22 Special Training Presentations for Administrators & Management

"Empowerment" Training

- 2.25 Empowering Individuals' Families & Advocates
- 2.27 Board Training on Individual Empowerment
- 2.29 Empowerment Training for Individuals – Individual

Individual Input and the Management Plan

- 2.30 Sources of Input Relevant to the Management Plan

MAKOR QI/QA MANAGEMENT PLAN

2026

PART 3 SELF SURVEY

QA Process

- 3.1 The “non-survey-related” work that QA does
- 3.3 Billing documentation reviews
- 3.4 Sampling methodology
- 3.5 Survey tools
- 3.6 Assessing quality
- 3.7 Individuals’ input at QA self-surveys
- 3.8 Documentation and distribution of survey findings
- 3.9 Tracking the correction of deficiencies
- 3.10 Reporting of findings
- 3.11 Procedure when there is imminent danger
- 3.12 Availability of technical assistance
- 3.13 Procedure for keeping records of QA surveys
- 3.15 Ability to maintain substantial compliance
- 3.16 Survey policy/procedure
- 3.17 The Completed Self Survey Cycle

PART 4 VALUED OUTCOMES

- 4.3 Assessment of Valued Outcome Achievement (VOAA)
- 4.4 VOAA form

PART 5 QUALITY IMPROVEMENT

Agency-wide Quality Improvement Plan

- 5.1 Communication of and responsiveness to feedback
- 5.2 Monitoring and supporting quality of services via feedback
- 5.3 Measurement and tracking of valued outcomes
- 5.4 Commitment to competence, service and compliance
- 5.5 QI process as an extension of the Agency’s Mission

MAKOR QI/QA MANAGEMENT PLAN

2026

Agency-Wide Quality Improvement Initiatives

5.6 QI Initiatives

5.7 Maintaining worthwhile activities

5.8 Description of Agency's current quality initiatives

MANAGEMENT PLAN -- PART 1

Board and Management Commitment to Providing Quality Services

1.2 Reporting to the Board re: Activities and Feedback

RESPONSIBILITY: OF EXECUTIVE SECRETARY

- The Agency's Board of Directors meets approximately 4 times per year.
- Among its other activities, the Board receives updates concerning program activities, feedback from Individuals served and comprehensive reporting by management and active discussion by Board members of issues relating to quality programming and services.

1.3 Board Meeting Minutes

RESPONSIBILITY OF: BOARD & EXECUTIVE SECRETARY

- Board meeting minutes document discussion on the above issues

1.4 Review of Mission Statement

RESPONSIBILITY OF: ADMINISTRATION

- Individuals served, the Agency's Board of Directors, Management, and staff review the Mission Statement and provide input concerning revisions, periodically, and as needed.

1.5 Individuals' involvement in decision making

RESPONSIBILITY OF: EXECUTIVE DIRECTOR & QA

- The Agency maintains systems to actively involve Individuals served in the Agency's decision-making processes.

1.6 Commitment to inclusion of Natural Supports

- The Agency's Board and Management are committed to actively promote Individuals' connections with natural supports and the maximum use of community resources.

1.7 Commitment to the diversity of the community served

- The composition of the Agency's Board and reflects a commitment to the diversity of the community it serves.

1.8 Text of current Mission Statement

- The current text can be found on the Agency's website.

“Makor Care and Services Network is a professional non-profit agency providing a broad spectrum of support, care, and services to Individuals with intellectual or physical challenges and their families. Our philosophy is based on the deep-seated value of every Individual's inherent self-worth and their right to be treated with respect, dignity, and love. Makor is a unique blend: we combine the warmth and dedication of family with the professionalism and expertise of an experienced and knowledgeable agency. Our passion for quality care, as evidenced by our very active and dedicated Quality Improvement team, has helped propel Makor's national recognition.”

MAKOR QI/QA MANAGEMENT PLAN – PART 2

Individual Input and Quality Assurance

2.9 Inclusion of Individuals' Input in the Self Survey Process

RESPONSIBILITY OF: QA

- Individuals receiving services will participate in the QA survey of his/her residential site. It is the responsibility of QA staff to implement this in a manner consistent with the OPWDD audit tools which are utilized for QA audits (See Section 3.7).

2.12 How Individuals Influence the Board's Decisions

RESPONSIBILITY OF: BOARD, DR. GLICKSMAN & CHIEF EXECUTIVE OFFICER

- The Agency's Board of Directors places the highest value on providing quality care and treatment to those served by the Agency, and, naturally, considers how their decisions may affect Individuals. At the same time, the Agency also values Individual input and seeks opportunities to empower Individuals to be involved in a meaningful way in the Board's decision-making process. Attendance of an Individual (when available) at Board meetings is encouraged and facilitated. Individuals may also participate when available on Human Rights and Incident Review Committees.

Empowerment through Learning

2.17 Coordination of Training

RESPONSIBILITY OF: TRAINING DIRECTOR & QA

- One of the objectives of the Management Plan is to promote Individual empowerment through enhanced training. To facilitate this objective, the Training Director and QA are responsible for monitoring the progress of training activities across the Agency for DSP staff, management and Board members.

2.18 Role of QA in Monitoring Training

RESPONSIBILITY OF: QA

- Through the Agency's self survey process, QA staff monitor staff training in topics required by regulation, i.e., the topics mandated by 633.8, OSHA, HIPAA privacy rules, Corporate Compliance, compliance with ADM 2014-3 and other applicable regulations or Agency policies.

2.19 Enhancement Training for DSP Staff

RESPONSIBILITY OF: TRAINING DIRECTOR

- The Training Director monitors to ensure that new DSP staff participate in the Agency's enhancement training curriculum.
- The Training Director monitors the progress of this training Agency-wide, identifies where the need for this training exists, and summarizes the progress of this training.
- The Training Director works with management to ensure that as many new DSP staff as possible take advantage of these training opportunities.

2.22 Special Presentations

RESPONSIBILITY OF: CEO, VP OF OPERATIONS, PUBLIC RELATIONS, TRAINING DIRECTOR OR QA

- At the discretion of the Chief Executive Officer, Vice President of Operations, Public Relations, Training Director or QA, special speakers or special training presentations can be arranged for staff, management and members of the community.

"Empowerment" Training

2.25 Empowering Individuals' Families & Advocates

RESPONSIBILITY OF MANAGEMENT, CLINICAL DIRECTOR AND ADMINISTRATION

- One of the principle means for empowering Individuals' families and advocates is accomplished via their routine contacts with management, supervisors and clinicians. Agency personnel are trained to view interactions with families as opportunities for exchanges of information concerning their rights and options. If a disagreement arises, Managers are required by policy to consult with the Clinical Director for guidance. After consultation, management or designated personnel will provide information and options as instructed by the Clinical Director. Should an issue rise to the level of an objection or appeal, the appropriate procedure will go into effect, i.e., the family member or advocate will be advised of their right to contact the Clinical Director directly.

2.27 Board Training on Individual Empowerment

RESPONSIBILITY OF: CHIEF EXECUTIVE OFFICER, TRAINING DIRECTOR & QA

- Training for Board members on topics related to the values of empowerment and choice making are periodic, typically arranged by the Chief Executive Officer. Training for management on topics related to the values of empowerment and choice making typically takes place at Management Meetings. These processes are monitored by QA and reported on as part of the Management Plan review.

2.29 Empowerment Training for Individuals

RESPONSIBILITY OF: MANAGERS & QA

- Training for Individuals in making choices and expressing preferences occurs in everyday settings at each program site by habilitation staff and management. This type of training occurs as part of the Individuals' routine counseling and formal habilitative training objectives. Training of Individuals in making choices and expressing preferences also takes place during the Person-Centered Planning Process, which is facilitated by the Care Manager and SAP development team.

Individual Input and the Management Plan

2.30 Sources of Input Relevant to the Management Plan

RESPONSIBILITY OF: ADMINISTRATION, MANAGERS, DR. GLICKSMAN, & QA...

- The typical process leading to revision of the Management Plan and the development of new initiatives can run in the following manner. QA solicits recommendations for new activities or initiatives. The proposed new activities and new initiatives run through a feasibility assessment and trial period before being incorporated into the Management Plan. The Management Plan is finally modified, based on Individuals' positive response, as well as management's consensus that the new initiative is successful. Once an initiative has been approved, QA writes the new information into the Management Plan. Other factors can influence changes in the Management plan. Based on experience, the following systems have been the most likely to contribute to revisions of the Management Plan and the development of new initiatives:
 - Experimentation by managers with new ideas and the process of trial and error to determine if individuals enjoy a new activity.
 - Direct feedback from individuals to Management about which activities were enjoyable or successful or not enjoyable or not successful.
 - Recommendations by Agency administrators or OPWDD.

MANAGEMENT PLAN - PART 3

QA and the Self Survey Process

3.1 **The “non-survey-related” work that QA does.**

- The QA Department’s primary role is to conduct routine audits of its own programs to assure Agency compliance with all applicable regulations. In addition to conducting internal reviews, the QA Department has other Agency responsibilities, i.e., technical assistance; training for Residence Managers and staff on an as needed basis; technical assistance for the Agency’s ICFs, at least, annually, and, more often, on an as needed basis; ICF POCA follow up, annual non-visit Independent Utilization Reviews for the Agency’s ICF residents; incident investigations for abuse/ neglect allegations or significant incidents (including compliance with the Access to Records Law); oversight and follow up of incident Corrective Action Plans, functioning as the HIPAA Privacy Officer, monitoring Agency compliance with HIPAA and MHL/CBC regulations; Personal Allowance and Petty Cash semiannual reviews; Corporate Compliance training and providing administrative oversight, monitoring and administrative reviews of fire drills and other tasks as needed.

3.3 **Billing documentation reviews.**

- There are QA reviews of “billing” documentation for Waiver services provided. Review findings are summarized and reported to Agency administrators, the appropriate program supervisors and service coordinators. Erroneous billings are identified and reversed.

3.4 **Sampling methodology.**

- For all HCBS Waiver program surveys, the sampling methodology will follow OPWDD’s survey protocol guidelines, as well as any additional instructions given by DQI.
- At the discretion of QA, additional areas of compliance and/or individuals’ files can be reviewed.
- For surveys of other program types, the sampling methodology will follow the guide for the specific OPWDD protocol being used.
- QA staff continue to follow the sampling guidelines for the OPWDD Site Review Protocol.
- In addition, QA can opt to add files to the sample (e.g., a new admission or someone who has not been reviewed recently).
- In addition, during these surveys, the agency’s QA surveyors can opt to check compliance “across-the-board” (i.e., 100% of individuals) in a particular regulatory area (e.g., personal allowance, waiver billing documentation, life safety, incidents, and 633.16).

3.5 **Survey tools.**

- QA staff utilize OPWDD’s review protocols when conducting surveys.

3.6 **Assessing quality.**

- In general, QA staff assess the quality of services provided to Individuals on the basis of regulatory compliance, staff competence, and the provision of needed and chosen supports.

3.7 **Individuals' input at QA self-surveys.**

- QA solicits Individuals' input during self-surveys in addition to more formal assessments of Individuals' valued outcome achievement (as described in Section 4). This is accomplished when QA implements the use of OPWDD's survey protocols which include procedures to interview Individuals and families.

3.8 **Documentation and distribution of survey findings.**

- After the review portion of each survey is completed, QA staff prepare written reports of findings which acknowledge achievement, cite deficiencies, make recommendations for improvement, and set a time frame for completion of the needed corrections. Corrective actions and time frames are discussed and mutually agreed upon.
- The written survey findings are reviewed with the relevant program management team: i.e., Manager, Nurse, etc. Survey reports are distributed to personnel having supervisory responsibility for the issues noted. The team members have the opportunity to respond to any of the issues raised and to offer evidence of compliance, in case any such documentation was overlooked by the QA staff. Any questions and/or additional evidence are reviewed by QA and a determination is made whether the related survey findings are still valid.
- Data from surveys is provided to DQI in the manner and format directed by DQI.

3.9 **Tracking the correction of deficiencies.**

- QA presents survey findings in a report format which serves as a working copy for QA to follow-up and track correction and as a status report for administrators.
- QA staff will follow up on the time limit for corrections, as set for each issue.
- Areas that have been cited previously are re-examined during the next survey cycle.
- Survey findings and progress of corrective actions are provided to DQI in the manner and format directed by DQI.

3.10 **Reporting of findings.**

- QA provides the Chief Executive Officer and other administrators with periodic reports on the progress of corrective actions.

3.11 **Procedure when there is "Imminent danger"**

- In regard to "Imminent danger" findings, when any are detected, they will always be addressed and corrected, immediately, as required.

3.12 **Availability of technical assistance.**

- If deficiencies are not corrected within the agreed upon time frame called for in the POCA, administrative oversight, technical assistance and training will be provided by QA staff to assist the site to come into compliance. If it is apparent to the QA Director that such intervention is needed sooner than what was originally agreed upon in the POCA, the assistance will begin immediately. The QA Director will make this determination at his discretion and will notify the Vice President of Operations if there will be long time delay before a regulatory area is compliant.
- In addition, QA assigns a dedicated Collaborative Assistance Coordinator (CAC) to each residence to aid and support the site management in organizing, managing and maintaining compliance throughout the year. The designated CAC also follows up on correction of survey issues in addition to general compliance.

3.13 **Procedure for keeping records of QA surveys.**

- Records of survey results, citations and verification of corrections are maintained by the QA Department for the current work cycle.

3.14 **Trend analysis and dissemination**

- QA shares information concerning QA activities and citation trends with management at Management meetings and with the Board, upon invitation, and with OPWDD, as directed.

3.15 **Ability to maintain substantial compliance.**

- The Agency, through its self-survey process, demonstrates the ability to evaluate program practices, identify and correct deficiencies, and thereby maintain substantial compliance with regulations.

3.16 **Survey policy/procedure.**

The following policy was adopted to help facilitate the self-survey process:

- a) QA staff will develop and maintain a work calendar, which will include each residence and program participating in the QA self-survey program.
- b) QA surveys are scheduled by mutual agreement. The site's QA survey will be scheduled for a date-range (e.g., for a particular week or month). However, QA staff are not bound by that period and can survey a site at any time.
- c) If there is a legitimate and pressing need to reschedule the survey, the residence manager must obtain the approval of the QA Director.
- d) In addition to surveys, the QA survey calendar can incorporate scheduled visits devoted exclusively to technical assistance, if requested. However, QA staff will not provide intensive technical assistance closer than 30 days before the anticipated site survey date.
- e) Each site / program manager must ensure that there are systems in place to ensure that his or her site / program maintains compliance with regulations.

- f) Each site / program manager is responsible to advise the Chief Executive Officer, Vice President of Operations or QA if there is any major component of regulatory compliance that is not being addressed or is unable to be addressed.
- g) If a site or program is unable to comply with the above guidelines, the agency Chief Executive Officer or Vice President of Operations will be notified.
- h) QA will implement Risk Stratified Oversight methodology in its self-survey activities in the manner described in its correspondence with OPWDD, re: Women's League Community Residence/ Makor DS's RSO Site Survey Proposal, dated 1/5/2022, by Yechiel Davis, QA Director, addressed to Candice Comer, OPWDD

MANAGEMENT PLAN PART 4

MEASUREMENT OF VALUED OUTCOME ACHIEVEMENT

Overview

4.1 Overview of Process

- A. Achievement of individual outcomes is measured through the Valued Outcome Achievement Assessment, which is a process developed by the Agency and Dr. Glicksman.
- B. Dr. Glicksman writes an annual report on valued outcomes, which summarizes the findings of both assessments, draws conclusions and makes recommendations. Dr. Glicksman reviews these findings with Administrators and Management at Management Meetings, to Board members when reporting to the Board about activities.
- C. The information in these reports can be used by administrators and management in formulating new initiatives, modifying services and when reviewing and updating the agency's Management Plan.
- D. When indicated, QA interviewers will recommend that valued outcomes be modified. In addition, the assessments can result in identifying general trends in what types of service modifications or activities individuals are interested in.

4.3 Assessment of Valued Outcome Achievement (VOAA)

- A. In order to measure valued outcomes achievement, the Agency and Dr. Glicksman developed a system to verify if written goals are relevant and related to personal outcomes for individuals. It also provides data on how well people are supported in achieving their personal outcomes. Individuals and families are interviewed and the data gathered from individuals is compared with data gathered from family/advocates.
- B. The objective of the VOAA process is to examine the types of valued outcomes being expressed and whether those Valued Outcomes were shared by all stakeholders (e.g., family, staff and Individuals). This information is then used to assess if the Agency is sufficiently "person centered" (i.e., whether the Individuals' valued outcomes also valued by others). This information is distributed within the Agency and is a starting point for discussion on what direction the Agency is taking and how to improve services.
- C. The Valued Outcome Achievement Assessment is conducted by QA staff for a sample of individuals during QA surveys at IRAs. The size of the sample for the purposes of the VOAA is not meant to be statistically valid. Ideally, the sample should be representative of the site's population. Minimally, QA staff complete one VOAA interview per IRA, preferably for the same file being reviewed. However, QA will attempt to obtain larger sample sizes to allow for a more adequate comparison of responses from year to year, in spite of the time constraints involved in completing a survey. If necessary, QA staff can conduct the VOAA

before or after the site survey, so that the demands of the survey do not detract from completing an adequate number of VOAA assessments.

- D. A specially designed form is used to collect data on the valued outcomes of the selected individual. The form is used to guide the assessment. QA staff follow the instructions on the form and fill in the required information. Information is derived mostly from interview with the individual, whenever possible, as well as a family member/advocate. If necessary, information is obtained from staff, and, as a last resort, information is taken from Life Plans. This gathering and recording of information is the first step of the assessment.
- E. The next step is to validate the information gathered. The purpose of this step is to gain a better understanding of any issues raised by an individual and/or his/her advocate during a discussion about their valued outcomes. The necessity for validation is as follows. In many cases, after the first assessment step is completed, it becomes apparent that background information is needed to clarify the issues raised. This is accomplished by the QA person who conducted the assessment reviewing the information with the Residence Manager or a staff member, referred by the Manager.
- F. During the verification of information, suggestions are raised on how to address a valued outcome or solve a problem. Very often, the Manager or staff are able to report that the suggestion had already been tried; or, there was a valid reason why the suggestion was not practical or appropriate. This additional information is helpful in understanding the depth of any issues raised.
- G. However, QA staff may, in fact, find that a recommendation or corrective action is appropriate and the Manager agrees. In this case, the suggestion is incorporated into the VOAA form. The Manager would then be expected to follow through with the suggestion and QA would follow up at a later date.
- H. The third step is: The QA person completes the information on the VOAA form and answers the relevant questions completely. The VOAA form is then typed, based on the written notes gathered. The typed VOAA forms are forwarded to the Clinical Director to review. In most cases, the Clinical Director is already familiar with the issues reflected in the VOAA reports. In the event that the Clinical Director detects an error in the VOAA information, (i.e., about a subject that has previously been discussed in clinical meetings, but is not accurately reflected in the current VOAA report) he/she will notify the QA person of the error and ensure that a correction is made. In the event that the Clinical Director detects information that may require clinical intervention or further inquiry, the Clinical Director will raise the issue at the next clinical meeting with the IRA program planning Team.
- I. Typed VOAA forms are batched and presented to Dr. Glicksman at the end of the cycle. As explained above, Dr. Glicksman reviews and summarizes the data and writes a summary report, which is distributed and reviewed at different levels of the Agency (as described above).

4.4 -FORM

<u>Valued Outcome Achievement Assessment</u>	
Individual's name:	
Care Manager:	Program:
Additional People Interviewed:	Interview Date(s)
<i>Identify Valued Outcomes for the individual from the point of view of the individual, staff and family or advocates.</i>	
<u>Individual</u>	→ “ <u>What does the individual say his/her Valued Outcomes are?</u> ” Have the individual’s VO’s been addressed? Has there been progress? Is the Individual satisfied with the progress? Explain:
<u>Staff</u>	→ “ <u>What Valued Outcomes or expectations do staff have for the individual?</u> ” Have these VO’s been addressed? Has there been progress? Are staff satisfied with the progress? Explain:
<u>Family/ Advocate</u>	→ “ <u>What Valued Outcomes or expectations do family / advocates have for the individual?</u> ” Have these VO’s been addressed? Has there been progress? Is the family member or advocate satisfied with the progress? Explain:
→ <u>Additional comments:</u>	

MANAGEMENT PLAN PART 5

Agency-wide Quality Improvement Plan

5.1 Communication of and responsiveness to feedback

- The Agency's QI process incorporates feedback and recommendations from Individuals, families/advocates, as well as staff, management and administrators about Agency operations and service delivery.
 1. In each juncture, input is sought from individuals on their overall satisfaction, satisfaction with specific areas of life, in addition to satisfaction with supports and services.
 2. In addition, Individuals' input is collected via the Valued Outcome Achievement Assessment system during the QA self-survey process. Dr. Glicksman collects the input data from the VOAA, analyzes the data and writes an interpretive summary of findings with recommendations.
 3. Dr. Glicksman's written findings are disseminated to Managers and Administrators at Management meetings. The exchange of information results in improved services by Management. In addition, Board members and Administrators consider this input when decisions are made.
 4. Agency management supports the implementation of plans which promote the attainment of Individuals' valued outcomes.

5.2 Monitoring and supporting quality of services via feedback

- The Agency's QI process uses feedback as a means to monitor and improve services.
- In addition, during the self-survey process, QA staff evaluate information concerning Individual's outcomes and how they are addressed by the residence.

5.3 Measurement and tracking of valued outcomes

- Valued outcome achievement is measured and tracked. Collected data undergoes annual analysis, the findings of which are communicated to stakeholders.

5.4 Commitment to competence, service and compliance

The Agency's QI process promotes regulatory compliance, staff competence, and the provision of needed and chosen supports and safeguards. The following examples of Agency practices illustrate the stated policy:

- In general, the Agency recognizes and supports competent personnel. The Agency also supports professionalizing staff and managerial roles to promote overall staff competence and retention.
- The Agency's QA Department provides technical assistance in addition to conducting regulatory self-surveys. Technical assistance contributes to staff and managerial training by utilizing opportunities for teaching and training to improve program quality and regulatory compliance.
- The Agency's Administration and Management meet periodically for dissemination of best practices, review of Individual feedback, as well as managerial training. Information relevant for DSPs is relayed as appropriate.

- The Agency's QA Department's self-survey process includes periodic updates to the Agency's administration about the progress of corrective action plans pending, corporate compliance training, monitoring of fire drills, as well as monitoring of fire safety compliance.
- Agency management supports the implementation of Individual and group plans which promote the attainment of valued outcomes.

5.5 QI process as an extension of the Agency's Mission

- The Agency's QI process is guided by the Agency's mission, which emphasizes promoting every Individual's inherent self-worth by promoting every person's right to be treated with respect, dignity and love; facilitating and supporting family connections; striving for excellence in quality of care through knowledge, professionalism, expertise and a vigorous quality assurance process. The Agency is committed to providing Individual's with greater opportunities for choice-making, self-expression, and growth as valued members of the community.

Implementation

- Data is collected to gauge attainment of desired outcomes; to identify trends and common themes in order to report reliably on the status of the quality of life of the Individuals served; and to enable management to modify services accordingly. New initiatives are developed by administrators, management and Individuals. New initiatives can be based on QI data if the resulting idea appears to generate sufficient interest. New initiatives tend more often to be based on spontaneous ideas, because it is recognized that the most successful goals are the ones that generate the most interest. In the long run, a goal that does not generate enthusiasm will not achieve its intended result. Goals can be modified or replaced.

5.6 QI Initiatives

RESPONSIBILITY OF: AGENCY ADMINISTRATION AND/OR DR. GLICKSMAN

- Quality improvement initiatives are developed by the Agency to promote its values, as articulated above.
- The Agency's initiatives include: Community Integration/Community Awareness, Jewish Cultural Education, Empowerment through Learning, and the Makor/YU College Experience Program, and Organizational Changes Directed Toward Improving and Expanding Services.

5.7 Maintaining worthwhile activities

RESPONSIBILITY OF: DR. GLICKSMAN AND QA

- Results of Quality Initiatives are summarized and shared with management and the Board. Initiatives are assessed, and successful goals and activities are carried over into the plan for the coming year. New initiatives are incorporated whenever possible. Reporting is done at Board meetings and Management meetings by Dr. Glicksman. QA reviews and updates the Management plan.

5.8 Agency-Wide Quality Improvement Initiatives

Community Integration / Community Awareness Initiative

Description: Organizing social and community events and weekend retreats

Time Frame: Community and social events are ongoing; Weekend retreats occur annually

Check Point: Management Meetings

Responsibility:

- 1) Makor's Public Relations Director organizes events for staff and for people in the community.
- 2) Makor's management and staff are encouraged to take the initiative to create and organize special events and innovative activities for their programs and for the agency at large.

Rationale:

A). Makor's Individuals enjoy weekends with family, weekend retreats, trips and vacations. Makor's residence managers are supported in planning trips and vacations for the Individuals they serve. Makor's residence managers are encouraged to support and facilitate individuals spending weekends away with their families.

B). Makor's Individuals enjoy parties, concerts and sports events in the general community, and staff have undertaken to organize recreational events.

C). Makor's Public Relations Director organizes events for staff and for people in the community. The objectives for these events are for outreach – to promote awareness of the agency its services to the community; and to provide supports for staff and people in the community

Jewish Cultural Education Project

Description: An Agency-wide coordinator works to promote education on Jewish culture and opportunities for participation in cultural activities for those Individuals who are interested.

Started in August 2002 and is continuing

Check Point: Annually

Responsibility: Neil Weinstein

Rationale: Makor's Individuals gain satisfaction from learning about and participating in cultural activities and customs in the same manner as those who live in the community. Individuals are empowered when they are offered opportunities to participate in various cultural activities throughout the year, both in their residences and in the community. Years ago, when the Agency operated on a smaller scale, program staff with professional backgrounds in both regular and special education were able to incorporate these values into the programs they worked in. As the Agency has grown in size and its workforce is more diverse, it has identified the need to coordinate and to promote Jewish cultural education and activities.

Empowerment Through Learning Initiative

Time Frame: Annually

Started in 12/2000 and is continuing

Check Point: Annually

Responsibility: Training Director

Description: This initiative began by offering staff enhancement training, and was eventually merged with other initiatives, i.e., 633.8 required training, Choking Prevention Initiative, Agency policy requiring staff learning individuals' health and safety needs prior to starting work, implementation of an on-line learning platform, implementation of ADM 2014-03, DSP Core Competencies

Makor / YU College Experience Program

Responsibility: Dr. Stephen Glicksman

Started: Fall 2017

Description: The College Experience Program is a four-year, non-degree program offered in partnership with Yeshiva University. The program is geared towards young men with intellectual disabilities between the ages of 18-25 who are looking to further their education after finishing high school. The program offers job training, life skills training and socialization in the YU college campus environment. Advisors and mentors work with the students to develop career-skills, determine an individual career path, and develop specific job plans and resumes. In addition, the students participate in the many activities and events on campus which allows them to feel part of the YU community and to experience the college lifestyle. Ultimately, the Makor students will leave the program with a certificate of completion, a resume, a reference letter to help them with future job applications, life skills, the tools and the education to make them significantly more independent and prepared for the future. The social aspect of the program is also significant. The Makor students access the resources and opportunities offered on campus and have many opportunities to interact and bond with other students. Likewise, the YU students have opportunities to get to know and be inspired by the Makor students.

Organizational Changes Directed Toward Improving and Expanding Services

Responsibility: Tzally Seewald, Chief Executive Officer

Implemented: 2021

Description: Implementing organizational changes, personnel assignments and infrastructure changes/upgrades, designed to enhance services, provide new services, and reach out to the community, in a manner consistent with the Agency's Mission.