OCEAN PARTNERSHIP for CHILDREN INC.

Changing Tides in the Lives of Families

FY 2022

ANNUAL REPORT

Quality Improvement, 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.
- Ensuring compliance with state & federal regulations 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 2022 (FY2022), which runs from July 1, 2021 – June 30, 2022, OPC set and achieved many strategic goals, despite the obstacles that the COVID-19 pandemic continued to present. In addition to its day-to-day operations, OPC was awarded a 3-year accreditation through the Commission for Accreditation of Rehabilitation Facilities (CARF) and was recognized with a 2022 NJ Top Workplace Award. Moreover, OPC maintained two county grants that expanded services for I/DD youth in the Ocean County community: The Connections Program and the I/DD Specialist role.

In the coming fiscal year, the NJ Department of Children & Families (DCF) is rolling out an 'Office of Monitoring', which will seek to assess the performance quality of DCF funded services. The office will strive to ensure uniformity of service delivery, regularly assess quality, improve referral and constituent experiences, ensure adherence to service models, and examine outcomes. OPC, along with the other 14 CMOs will be an active participant in this initiative as it rolls out in the coming year.

Some highlights from FY2022 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 and juvenile detention).
  - Maintaining overall family satisfaction with the services provided by OPC.
  - Ensuring compliance with service plan timeframes set forth by the Department of Children & Families
  - Improving overall chart audit outcomes in both administrative and clinical areas.
- In the area of Compliance, OPC met or exceeded its goals in the following areas:
  - Full review of Policies & Procedures and establishment of an annual 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
  - Ongoing bi-annual tabletop testing simulations focusing on business continuity, disaster recovery, and HIPAA compliance.

- OPC also successfully met, improved upon, or exceeded goals in the following areas as it relates to its Workforce and Corporate Goals:
  - Standardization of a job description format to ensure ADA compliance
  - Full implementation of an updated performance evaluation system and 100% compliance with timeframes for completion of evaluations.
  - High Retention of Care Management staff who have been with the agency for 3+ years

- Completion of a third-party employee survey with outcomes showing excellent employee satisfaction and a NJ Top Workplace designation.
- Establishment of a health and safety committee to focus on wellness and safety initiatives throughout the agency.
- Achievement of 3-year CARF Accreditation.
- Significant movement forward in the areas of marketing, fundraising, and branding.

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 agency is rolling out a 'Weighted Strength & Needs' system that will allow for better monitoring of risk and lead to higher rater reliability.
- OPC should continue to assist families with accessing DD eligibility and linkage to sustainable resources continues to be a challenge for our I/DD youth population. Continued efforts and collaboration with the MCOs & OPC's I/DD Specialist need to occur as well as the ongoing identification (and building) of new resources to serve this population.
- The average length of stay in behavioral health Out of Home Treatment facilities has begun to steadily increase over the course of the last two years. While it is likely that this is a result of challenges presented by the COVID-19 pandemic (i.e. holds on admissions, staffing shortages, lack of family engagement, etc.), it is a data point OPC should monitor closely in the coming FY.
- Outcomes of the Chart Audit process showed significant improvement in many practice areas of Care Management; however, a strategic focus on outreach efforts to non-clinical system partners (including schools) and inclusion of information regarding psychiatric medication will occur during the coming FY.
- Unusual Incident Report (UIR) completion rates among Care Managers, compliance with timeframes for submission, and consistency across teams remains an area of improvement for OPC. The Quality Improvement Specialist will continue to educate staff and proactively monitor compliance as it relates to UIRs.
- OPC will continue to participate in statewide efforts to collect collaborative data for Family Experience Surveys to use as a tool for benchmarking and marketing efforts. OPC should strive for results at or above the average for CMOs across the state. Further, OPC should seek to increase its return rate on surveys, especially for youth.
- While significant growth was made in the areas of new staff orientation and training compliance, OPC needs to ensure that accurate tracking occurs, and that scheduling occurs proactively throughout the year.
- Policy and Procedure development and management was area of focus during FY22, and the agency showed incredible progress. With the agency successfully establishing an institutionalized process for development and ongoing review of P&Ps complete, a focus for FY23 will be on the review and revision of the Employee Handbook. This project is underway and is expected to be completed during this FY.
- OPC's Leadership team underwent a robust strategic planning process during FY22. A joint Board/Leadership team retreat is scheduled for FY23 to solidify a new strategic plan moving forward. Once established, OPC needs to move forward with the strategic goals and initiatives set forth within the plan.

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 2022

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, emotional/behavioral stability, and sustainable linkage to resources.**

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a)Youth will improve or remain stable in *behavioral/emotional needs* **at or above the state average.** *Standard 1.M.4 Results for the Persons Served (Effectiveness)*	**Metrics:** CYBER SNA Outcomes Data & CMO Dashboard. **Measured:** Quarterly **Applied to:** Children & Families	• CMs to complete updated SNAs every 75 days and re-evaluate needs and plan strategies regularly. • Program Managers to review key areas where needs 'persist' to identify barriers. • Trends will be identified agency wide with changes implemented as needed. • A new report including weighted SNA ratings will be rolled out.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs) QA Team.	• Possible lack of resources in identified areas • Family and environmental factors outside CM's control. • Accurate completion of SNA by Care Manager.	• **OPC – 78% of youth improved or remained stable in behavioral/emotional needs** • State average – 82% 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 – 83% 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.** *Standard 1.M.4 Results for the Persons Served (Effectiveness)*	**Metrics:** CYBER SNA Outcomes **Measured:** Quarterly **Applied to:** Children & Families	• 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 – 96% 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 – 96% 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	**Metrics:** PBI Transitions Report.	• Transition Planning will be measured via admin supervision.	Care Management Staff (Clinical Director,	• Unforeseen reasons for transition (i.e. youth missing) and/or transition at	• **75% of transitions were planned and successful**	• **76% of transitions were planned and successful**	**≥ 70%=Green** **65%-69%=Yellow**

considered *planned* and *successful*. *Standard 1.M.4* *Results for the Persons Served (Effectiveness)*	**Measured:** Quarterly **Applied to:** Care Management	• Discussions surrounding "readiness" will occur during supervision. • All TISPs will be reviewed by the Clinical Director prior to submission.	Program Managers, Supervisors & CMs). QA Team.	the request of the family despite lack of readiness.			**< 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**. *Standard 1.M.7* *Resources used to achieve results for the persons served (Efficiency)*	**Metrics:** Internal Re-enrollments Report in Power BI & CYBER Re-enrollment report **Measured:** Quarterly **Applied to:** Children & Families	• 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.	• **16% of OPC re-enrollments occurred between 0 – 6 months** • 19% of all CMOs re-enrollments occurred between 0 – 6 months	• **15% of OPC re-enrollments occurred between 0 – 6 months** • 20% of all CMOs re-enrollments occurred between 0 – 6 months	**≤ State Average=Green** **> State Avg=Yellow** **>6% from State Avg=Red** **PRIORITY: MEDIUM**
(e) At least 70% of youth with I/DD diagnoses will be successfully linked to DD eligibility through CSOC. *Standard 1.M.8* *(Service Access)* *****New for FY2022*******	**Metrics:** Power BI I/DD Youth Report (OPC Power) **Measured:** Quarterly **Applied to:** Children & Families	• CMs and Supervisors will work with the I/DD Specialist to facilitate DD eligibility application submission. • I/DD Supervisor will monitor rates of eligibility and provide consultation regarding the process as requested.	Care Management Staff (Clinical Director, Program Managers, Supervisors & CMs). I/DD Specialist.	• Family choice not to apply. • Lack of access to timely evaluations or assessments.	• **47% of youth with I/DD diagnoses have obtained DD eligibility (172 of 363 as of 8/15/2022)** **NOTE: The CYBER report that is utilized for this item was changed which increased the # of I/DD youth. As of 4/4/22, 173 of 283 or 61% were eligible)**	• **This is a new objective for FY22. At the end of F21, 66% of youth with I/DD diagnoses have obtained DD eligibility.**	**≥ 70%=Green** **65%-69%=Yellow** **< 64% =Red** **PRIORITY: HIGH**

2. Desired Outcome: Keep kids at home, in school, and in their communities.

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) OPC will work to ensure at least 85% of youth enrolled are in the community. *Standard 1.M.7 Resources used to achieve results for the persons served (Efficiency)*	**Metrics:** CYBER OOH Dashboard, Power BI OOH Report. **Measured:** Quarterly **Applied to:** Children & Families	• 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. • Increasing number of I/DD Youth with persistent needs requiring OOH.	• **92% of youth enrolled are in the community**	• **90% 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. **Measured:** Quarterly **Applied to:** Children & Families	• 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 10.2 months**	• **Average length of stay in a Behavioral Health or Substance Abuse OOH treatment setting is 9.2 months**	**≤ 9 mon. = Green** **10-12 mon=Yellow** **> 12 mon. = Red** **PRIORITY: HIGH**

Standard 1.M.7 Resources used to achieve results for the persons served (Efficiency)							

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

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) At least 95% of families (active & transitioned) will indicate that they are satisfied or very satisfied with the services provided to them by OPC. *Standard 1.M.5 Feedback from persons served.*	**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, QA Manager, CM Assistants	• Family willingness to participate in surveys.	• **Results from Active Family surveys conducted in April 2022 show a 95% overall satisfaction with OPC (out of 281 surveys)** • **Results from Transition surveys show a 99% overall satisfaction rating with OPC services (out of 96 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.**	**≥ 95% = Green** **90%-94% = Yellow** **< 90% = Red** **PRIORITY: HIGH**
(b) OPC will score at or above the state average on benchmarked family satisfaction measures. *Standard 1.M.5 Feedback from persons served.* ****New for FY2022****	**Metrics:** Active & Transitioned Family Satisfaction Surveys **Measured:** Yearly	• Participating Care Management Organizations throughout the state will share data at regular intervals. • Statewide data will be compared with OPC agency data.	QA Manager & Director of Org Development & Technology	• Consistent and timely collection of data among CMOs.	• **For Active Family Surveys, OPC scored at or above the state average for 3 of 6 questions. Of the 3 questions where OPC benchmarked lower than the state avg., results were within 4% points.** • **Post-transition Surveys – Data not available at this time.**	**This is a new objective for FY22. Surveys were rolled out at the end of FY21.**	**≥ State Average=Green** **≤ 5% from State Avg=Yellow** **<6% from State Avg=Red** **PRIORITY: MEDIUM**

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

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	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. *Standard 1.M.8 (Service Access)*	**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, QA Manager, CM Assistants	• Family requesting delay in scheduling CFT meeting (Family Choice).	**OPC Average service plan compliance rate: 81%** Statewide CMO Average service plan compliance rate: 74%	**OPC Average service plan compliance rate: 85%** Statewide CMO Average service plan compliance rate: 77% **Note: While OPC scored high overall in compliance, rates of timely submission of Transition ISPs were consistently lower than the state average. Overall compliance is a key factor in compliance with DCF guidelines, however a new item (below) has been added to focus specifically on improvement of TISP submission.	**≤ State Average=Green** **> State Avg=Yellow** **>6% from State Avg=Red** **PRIORITY: MEDIUM**
(b) OPC will ensure specifically that TISP's are submitted at or above the state average timeframe. *Standard 1.M.8 (Service Access)*	**Metrics:** CYBER CMO Dashboard Service Plan Report. **Measured:** Monthly	• TISPs will be submitted to the Director of Clinical Operations for review and immediately forwarded to the QA Manager for processing and tracking. • Supervisors will review ISP deadline dates to ensure that a CFT meeting occurs within 75 days of the last CFT, even if a transition is scheduled to occur in the next 30 days.	Supervisors, QA Manager, Clinical Director.	• Family requesting delay in scheduling CFT meeting (Family Choice). • Multiple layers of processing required for clinical review and tracking purposes.	**OPC Average TISP compliance rate: 77.4%** Statewide CMO Average TISP compliance rate: 79%	**This is a new objective for FY22. Surveys were rolled out at the end of FY21.** **OPC Average TISP compliance rate: 76%** Statewide CMO Average TISP compliance rate: 78%	**≤ State Average=Green** **> State Avg=Yellow** **>6% from State Avg=Red** **PRIORITY: MEDIUM**

New for FY2022							
(c) OPC will show improvement in its Overall Chart Audit 'Score'. *Standard 1.M.7 Resources used to achieve results for the persons served (Efficiency)* ***New for FY2022***	**Metrics:** Peer Chart Review Data Power BI Report **Measured:** Yearly	• The Director of Clinical Operations will work in collaboration with the QA team, finance, and admin departments to complete monthly peer chart reviews. • The QA Manager and Care Management team will implement agreed upon improvement strategies for areas identified.	QA Manager & Care Management Team	• Competing priorities for areas to focus on. • Consistency in reviews and ratings.	**Total Score for Chart Audits completed thus far in FY 2022 was 80% (39 chart audits were completed in FY22)**	**FY 2021 objective in this area was to establish a comprehensive chart review process. This was accomplished.** **Total Score for Chart Audits completed in FY 2021 was 71% (19 chart audits were completed in FY21)**	**Improvement of 5% or more = Green** **Improvement of 1%-4% = Yellow** **No Improvement or Worsen = 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.**

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) Ensure OPC's policies and procedures are up to date and in compliance with appropriate standards. *Standard 1.M.9 (Business Functions)*	**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 throughout the year and at least once per year for ALL P&Ps	Leadership Team & OPC Board	• Continuous system-based changes that impact internal procedures and policies.	• **All P&Ps were reviewed at the beginning of Calendar year 2022 in ordinance with CARF standards.**	• **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.**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**
(b) On average, OPC will bill Medicaid for at least 95% of enrolled youth. *Standard 1.M.9 (Business Functions)*	**Metrics:** EZ Claim Billing Report & Quarterly Medicaid Report **Measured:** Monthly & Annually	• 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 96.7% of youth**	• **Billed for 98.1% of youth**	**≥ 95%=Green** **≤ 90%-94%=Yellow** **<90%=Red** **PRIORITY: HIGH**

(c) 90% of youth enrolled without Medicaid will complete the NJ Family Care application within 30 days. *Standard 1.M.8 (Service Access)* ***Increased Goal for FY2022 by 10%****	**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.	• **92% of youth enrolled with OPC during FY-2022 completed the NJ FamilyCare application within 30 days.**	• **95.6% of youth enrolled with OPC during FY-2021 completed the NJ FamilyCare application within 30 days.**	≥ 90%=Green 80%-89%=Yellow < 79% =Red **PRIORITY: MEDIUM**
(d) OPC will ensure compliance in Medicaid billing procedures. *Standard 1.M.9 (Business Functions)*	**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 completes Quarterly Audits and reports to CFO.	Accountant, Clinical Director, CFO, QA Manager	• None identified.	• **Quarterly audits completed with No Issues Identified.**	• **Quarterly and annual audits 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. *Standard 1.M.7 Resources used to achieve results for the*	**Metrics:** UIR Reporting Data; Power BI UIR Data Page **Measured:** Annually	• Care Managers & Supervisors will receive ongoing training on the UIR process. • OPC will work with the CSOC on the revision of current codes and utilize the newly developed UIR dashboard to compare with state data.	Care Management Staff, Director or Org Development, QA Manager	• UIR Codes are not clear and specific guidance is lacking.	• **There were 157 UIRs submitted during FY22.** • **The avg # of days UIRs were submitted after being notified of incident was 3.12 days.** • **86% were submitted within 5 days or less.** • **71 Care Managers submitted** • **Every Supervisor team submitted UIRs, variation in # of UIRs**	• **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).** •	**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

persons served (Efficiency)					**submitted remains (ranging from as many as 36 from one team to as low as 4).**		**No Improvement = Red** **PRIORITY: HIGH**

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

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) OPC will conduct an annual security risk assessment to identify opportunities for security enhancement. *Standard 1.M.9 (Business Functions)*	**Metrics:** Yearly Risk Assessment Report **Measured:** Yearly	• An Annual HIPAA Security Risk Assessment will be conducted. • Review of recommendations will occur at the Leadership level for changes to be implemented. • Additional assessments may occur annually based upon need.	Director of Technology & HIPAA Privacy Officer.	• None identified.	• **An annual security risk assessment with outside consultant, ComplyAssist, completed in February 2022.**	• **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.**	**Completed=Green** **Not Completed=Red** **PRIORITY: HIGH**
(b) OPC will provide training on Corporate Compliance during orientation and annually for all staff. *Standard 1.M.9 (Business Functions)*	**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 Comp. • 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 November 2021.** • **Yearly required compliance trainings were assigned in Relias.** • **An annual training on compliance was pushed out as part of the agency's annual training plan in Relias.**	• **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	**Metrics:** HIPAA Log; Quarterly Privacy/Security Audits.	• HIPAA Privacy Officer will keep a log of HIPAA violations and conduct random audits in conjunction with QA Manager.	Privacy Officer & Compliance Committee.	• None identified.	• **There were 4 HIPAA privacy and security incidents during the fiscal year. However, the incidents were not deemed a "high risk" HIPAA breach.** • **Each incident was considered "low risk".**	• **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**	**No Identified Issues and/or Identified Issues Rectified= Green** **Issues identified and not rectified= Red**

reports of potential breaches. *Standard 1.M.9 (Business Functions)*	**Measured:** Ongoing & Quarterly	• Breaches will be addressed at reported as per guidelines.			• **A log is kept of any potential HIPAA violations and resolutions to address the issues.**	**present during a CFT meeting via Zoom. Appropriate follow-up actions were taken and documented.** • **A log is kept of any potential HIPAA violations and resolutions.**	**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.

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) 100% of staff will complete required annual training hours. *Standard 1.M.9 (Business Functions)*	**Metrics:** Relias Training Report **Measured:** Annually	• Annual Training program will be sent out in Relias. • Training hours will be reviewed as part of each employee's performance evaluation. • The Org Development area will assist with simplifying training reports to be reviewed more regularly.	All Staff	• Reporting in Relias is cumbersome. • Competing priorities when youth assignments are high. • Attendance at trainings is not always recorded.	• **83% of eligible employees completed their required annual training hours in FY-22.** • **57% of staff who did NOT complete their hours were within 3 hours of completion.**	• **61% 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 & provide a copy of their orientation & training plans to HR. *Standard 1.M.9 (Business Functions)*	**Metrics:** Relias Training Report **Measured:** Annually	• Orientation & job specific training plans will be created for all incoming staff. • Copies of Orientation & Training plans will be submitted by the supervisor with an employee's 90 day performance evaluation.	All Staff	• During COVID, Orientation tracking had to be shifted from traditional 'sign off' • Staff who complete training/orientation prior to 90 days forget to hand in.	• **71% of new staff hired from 10/25/2021-06/30/2022 completed their orientation within 90 days of hire (15 of 21).** • **4 of the 6 staff who did not finish within 90 days were a result of not having completed the PE/FFR portion of orientation.**	• **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.**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: MEDIUM**

2. Desired Outcome: OPC will maintain high performance standards and clear expectations for job responsibilities with staff to achieve operational excellence.

Objective:	Metrics/Tools & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) OPC will revise and update Performance Evaluations. *Standard 1.M.9 (Business Functions)*	**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.	• **OPC revised and updated all of its Performance Evaluation Templates**	• **A performance evaluation template was developed for use with ALL agency staff. Position specific performance evals and rubrics were developed for most agency roles.**	Completed=Green Some Progress Made = Yellow Not Completed=Red **PRIORITY: HIGH**
(b) 100% of employees will have current performance reviews completed (90 Day & Annual). *Standard 1.M.9 (Business Functions)*	**Metrics:** Annual HR report **Measured:** Ongoing & Annually	• Supervisor will monitor their staff hire dates and complete performance reviews after 90 days of hire. • 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.	• **100% of employees have current Performance Evaluations on File.**	• **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%=Green 99%-90% = Yellow <90%=Red **PRIORITY: HIGH**
(c) OPC will update and standardize all job descriptions. *Standard 1.M.9 (Business Functions)* ***New for FY2022****	**Metrics:** Annual HR report **Measured:** Ongoing & Annually	•	Management & Leadership Teams	• Lack of system to "remind" that reviews are due. • Performance Reviews need to be updated.	• **OPC revised and updated all of its Job Descriptions to a standardized format compliant with ADA laws.**	• **This is a new objective for FY-2022.**	100%=Green 99%-90% = Yellow <90%=Red **PRIORITY: HIGH**

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:	FY2022	FY 2021	Target & Priority Level:
(a) OPC will maintain its 3+ year employee	**Metrics:** HR Census Data	• Continued review of employee satisfaction through surveys and	Leadership Team & OPC Board	• None identified	• **For Care Managers who worked with OPC for 3+ years there was 90%**	• **For Care Managers who worked with OPC for 3+ years**	≥ 90%=Green

retention rate for Care Management Staff at 90% or above. *Standard 1.M.9 (Business Functions)*	**Measured:** Annually	individual "pull in" conversations. • Leadership Team and Board will review benefits packages			**retention rate and 10% turnover.** • **Overall retention rate for all OPC employees was 79%, with 26 terminations.** • **Retention rate for all Care Managers was 79%, with 26 terminations.** • **No employees from other departments or supervisor's left OPC in FY 22**	**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.**	**85%-89% = Yellow** **<85%=Red** **PRIORITY: HIGH**
(b) OPC will maintain an overall employee satisfaction at or above 'similar social and human service non-profits' who participate in the energage survey *Standard 1.M.9 (Business Functions)* *****New for FY2022*****	**Metrics:** HR Tracking Data **Measured:** Annually	• OPC will conduct an annual staff survey through a third-party vendor.	Leadership Team & OPC Board	• None identified	• **OPC scored 9% higher than the average of similar agencies who participated in the Energage survey.** **NOTE: OPC was awarded a 2022 Top Workplace following this survey.**	• **For FY2021 Employee Survey, 98% of OPC employees 'Strongly Agreed' or 'Agreed' when asked about the statement "Taking all aspects of my job into consideration, I am generally satisfied with OPC as a place to work."**	**≥ Energage Average=Green** **≤ 5% from Energage Avg=Yellow** **<6% from Energage Avg=Red** **PRIORITY: HIGH**
(c) OPC will maintain a safety record of 0 OSHA reportable accidents per year. *Standard 1.M.9 (Business Functions)*	**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-2022**	• **0 OSHA reportable accidents occurred during FY-2021**	**0 =Green** **≤ 2 = Yellow** ***> 3 = Red*** **PRIORITY: HIGH**
(d) OPC will establish a health and safety	**Metrics:** HR Tracking Data	• OPC will provide training on safety in the workplace.	Leadership Team & OPC Board	• None identified •	• **Health & Safety Committee was established. Meetings occur quarterly.**	• **This is a new objective for FY-2022.**	**0 =Green** **≤ 2 = Yellow**

committee to spearhead wellness and safety initiatives for the agency. *Standard 1.M.9 (Business Functions)* ***New for FY2022***	**Measured:** Annually	• External health/safety inspections will occur based upon regulatory requirements.					***> 3 = 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.

Standard, Domain & Objective:	Indicator, Data Source & Frequency:	Implementation Strategies:	Person(s) Responsible:	Identified Barriers:	FY2022	FY 2021	Target & Priority Level:
(a) OPC's Leadership team and Board of Trustees will review and update its previously established Strategic Plan. *Standard 1.M.9 (Business Functions)* ***New for FY2022****	**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.	• **The leadership team conducted a retreat to develop a DRAFT strategic plan in January 2021. A joint Board/Leadership retreat is scheduled for September 2022 to finalize the plan.**	• **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.**	**Ongoing Progress Made=Green** **Some Consistent Progress = Yellow** **No Progress =Red** **PRIORITY: HIGH**
(b) OPC will continue to prepare for CARF Accreditation with a goal of undergoing an on-site survey during FY2022.	**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	Leadership Team, OPC Board, CARF Committee members.	• Budget, 'people power' & time constraints	• **OPC successfully completed CARF accreditation in May 2022. A 3-year accreditation was awarded.**	• **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**	**Survey Completed =Green** **Significant Progress Made but additional time needed = Yellow** **Minimal Progress Made =Red** **PRIORITY: MEDIUM**

Standard 1.M.9 (Business Functions)		and make recommendations.				**accreditation was pushed back.**	
(c) OPC will provide education and marketing (internally & externally) regarding CSOC/OPC, accessing services, & how to "talk about" Care Management. *Standard 1.M.9 (Business Functions)*	**Metrics:** Increased community awareness. Referral numbers. Referral Source Data **Measured:** Ongoing & Yearly	• OPC's Board/Staff Marketing Committee will continue efforts to improve OPCs 'brand' awareness.	Director of Community Resources, Board/Staff Marketing Committee, & Leadership Team	• Continued communication challenges related to the COVID-19 pandemic • Pre-existing community/system partner knowledge about CMO. • Need to create "branding".	• **OPC's board marketing committee merged with the fundraising committee to implement a more robust plan. Fundraising software was purchased and a search for a marketing firm is underway.**	• **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.**	**Ongoing Progress Made=Green (i.e. significant increase in referrals, marketing materials developed, etc.)** **Some Consistent Progress = Yellow** **No Progress =Red** **PRIORITY: MEDIUM**
(d) OPC will analyze feedback received from key stakeholders and implement an action plan in response to ensure effective delivery of service and improvement in relationship with key community partners. *Standard 1.M.6 Experience of services and other feedback from other stakeholders* *****New for FY2022*****	**Metrics:** Provider Feedback Surveys **Measured:** Annually	• The Community Resource Director will work alongside the leadership team to analyze survey results and implement an action plan. • A 'Community Events' Committee will be established to ensure ongoing relationship building in the community and ensure clarity on the role of OPC.	Director of Community Resources, Leadership Team, Community-Events Committee	• Longstanding relationship barriers with certain system partners. • 'Systems Issues' beyond the control of CMO that create tension between coordinating agencies. • Lack of widespread response to survey (likely due to 'over surveying' of folks).	• A 'Community Events' Committee was established to ensure ongoing relationship building in the community and ensure clarity on the role of OPC. • FY 21 Survey results were not analyzed.	**This is a new objective for FY-2022.**	**Completed =Green** **Partially Completed= Yellow** **Not Completed=Red** **PRIORITY: MEDIUM**