FY 2020

ANNUAL REPORT

Quality Assurance & Corporate Compliance

The mission of Ocean Partnership for Children is to enhance the well-being of youth and their families through natural and community supports.

Overall Summary of Performance

Ocean Partnership for Children (OPC), Inc., Ocean County's Care Management Organization (CMO) has a robust Quality Assurance and Corporate Compliance Program, with a focus on:

- Improving outcomes for youth and their families and monitoring satisfaction with the services OPC has to offer.
- Ensuring compliance with state, federal, and local laws/statues as well as agency policies and procedures.
- Attracting, developing, and retaining a motivated, satisfied, and well-qualified workforce.
- Affirming and expanding strategic presence in the community.

For Fiscal Year 2020 (FY2020), which runs from July 1, 2019 – June 30, 2020, OPC set and achieved many strategic goals. This year, the agency underwent a comprehensive strategic planning process collaboratively between Leadership and the Board of Trustees. Strengths, Weaknesses, Opportunities and Threats were identified and strategies were developed for all areas of the agency, including moving toward a more sustainable business model, recruitment and retention operations, marketing, fundraising and financial investments.

Moreover, this fiscal year OPC undertook a large initiative to transition from a more "traditional" office model (with most operations in person and assigned spaces) to a "progressive", collaborative work environment. This transition allowed for flexible work spaces, increased remote work opportunities, and an overall re-invention of how to maximize space and increase collaboration.

Additional highlights from FY2020 include:

- OPC successfully met or exceeded its goals in many areas of Care Management Operations, including:
    - Improving/Stabilizing risk behaviors for youth/families
    - Ensuring successful and planned transitions from CMO services
    - Minimizing re-enrollment rates within 0-6 months from transition
    - Keeping kids in the community (avoiding Out of Home treatment) and reducing "length of stay" when youth require Out of Home treatment in behavioral/mental health settings.
    - Maintaining overall family satisfaction with the services provided by OPC.
    - Ensuring compliance with service plan timeframes set forth by the Department of Children & Families
- In the area of Compliance, OPC met or exceeded its goals in the following areas:
    - Accurate, timely and successful billing for Medicaid services.
    - Updating the Corporate Compliance Plan and implementing new initiatives surrounding compliance, including comprehensive steps to improve HIPAA compliance, education and practices within the agency.

- OPC also successfully met, improved upon, or exceeded goals in the following areas as it relates to its Workforce:
    - Retention of staff who have been with the agency for 3 years or more
    - Significant improvements were made in areas of performance evaluation completion and annual training completion.
    - Maintaining an accident free and safe workplace

While measuring success and achieved outcomes is key component of the Quality Assurance Program, OPC recognizes the importance of also identifying areas that need improvement to allow for continued growth and success of the agency. Some of these identified areas include:

- OPC identified a need for Leadership and Management staff to:
    - Review the Family Satisfaction Survey process as part of a state-wide initiative to collect meaningful, shared data for comparison and benchmarking purposes.
    - Look at ways to monitor data throughout the year to create proactive action plans.
    - Identify how to integrate the findings of these surveys into changes in Care Management practice and/or identify systemic barrier for sustainability.
- OPC Care Management staff needs to explore further Strength and Needs outcomes and ratings in comparison to state averages to identify potential causes of "persistent" identified needs for youth/families.
- OPC identified an overall need to monitor alerts, reports, surveys, etc. in "real time." A need to move the Hyperoffice database system to Office 365 for better integration of forms and reports with Power BI has been identified. A workgroup has been formed to expedite this process.
- OPC identified a need to provide additional training in regards to completion of Unusual Incident Reports to ensure they are being completed when required and within the established timeframes.
- Outcomes of the Chart Audit Summary indicated a need to establish a more comprehensive, committee based approach to the Chart Audit/Quality Review process. This will be a cross-departmental initiative.
- While significant growth was made in the areas of performance evaluation and training hours completion, OPC needs to complete the design of a new performance evaluation system and continue to educate staff on the use of the Relias training software.
- Policy and Procedure development and management has been identified as an areas that requires continued attention, especially as the agency undertakes the accreditation process.

The reports following this overall performance summary detail specific data points and the in-depth audit process that took place in the areas of reporting/auditing, compliance, surveying, and overall quality management.

Quality Assurance & Performance Improvement Plan

FY 2020

Care Management & Operations Goal:

Children & Families will be better able to manage their needs in a sustainable manner as a result of their participation and feel satisfied with the care they have received from OPC.

1. Desired Outcome: Improved clinical outcomes and emotional/behavioral stability.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) Youth will improve or remain stable in *behavioral/emotional needs* **at or above the state average.**	**Metrics:** CYBER – Strength and Needs Assessment Outcomes Data & CMO Dashboard. **Measured:** Quarterly	• CMs will complete updated SNAs every 75 days and re-evaluate needs and plan strategies regularly. • Supervisors will review progress (or lack thereof) in supervision. • Trends will be identified agency wide with changes implemented as needed.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Youth lacks capability and/or desire to change. • Family and environmental factors outside CM's control.	• **OPC – 79% of youth improved or remained stable in behavioral/emotional needs** • State average – 84% of all CMOs in NJ improved or remained stable in behavioral/emotional needs	• **OPC – 80% of youth improved or remained stable in behavioral/emotional needs** • State average – 85% of all CMOs in NJ improved or remained stable in behavioral/emotional needs	**≥ State Average=Green** **≤ 5% from State Avg=Yellow** **<6% from State Avg=Red**
(b) Youth will improve or remain stable in *risk behaviors* **at or above the state average.**	**Metrics:** CYBER – Strength and Needs Assessment Outcomes Data & CMO Dashboard. **Measured:** Quarterly	• CMs will complete updated SNAs every 75 days and re-evaluate needs and plan strategies regularly. • Supervisors will review progress (or lack thereof) in supervision. • Trends will be identified agency wide with changes implemented as needed. •	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Youth lacks capability and/or desire to change. • Family and environmental factors outside CM's control.	• **OPC – 95% of youth improved or remained stable in risk behaviors** • State average – 95% of all CMOs in NJ improved or remained stable in risk behaviors	• **OPC – 95% of youth improved or remained stable in risk behaviors** • State average – 95% of all CMOs in NJ improved or remained stable in risk behaviors	**≥ State Average=Green** **≤ 5% from State Avg=Yellow** **>6% from State Avg=Red**

(c) At least 70% of transitions will be considered *planned* and *successful*.	**Metrics:** Transition ISP data & transitions spreadsheet. Power BI. **Measured:** Monthly	• CMs will have regular conversations about transition with the CFT to ensure families are prepared. • Discussions surrounding "readiness" will occur during supervision. • All TISPs will be reviewed by the Clinical Director prior to submission.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Unforeseen reasons for transition (i.e. youth missing) and/or transition at the request of the family despite lack of readiness.	• **71% of transitions were planned and successful**	• **72% of transitions were planned and successful**	**≥ 70%=Green** **65%-69%=Yellow** **< 64% =Red**
(d) Youth and families will be able to maintain stability and avoid re-enrollment for at least 6 months following transition **at or below the state average**.	**Metrics:** Internal Re-enrollments Report in Power BI & CYBER Re-enrollment report **Measured:** Monthly	• CMs will have regular conversations about transition with the CFT to ensure families are prepared and linked to the appropriate services prior to transition. • Discussions surrounding "readiness" will occur during supervision. • Review of previous services will occur at the time of re-enrollment.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Diagnoses that are cyclical in nature. • Change in family circumstances. • Lack of sustainable services to link to in the county.	• **14% of OPC re-enrollments occurred between 0 – 6 months** • 21% of all CMOs re-enrollments occurred between 0 – 6 months	• **13% of OPC re-enrollments occurred between 0 – 6 months** • 21% of all CMOs re-enrollments occurred between 0 – 6 months	**≤ State Average=Green** **> State Avg=Yellow** **>6% from State Avg=Red**

2. Desired Outcome: Keep Kids at home and in their communities. Reduce length of stay in Out of Home treatment.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will work to ensure at least 85% of youth enrolled are in the community.	**Metrics:** CYBER OOH Dashboard, Power BI OOH Report. **Measured:** Monthly	• CFTs will exhaust all community-based resources before moving to OOH tx. Referral. • CMs will ensure the plan is revised on a regular basis if progress is not being made. • When youth are in an OOH tx. Facility, CMs will ensure conversations about transition home occur at every meeting.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Permanency Challenges • Family inability to manage youth in the home despite community-based services. • Court Ordered OOH tx.	• **89% of youth enrolled are in the community**	• **87% of youth enrolled are in the community**	**≥ 85% = Green** **84%-80%=Yellow** **<80%=Red**
(b) OPC will work to ensure the average length of stay in an OOH behavioral health treatment setting is 9 months or less (across ALL OOH episodes).	**Metrics:** CYBER OOH Dashboard, Power BI OOH Report. Length of Stay Report. **Measured:** Monthly	• CMs will coordinate Case Conferencing with DCPP when appropriate to discuss permanency challenges. • CMs will attend all JCR meeting to discuss progress and move youth forward. • OPC will collaborate to continue to provide NHA training and reminders to system partners.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Permanency Challenges • Family inability to participate in family therapy due to distance or lack of engagement. • OOH policies/resistance to change	• **Average length of stay in a Behavioral Health or Substance Abuse OOH treatment setting is 9.1 months**	***N/A – This is a new objective for FY2020***	**≤ 9 mon. = Green** **10-12 mon=Yellow** **> 12 mon. = Red**
(c) OPC will work to decrease the average length of stay in an I/DD OOH treatment setting by 5% from the previous FY.	**Metrics:** CYBER OOH Dashboard, Power BI OOH Report. Length of Stay Report. **Measured:** Monthly	• CMs will coordinate Case Conferencing with DCPP when appropriate to discuss permanency challenges. • CMs will attend all JCR meeting to discuss progress and move youth forward. • OPC will continue to advocate for more community-based services for I/DD youth in Ocean County.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). QA Team.	• Permanency Challenges • Family inability to participate in family therapy due to distance or lack of engagement. • OOH policies/ resistance to change. • Lack of services for I/DD youth in the community.	• **Average length of stay in an I/DD OOH treatment setting is 27.6 months**	***N/A – This is a new objective for FY2020. The data collected from FY2020 will be utilized in the QAPI for FY2021***	**5% or More=Green** **Some improvement = Yellow** **No Improvement or worsening = Red**

3. Desired Outcome: Families will maintain satisfaction with the CMO process.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) 95% of families (active & transitioned) will indicate that they are satisfied or very satisfied with the services provided to them by OPC.	**Metrics:** Active & Transitioned Family Satisfaction Surveys **Measured:** Monthly	• One active family per care manager per month will be contacted to complete a family satisfaction survey. • 20 transitioned families will be contacted per month after 90 days of transition. • Feedback (positive and negative) will be shared to improve practice and recognize staff.	Supervisors, QA Manager, CM Assistants	• Family willingness to participate in surveys.	**96% of families indicated they are satisfied or very satisfied with the services provided to them by OPC.**	**94% of families indicated they are satisfied or very satisfied with the services provided to them by OPC.**	**≥ 95% = Green** **90%-94% = Yellow** **< 90% = Red**
(b) OPC will revise, update and implement a new, comprehensive formal grievance policy and procedure.	**Metrics:** Evidence of newly created and implemented policy **Measured:** Ongoing	• OPC will contract an attorney to review and revise current policy. • Once revised, OPC will update intake packets and ensure all families are aware of the formal grievance process.	Leadership Team & Ombudsman.	• None Identified	**Developed, reviewed by attorney and received board approval.**	***N/A – This is a new objective for FY2020***	**Completed= Green** **Not Complete=Red**

4. Desired Outcome: OPC will remain in compliance with DCF/CSOC's Clinical Services Standards & National best practices.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will ensure that all ISP's (FCPs, Initial ISPs, 90 Day ISPs, and TISPs) are submitted at or above the state average timeframe.	**Metrics:** CYBER CMO Dashboard Service Plan Report. Power BI. **Measured:** Monthly	• Care Managers will schedule CFT meetings at the 75-day mark to ensure that meetings can occur within 90 days. • Initial family crisis plans will be completed ideally in person or via phone with the family immediately if initial meeting cannot occur within 72 hours. • Supervisors will review plans within 48 hours of receipt and submit to Performcare for approval.	Supervisors, QA Manager, CM Assistants	• Family requesting delay in scheduling CFT meeting (Family Choice).	**OPC Average service plan compliance rate: 88%** Statewide CMO Average service plan compliance rate: 76%	**OPC Average service plan compliance rate: 86%** Statewide CMO Average service plan compliance rate: 76%	**≥ 95% = Green** **90%-94% = Yellow** **< 90% = Red**
(b) OPC's Wraparound Fidelity Index Assessments will exceed national standards.	**Metrics:** National WFI Data. **Measured:** Quarterly	• Conduct (ideally) 3 WFI surveys a month and input data into the national system. • Identify areas of concern/growth and provide feedback to the CM, Supervisor and Program Manager.	QA Manager, CM, CM Supervisor, Program Manager.	• Family willingness to participate in survey. • Differences in National Wraparound expectations and DCF deliverables	• **OPC exceeded the national fidelity score. OPC's total fidelity score was 73% vs. National standards of 72%. ???**	• **OPC exceeded the national fidelity score. OPC's total fidelity score was 75% vs. National standards of 72%.**	**≥ 75%=Green** **74%-65%=Yellow** **< 65% =Red**

Compliance Goal:

OPC will ensure that all operational areas are 100% compliance with federal, state and local statutory and regulatory requirements (including Medicaid, HIPAA, & Labor Laws).

1. **Desired Outcome: Implement all regulatory mandates and fulfill contractual obligations.**

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) Ensure OPC's policies and forms are in compliance with appropriate standards.	**Metrics:** Yearly Policy & Procedure Review **Measured:** Annually	• A yearly review of policies and procedures will occur to ensure all are up to date. • Staff will be required to sign off on any changes that occur. • OPC will contract with a compliance attorney as needed.	Leadership Team & OPC Board	• Continuous system-based changes that impact internal procedures and policies.	• **While Progress was made in the area of policy review and development, continued improvement in this area is needed.**	• **Not Completed**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red**
(b) On average, OPC will bill Medicaid for at least 95% of enrolled youth.	**Metrics:** EZ Claim Billing Report & Quarterly Medicaid Report **Measured:** Monthly & Quarterly	• Upon enrollment, the PE Coordinator will review eligibility and communicate with the CM staff. • Monthly billing review will occur to identify issues with billing/rectify back-billing need. • Trends will be identified agency wide with changes implemented as needed.	Accountant, Clinical Director, PE Coordinator, CFO.	• Family refusal or inability to complete Medicaid app. • Delays due to extenuating circumstances with family. • CM lack of documentation • Youth incarceration	• **Billed for 97.94% of youth**	• **Billed for 98% of youth**	**≥ 95%=Green** **≤ 90%-94%=Yellow** **<90%=Red**

(c) 80% of youth enrolled without Medicaid will complete the NJ Family Care application within 30 days.	**Metrics:** PE Coordinator Medicaid Report **Measured:** Monthly	• Upon enrollment, PE Coordinator will review eligibility and communicate with CM staff. • CM's will collaborate with PE staff to ensure application is received at the initial FTF or the initial CFT (latest).	PE Coordinator, CMs, CM Supervisors.	• Delays in initial contact. • Family refusal or inability to complete app.	• **98.7% of youth enrolled with OPC during FY-2020 completed the NJ FamilyCare application within 30 days.**	• **89% of youth enrolled without Medicaid completed the NJ FamilyCare application within 30 days**	**≥ 70%=Green** **65%-69%=Yellow** **< 64% =Red**
(d) OPC will ensure compliance in Medicaid billing procedures.	**Metrics:** EZ Claim Billing Report, Monthly Billing Process & Quarterly Medicaid Audit **Measured:** Monthly & Quarterly	• Clinical Director and Accountant meet monthly to review billing prior to submitting bills. Information is cross-checked with Power BI and CYBER records. • QA Manager completed Quarterly Medicaid Audit and reports to CFO.	Accountant, Clinical Director, CFO, QA Manager	• None identified.	• **COMPLETED With No Issues Identified**	• **COMPLETED With No Issues Identified**	**No Identified Issues and/or Identified Issues Rectified= Green** **Issues identified and not rectified= Red**

2. Desired Outcome: Implement OPC's Corporate Compliance Plan.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will revise, update and implement a new, comprehensive corporate compliance plan	**Metrics:** Corporate Compliance Plan **Measured:** Ongoing	• Re-establish Board QA/Corporate Compliance Committee • Review and revise current plan. • Training for all staff once revisions are made.	Leadership Team & OPC Board	• None identified	• **Completed**	***N/A – This is a new objective for FY2020***	Completed=Green Not Completed=Red
(b) OPC will conduct an annual security risk assessment to identify opportunities for security enhancement.	**Metrics:** Yearly Risk Assessment **Measured:** Yearly	• Director of HR/IT will interview and select a firm to conduct a risk assessment. • Review of recommendations will occur at the Leadership level for changes to be implemented.	Director of HR/IT.	• None identified.	• **A risk assessment was completed with Comply Assist. No major issues were found. Recommendations were made for improvements to procedures.** • **A "Walk-Through" HIPAA Audit was developed and QA Manager conducted quarterly walk throughs (prior to COVID-19) of the office. No major issues were identified.** • **Procedures for monthly and quarterly security audits were developed and implemented.**	• **An informal risk assessment was completed by a third party**	Completed=Green Not Completed=Red
(c) OPC will provide training on Corporate Compliance during orientation and annually for all staff.	**Metrics:** Signed acknowledgment forms at time of orientation. Yearly Staff sign off. **Measured:** Annually & Ongoing	• QA Manager and Dir. Of Org. Development will conduct orientation regarding Corporate Compliance. • Yearly training will occur with all staff in regards to Medicaid waste, abuse, and fraud and other aspects of compliance.	Director of Org Development, QA Manager, Compliance Committee.	• None Identified	• **OPC continued to incorporate corporate compliance as a key component of the new employee orientation process.** • **Corporate Compliance Week was held during the first week of November.** • **Yearly required compliance trainings were assigned in Relias.** • **A training on compliance was conducted at an All Staff Meeting.**	• **Incorporated corporate compliance as a key component of the new employee orientation process.**	Completed=Green Not Completed=Red

(d) OPC will maintain compliance with HIPAA privacy and security.	**Metrics:** HIPAA Log; Quarterly Audits. **Measured:** Ongoing & Quarterly	• HIPAA Privacy Officer will keep a log of HIPAA violations and conduct random audits in conjunction with QA Manager. • Breaches will be addressed at reported as per guidelines.	Privacy Officer & QA Manager	• None identified.	• **There were 7 HIPAA privacy and security incidents during the fiscal year. However, none of the incidents were deemed "high risk" HIPAA breaches.** • **A log is kept of any potential HIPAA violations and resolutions to address the issues.** • **A HIPAA "Breach Risk Assessment" was developed this FY in consultation with OPCs CYBER Insurance Provider, Beezley.**	• **There were 7 HIPAA privacy and security incidents during the fiscal year. However, none resulted in PHI being disclosed to an unauthorized person. The Director of Organizational Development keeps a log of any potential HIPAA violations and resolutions to address the issues.**	**No Identified Issues and/or Identified Issues Rectified= Green** **Issues identified and not rectified= Red**
(e) OPC will complete a review of all HIPAA related forms to ensure compliance.	**Metrics:** Attorney Review of forms **Measured:** Ongoing	• OPC will contract with an attorney to complete a review of HIPAA related forms. • OPC will ensure any new forms and/or changes are updated in English and Spanish and distributed to families as providers as required.	Director of Org. Development, Executive Director.	• None identified.	• **An attorney reviewed OPC's policies and procedures ensuring that they are HIPAA compliant. An audit was completed in February.**	***N/A – This is a new objective for FY2020***	**Completed=Green** **Not Completed=Red**

Workforce Goal:

OPC will attract, develop, and retain a motivated, satisfied, and well-qualified workforce.

1. **Desired Outcome: OPC will provide a comprehensive orientation & training program for all staff.**

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) 100% of staff will complete required annual training hours.	**Metrics:** Relias Training Report **Measured:** Annually	• Establish an Annual Training program in Relias. • Assign and monitor implementation	All Staff	• Relias is a newly implemented system. Some learning curve may exist.	• **82% of employees completed their required annual training hours.**	***44% (46 out of 105) of employees completed their required annual training hours.***	**100%=Green** **99%-90% = Yellow** **<90%=Red**
(b) 100% of new staff will complete orientation within 90 days of hire.	**Metrics:** Relias Training Report **Measured:** Annually	• Assign Orientation training plans to all incoming staff. • Monitor implementation	All Staff	• Relias is a newly implemented system. Some learning curve may exist.	• **While many supervisors reported that their staff completed orientation within 90 days, Relias reports indicate that assigned Relias Training Plans are not being completed and Orientation "Packets" are not being submitted.**	***N/A – This is a new objective for FY2020***	**100%=Green** **99%-90% = Yellow** **<90%=Red**

2. **Desired Outcome: OPC will maintain high performance standards to ensure operational excellence.**

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will revise and update Performance Evaluations to allow for a performance-based incentive system.	**Metrics:** Performance Evaluation **Measured:** Ongoing	• Leadership Team will systematically review current performance evaluations and revise. • Performance Evaluation format will be standardized across all departments. •	Leadership Team	• Training needs to ensure consistency across all managers.	• **A performance evaluation template was developed for use with ALL agency staff. Position specific performance evals and rubrics were developed for some roles, however some remain incomplete.**	***N/A – This is a new objective for FY2020***	**Completed=Green** **Some Progress Made = Yellow** **Not Completed=Red**

(b) 100% of employees will have current performance reviews completed.	**Metrics:** Annual HR report **Measured:** Ongoing & Annually	• Supervisor will monitor their staff hire dates and complete performance reviews annually.	Management & Leadership Teams	• Lack of system to "remind" that reviews are due. • Review dates vary based on employee's hire date. • Performance Reviews need to be updated.	• **94% (or 87 of 93) of employees received performance reviews. (*Note – some of the employees received both the 90-day performance evals as well as yearly evals during FY2020 due to hire date late in FY2019)**	***70% of eligible active and newly hired employees during FY 2019 were given performance reviews.***	**100%=Green** **99%-90% = Yellow** **<90%=Red**
(c) 100% of all new hires will receive performance reviews after 90 days of hire.	**Metrics:** Annual HR report **Measured:** Ongoing & Annually	• Supervisor will monitor their staff hire dates and complete performance reviews after 90 days of hire.	Management & Leadership Teams	• Lack of system to "remind" that reviews are due. • Performance Reviews need to be updated.	• **100% (or 30) of new hires received performance reviews**	***100% of new employees were given performance reviews.***	**100%=Green** **99%-90% = Yellow** **<90%=Red**
(d) At least 90% or more of all eligible Care Managers will obtain their state CM certification within the appropriate timeframe.	**Metrics:** Relias Requirements Tracker Report **Measured:** Ongoing & Annually	• Staff will be assigned a module in Relias upon hire set to the correct date for initial certification. • Staff will be notified in Relias when they are due for re-certification. • Supervisors will monitor ongoing to ensure staff complete the certification.	CMs, Sups, and Program Managers.	• Newer Process that the state is still refining.	• **Based upon reports available from the CSOC, it appears all eligible Care Managers have received their certifications. However, CSOC reported that an issue with the system is preventing CMs from taking the year 2 certification. As a result, these CMs show as "Expired".**	***During the fiscal year 66 CMs attained CMO certification.***	**≥ 90%=Green** **85%-89% = Yellow** **<85%=Red**

3. Desired Outcome: OPC will maintain a safe and productive workplace with a strong focus on workforce retention and employee satisfaction.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will improve its a 3+ year employee retention rate for Care Management Staff by 5%.	**Metrics:** HR Census Data **Measured:** Annually	• Continued review of employee satisfaction through surveys and individual "pull in" conversations. • Leadership Team and Board will review benefits packages	Leadership Team & OPC Board	• None identified	• **For Care Managers who worked with OPC for 3+ years there was 94% retention rate and 6% turnover.**	***N/A – This is a new objective for FY2020***	**5% or More=Green** **Some improvement = Yellow** **No Improvement or worsening = Red**
(b) OPC will maintain a workplace safety record of 0 accidents per year.	**Metrics:** HR Tracking Data **Measured:** Annually	• OPC will provide training on safety in the workplace. • External health/safety inspections will occur based upon regulatory requirements.	Leadership Team & OPC Board	• None identified	• **0 OSHA reportable accidents occurred during FY-2020**	***0 accidents occurred during FY-2019***	**0 =Green** **≤ 2 = Yellow** ***> 3 = Red***
(c) OPC will respond to employee grievances as per policy and procedure	**Metrics:** HR Tracking Data **Measured:** Ongoing & Annually	• OPC will ensure an open door atmosphere is established to encourage employees to share their concerns. • Employees will be provided the opportunity to file a grievance through HR.	HR Director, Executive Director	• None identified	• **0 grievances filed in FY-2020**	***0 grievances filed in FY-2019***	**No Grievances filed and/or Grievances investigated as per policy = Green** **Grievance policy and process is not followed = Red**

Corporate Goal:

OPC will affirm and expand our strategic presence and ensure our business model is sustainable.

1. **Desired Outcome: OPC will ensure a comprehensive strategic plan exists and is implemented at all levels of the organization to further OPC's strategic and corporate goals.**

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2020:	FY2019:	Item Scale:
(a) OPC will coordinate the development and implementation of a new strategic plan.	**Metrics:** Strategic Plan **Measured:** Ongoing & Annually	• Identify a consultant to lead the planning process. • Coordinate a retreat, establish a plan, and implement. • Assign a "task master" who will ensure plan is being executed.	Leadership Team & OPC Board. All Staff	• Potential Cost. • Volunteer Board time commitment for planning process	• **A new Strategic Plan was developed and implemented by the Board of Trustees and the Leadership Team.**	***N/A – This is a new objective for FY2020***	**Plan Developed =Green** **No Plan Established =Red**
(b) OPC will begin to prepare for CARF Accreditation with a goal of requesting the survey application at the end of FY2020.	**Metrics:** CARF Work Plan Grid **Measured:** Monthly	• OPC will establish a committee charged with tackling tasks related to accreditation. • OPC will bring in a consultant to conduct a "mock" survey" to evaluate progress and make recommendations.	Leadership Team, OPC Board, CARF Committee members.	• Budget & Time constraints	• **Progress was being made on preparation for CARF Accreditation until mid-March when COVID-19 caused a delay due to a need to focus on more immediate work concerns. Preparation continues however the timeline for accreditation was pushed back.**	***N/A – This is a new objective for FY2020***	**Survey Application Ready =Green** **Significant Progress Made but additional time needed = Yellow** **Minimal Progress Made =Red**