OCEAN PARTNERSHIP for CHILDREN INC.

Changing Tides in the Lives of Families

FY 2021

ANNUAL REPORT

Quality Assurance, Corporate Compliance & Organizational Excellence

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 2021 (FY2021), which runs from July 1, 2020 – June 30, 2021, OPC set and achieved many strategic goals, despite the obstacles that the COVID-19 pandemic presented. OPC was able to seamlessly pivot to remote work by implementing new technological systems and processes, many of which will continue to be utilized as staff return to the office and field.

Some highlights from FY2021 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
  - Establishing a comprehensive chart review process involving interdepartmental involvement and analysis.
- In the area of Compliance, OPC met or exceeded its goals in the following areas:
  - Full review of Policies & Procedures and establishment of annual and ongoing review process.
  - Accurate, timely and successful billing for Medicaid services.
  - Increasing compliance with completion of DCF Unusual Incident Reports (UIRs).
  - Completion of an annual HIPAA security risk assessment
  - Roll out of a comprehensive disaster recovery plan and bi-annual table top testing procedures.

- OPC also successfully met, improved upon, or exceeded goals in the following areas as it relates to its Workforce:
    - Standardization of a job description format and implementation of an updated performance evaluation system.
    - High Retention of Care Management staff who have been with the agency for 3 years or more
    - Roll out of annual policy review attestation within the Relias system as well as an annual training matrix.
    - 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 Care Management staff needs to continue to explore Strength and Needs outcomes and ratings in comparison to state averages to identify potential causes of "persistent" identified needs for youth/families. The areas in which youth persist have been identified, however, further exploration of WHY this is needs to occur.
- OPC Quality Improvement Staff needs to ensure that data collected as part of the statewide family satisfaction survey process is analyzed and used for benchmarking. While the survey process was established and rolled out, the analysis of the data has not yet occurred.
- OPC recognized that a focus on decreasing length of stay for I/DD out of home programs is likely not an achievable goal. As a result of the persistent needs of youth with I/DD diagnoses, many remain in treatment programs long-term. This trend has been identified state-wide. As a result, OPC is shifting its priorities for these youth to focus on applications for DD eligibility and linkage to sustainable resources.
- Outcomes of the new Chart Audit process identified challenges in certain practice areas of Care Management. A focus on follow-up on Chart Audits and overall improvement strategies is needed to ensure action is taken in response to issues discovered.
- While significant growth was made in the areas of performance evaluation forms and training plan development, OPC needs to ensure that accurate tracking occurs. Systems have been developed for ongoing tracking, however utilization of these systems needs to occur on a regular basis.
- Policy and Procedure development and management has been identified as an area that requires continued attention. OPC made significant progress in this area during FY21, establishing an annual review process, ensuring attestation, and ensuring storage of P&Ps in an accessible place. One remaining item in this area however is the review and revision of the Employee Handbook. This project is underway and is expected to be completed in the fall.
- OPC underwent a robust strategic planning process in 2019, however, the COVID-19 pandemic created challenges in the execution of some items. OPC has reviewed this plan regularly for relevance, however a review and update to the goals needs to occur during the 2022 fiscal year.

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 2021

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:	FY2021	FY 2020	Target & Priority Level::
(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	• Program Managers will conduct a training with all Care Management staff to ensure accurate completion of the SNA. • 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. • Accurate completion of SNA by Care Manager.	• **OPC – 79% of youth improved or remained stable in behavioral/emotional needs** • State average – 83% of all CMOs in NJ improved or remained stable in behavioral/emotional needs	• **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	**≥ State Average=Green** **≤ 5% from State Avg=Yellow** **<6% from State Avg=Red** **PRIORITY: HIGH**
(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 – 96% 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** **PRIORITY: HIGH**
(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.	• **76% of transitions were planned and successful**	• **71% of transitions were planned and successful**	**≥ 70%=Green** **65%-69%=Yellow** **< 64% =Red** **PRIORITY: HIGH**

(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.	• **15% of OPC re-enrollments occurred between 0 – 6 months** • 20% of all CMOs re-enrollments occurred between 0 – 6 months	• **14% 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** **PRIORITY: HIGH**

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:	FY2021	FY2020	Target & Priority Level:
(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.	• **90% of youth enrolled are in the community**	• **89% of youth enrolled are in the community**	**≥ 85% = Green** **84%-80%=Yellow** **<80%=Red** **PRIORITY: HIGH**

(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 9.2 months**	• **Average length of stay in a Behavioral Health or Substance Abuse OOH treatment setting is 9.1 months**	**≤ 9 mon. = Green** **10-12 mon=Yellow** **> 12 mon. = Red** **PRIORITY: HIGH**
(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 30.1 months**	• **Average length of stay in an I/DD OOH treatment setting is 27.6 months**	**5% or More=Green** **Some improvement = Yellow** **No Improvement or worsening = Red** **PRIORITY: HIGH**

3. Desired Outcome: Families will maintain satisfaction with the CMO process & achieve sustainable outcomes.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2021	FY2020	Target & Priority Level:
(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:** Yearly	• Once a year, surveys will be automatically sent to active families that have been enrolled for 6 months or more. • Families will be surveyed post transition at an agreed upon interval statewide. • Families will be surveyed at the time of transition. • Feedback (positive and negative) will be shared to improve practice and recognize staff.	Supervisors, Quality Improvement Specialist, CM Assistants	• Family willingness to participate in surveys.	○ **Results from Active Family surveys show a 95% overall satisfaction rating with OPC services.** ○ **Results from Transition surveys show a 99% overall satisfaction rating with OPC services (out of 77 surveys).** ○ **Post-transition Surveys are scheduled to be sent out in Sept/Oct 2021.**	**96% of families indicated they are satisfied or very satisfied with the services provided to them by OPC.**	**≥ 95% = Green** **90%-94% = Yellow** **< 90% = Red** **PRIORITY: HIGH**

(b) OPC will implement a new satisfaction survey process that aligns with CMOs statewide to allow for benchmarking and better data collection opportunities	**Metrics:** Evidence of newly created and implemented survey & process. **Measured:** Ongoing	• The rate at which surveys are administered will be changed based upon agreed upon timeframes. • Standard "Core" questions will be added to the survey for data sharing and benchmarking. • A Power BI Page will be developed for tracking purposes over time.	Leadership Team & Quality Improvement Specialist.	• Family willingness to participate in surveys. • Timeframe for development of agreed upon survey. •	**A committee of all the CMOs in the state created a uniform satisfaction survey that all the CMOs will use one month in the year as well as a post transition survey that will be administered one month in the year. The survey for active youth was offered to families, with 95% overall satisfaction rating with OPC services. The post transition survey will be rolled out in the Fall of 2021.**	**This is a new Objective for FY 2021.**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: MEDIUM**

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

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2021	FY2020	Target & Priority Level:
(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. Administrative Supervision Power BI Report **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, Quality Improvement Specialist, CM Assistants	• Family requesting delay in scheduling CFT meeting (Family Choice).	**OPC Average service plan compliance rate: 85%** Statewide CMO Average service plan compliance rate: 77%	**OPC Average service plan compliance rate: 88%** Statewide CMO Average service plan compliance rate: 76%	**≥ 95% = Green** **90%-94% = Yellow** **< 90% = Red** **PRIORITY: MEDIUM**

(b) OPC will develop and implement a new comprehensive Chart Review Process that involves cross-departmental collaboration.	**Metrics:** Establishment of Committee **Measured:** Yearly	• The Director of Clinical Operations will work in collaboration with the QA team, finance, and admin departments to establish a written process and "committee" • Through this committee, overall qualitative & quantitative data will be collected for performance improvement strategies.	Leadership Team, Director of Clinical Ops. & Quality Improvement Specialist	• Competing staff responsibilities and commitments as well as overall agency priorities.	**FY 2021 objective in this area was to establish a comprehensive chart review process. This was accomplished.**	**This is a new objective for FY2021**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**

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:	FY2021	FY2020	Target & Priority Level:
(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.	• **Significant Progress was made in this area during FY21. A procedure for annual review of P&Ps was rolled out and all existing policies and procedures were reviewed and sent out for attestation by staff. Continued work on the employee handbook as well as the creation of new procedures is underway.**	• **While Progress was made in the area of policy review and development, continued improvement in this area is needed.**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**
(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 98.1% of youth**	• **Billed for 97.94% of youth**	**≥ 95%=Green** **≤ 90%-94%=Yellow** **<90%=Red** **PRIORITY: HIGH**

(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.	• **95.6% of youth enrolled with OPC during FY-2021 completed the NJ FamilyCare application within 30 days.**	• **98.7% of youth enrolled with OPC during FY-2020 completed the NJ FamilyCare application within 30 days.**	**≥ 80%=Green** **75%-79%=Yellow** **< 74% =Red** **PRIORITY: MEDIUM**
(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. • Quality Improvement Specialist completed Quarterly Medicaid Audit and reports to CFO.	Accountant, Clinical Director, CFO, Quality Improvement Specialist	• None identified.	• **Quarterly and annual audits 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** **PRIORITY: HIGH**
(e) OPC will ensure compliance in completion of DCF Unusual Incident Reports.	**Metrics:** UIR Reporting Data; Power BI UIR Page (To be built) **Measured:** Quarterly	• Care Managers & Supervisors will be provided training on the UIR process. • The UIR form will be moved to 365 from Hyperoffice for better reporting capabilities. • A Power BI Page will be built for real-time monitoring and tracking of UIR submissions to identify trends.	Care Management Staff, Director or Org Development, Quality Improvement Specialist	• UIR Codes are not clear and specific guidance is lacking.	• **There were 183 UIRs submitted during FY21.** • **The avg # of days UIRs were submitted after being notified of incident was 3.6 days.** • **67 Care Managers submitted** • **Every Supervisor team submitted UIRs, large variation in # of UIRs submitted remains (ranging from as many as 34 from one team to as low as 3).** **A UIR refresher training for Care Managers occurred on 11/18/20.**	**This is a new objective for FY2021.** • **There were 97 UIRs submitted during the fiscal year.** • **The average number of days UIRs were submitted after being notified of incident was 3 days** • **There were 46 Care Managers who submitted UIRs** • **Every Supervisor team submitted UIRs, with a big variation in number of UIRs submitted ranging from as many as 23 from one team to as low as 1 from another team.**	**UIRs submitted within 5 days or less** **90% = Green** **89%-85% = Yellow** **<85% = Red** **Submission rate consistency across CMs & Sups** **Significant Improvement = Green** **Some improvement = Yellow** **No Improvement = Red** **PRIORITY: HIGH**

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

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2021	FY2020:	Target & Priority Level:
(a) 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 Technology & HIPAA Privacy Officer.	• None identified.	• **An annual security risk assessment was conducted by an outside consultant, ComplyAssist. OPC was determined to be 'low risk' for a HIPAA Breach. Recommendations were made for ongoing improvement in processes as it relates to security.** • **In addition to the HIPAA security assessment, OPC underwent a cyber security penetration test and implemented changes based on the results of the test.**	• **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 Quality Improvement Specialist 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.**	Completed=Green Not Completed=Red **PRIORITY: HIGH**
(b) 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	• Quality Improvement Specialist 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, Quality Improvement Specialist, Compliance Committee.	• None Identified	• **OPC continues 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 are assigned in Relias.** • **A training on compliance was conducted at an All Staff Meeting.**	• **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.**	Completed=Green Not Completed=Red **PRIORITY: HIGH**
(c) OPC will maintain compliance with HIPAA privacy and security and investigate any/all reports of potential breaches.	**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 Quality Improvement Specialist. • Breaches will be addressed at reported as per guidelines.	Privacy Officer & Compliance Committee.	• None identified.	• **There were 3 HIPAA privacy and security incidents during the fiscal year. However, the incidents were not deemed a "high risk" HIPAA breach.** • **One incident was deemed a "medium risk" involved an outside provider allowing an unidentified person to be present during a CFT meeting via Zoom. Appropriate follow-up actions were taken and documented.**	• **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.**	No Identified Issues and/or Identified Issues Rectified= Green Issues identified and not rectified= Red **PRIORITY: HIGH**

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:	FY2021	FY2020:	Target & Priority Level:
(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 • Add to newly developed performance evaluations.	All Staff	• Relias is a newly implemented system. Some learning curve may exist.	• **61% of employees completed their required annual training hours.**	• **82% of employees completed their required annual training hours.**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: MEDIUM**
(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 • Add to 90 day performance evaluation.	All Staff	• Relias is a newly implemented system. Some learning curve may exist.	• **The COVID-19 Pandemic created challenges in tracking Orientations, as the procedure prior to remote work was manual/paper based. A temporary system for tracking was established, however it did not provide satisfactory tracking as the previous system did. A new system has been implemented as of 9/1/2021.**	• **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.**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: MEDIUM**

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

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2021	FY2020:	Target & Priority Level:
(a) OPC will revise and update Performance Evaluations.	**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 most agency roles.**	• **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.**	Completed=Green Some Progress Made = Yellow Not Completed=Red **PRIORITY: HIGH**

(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	• Review dates vary based on employee's hire date. • Performance Reviews need to be updated.	• **OPC underwent a change in the Director of Human Resources role. During the transition, some information regarding tracking of performance reviews was lost, therefore the data in this area is inaccurate. A new tracking system has been established moving forward.**	• **94% 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).**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: HIGH**
(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.	• **OPC underwent a change in the Director of Human Resources role. During the transition, some information regarding tracking of performance reviews was lost, therefore the data in this area is inaccurate. A new tracking system has been established moving forward.**	• **100% (or 30) of new hires received performance reviews**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: HIGH**
(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.	• **Of 78 Care Managers, 61 or 78% were certified.** ****It should be noted that while it seems as if this was a significant decline from last FY, the data from last FY was provided from the state system which had some reporting glitches. OPC developed an internal tracking system to allow for better tracking. Additionally, the state will be moving this system to a new system this coming FY.**	• **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".**	≥ 90%=Green 85%-89% = Yellow <85%=Red **PRIORITY: MEDIUM**

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:	FY2021	FY2020:	Target & Priority Level:
(a) OPC will maintain its 3+ year employee retention rate for Care Management Staff at 90% or above.	**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 91% retention rate and 9% turnover.** • **Overall retention rate for all OPC employees was 76%, with 25 terminations.** • **Retention rate for all Care Managers was 70%, with 22 terminations**	• **For Care Managers who worked with OPC for 3+ years there was 94% retention rate and 6% turnover.**	**≥ 90%=Green** **85%-89% = Yellow** **<85%=Red** **PRIORITY: HIGH**
(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-2021**	• **0 OSHA reportable accidents occurred during FY-2020**	**0 =Green** **≤ 2 = Yellow** ***> 3 = Red*** **PRIORITY: HIGH**
(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-2021. There was one employee who shared a grievance or concern via OPC's anonymous Safe Hotline. This however was not a formal grievance and the concern was followed up as per OPC's policy and procedure.**	• **0 grievances filed in FY-2020**	**No Grievances filed and/or Grievances investigated as per policy = Green** **Grievance policy and process is not followed = Red** **PRIORITY: HIGH**

Corporate Goal:

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

1. Desired Outcome: OPC will continue to implement OPC's established strategic and corporate goals.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2021	FY2020:	Target & Priority Level:
(a) OPC will implement its newly developed strategic plan.	**Metrics:** Strategic Plan **Measured:** Ongoing & Annually	• Identify and operationalize board "committees" • Assign a "task master" who will ensure plan is being executed. • Continue to have strategic plan items included on leadership & board agendas.	Leadership Team & OPC Board. All Staff.	• COVID-19 Pandemic and changes in financial position and processes as a result. • Cost restrictions • Volunteer Board time commitment for planning process.	• **OPC has been working toward the goals set forth in its current strategic plan, however, the COVID-19 pandemic has created delays and some shifts in priorities for the agency. The plan will need to be reviewed again for relevance during FY22.**	• **A new Strategic Plan was developed and implemented by the Board of Trustees and the Leadership Team.**	**Ongoing Progress Made=Green** **Some Consistent Progress = Yellow** **No Progress =Red** **PRIORITY: HIGH**
(b) OPC will begin to prepare for CARF Accreditation with a goal of undergoing an on-site survey during FY2021.	**Metrics:** CARF Accreditation **Measured:** Ongoing & Yearly	• OPC's CARF committee will continue to meet to tackle 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.**	• **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.**	**Survey Completed =Green** **Significant Progress Made but additional time needed = Yellow** **Minimal Progress Made =Red** **PRIORITY: MEDIUM**
(c) OPC will provide education and marketing (internally & externally) regarding CSOC/OPC, accessing services, & how to "talk about" Care Management.	**Metrics:** Increased community awareness. Referral numbers. Referral Source Data **Measured:** Ongoing & Yearly	• OPC will explore developing a video orientation program? • OPC will obtain a marketing and outreach/social media intern to assist. • OPC will complete individual outreaches to specific system partners (i.e. individual police departments, individual schools, etc.)	Director of Community Resources & Leadership Team	• COVID-19 pandemic and the availability of community-based services. • Pre-existing community/system partner knowledge about CMO. • Need to create "branding".	• **OPC established a Marketing Committee that undertook multiple initiatives throughout the FY. These include the creation of a marketing video, review of OPCs mission & vision, increased social-media presence, a 'refresh' of the OPC logo, and a storytelling workshop attended by the Leadership Team.**	**This is a new objective for FY-2021.**	**Ongoing Progress Made=Green (i.e. significant increase in referrals, marketing materials developed, etc.)** **Some Consistent Progress = Yellow** **No Progress =Red** **PRIORITY: MEDIUM**