Quality Assurance & Performance Measurement and Management CY 2025-2026

1. Desired Outcome: Improved outcomes, emotional/behavioral stability, and sustainable linkage to resources
2. Desired Outcome: Keep kids at home, in school and in their communities
3. Desired Outcome: Partners for Kids and Families will provide individualized and accessible services where youth and families maintain satisfaction with the CMO process.
4. Desired Outcome: Partners for Kids and Families will remain in compliance with DCF/CSOC's Services Standards, Conformance with CARF Care Management Program Standards, and Overall Industry best practices.

Care Management & Operations Goals: Youth & 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 Partners for Kids and Families.							
Standard, Domain & Objective	Indicators, Data Source, Frequency & Applied to	Implementation Strategies	Person (s) Responsible	Identified Barriers	Contract Year (CY) 2024/2025	Contract Year (CY) 2025/2026	Target & Priority level
Families participating in the CMO will demonstrate their ability to manage their family plan. *Standard 1.M.5 Results for the Persons Served (effectiveness)*	**Metrics:** Strengths and Needs Assessments **Measured**: Caregiver Strengths from the CSA CMO Dashboard (quarterly) **Applied To:** Youth & Families	Care Managers to complete updated SNA 75 to 90 Days and reevaluate needs and plan strategies regularly.	**Care Management Operations; Care Managers, Operation Managers, Care Manager Supervisor & Director of Operations**	Accurate completion of SNA's.	**89%** of PFKF families maintained or improved their Caregiver Strengths Optimism, Family Stress and Involvement with Care.	**88%** of PFKF families maintained or improved their Caregiver Strengths Optimism, Family Stress and Involvement with Care.	**85%** of families will report that they maintained or improved their Caregiver Strengths: Optimism, Family Stress and Involvement with Care. **≥ 85% = Green** **79% - 84% = Yellow** **<78% from State Avg = Red** **PRIORITY: HIGH**

Partners for Kids and Families will provide quality care management services through the consistent application of the wraparound values. *Standard 1.M.5 Results for the Persons Served (effectiveness)*	**Metrics:** Team Observation Measure (TOM). Random youth selection. **Measured**: Monthly **Applied To:** Care Management	The Program Coordinators and Quality Assurance Specialist conduct random selected TOMs with the child and family team.	**Quality Assurance; Quality Assurance Specialist, Program Coordinators, Quality Assurance Manager & Quality Assurance Director**	Scheduling of CFT's, communication barriers.	**94%** average in overall wraparound fidelity.	**94%** average in overall wraparound fidelity.	**95 %** average in overall wraparound fidelity. **≥ 95 = Green** **89% - 94% = Yellow** **<88% from Target= Red** **PRIORITY: HIGH**

Partners for Kids and Families will review trends and patterns of Formal Grievances and Complaints. *Standard 1.M.5 Results for the Persons Served (effectiveness)*	**Metrics:** Grievance and Complaint tracking spreadsheet **Measured**: Quarterly **Applied To:** Care Management	Documentation of all calls and written complaints to the Quality Assurance Director, Executive Director & Director of Operation.	**Executive Director, Quality Assurance Director & Director of Operations**	Ensuring that documentation is current.	**4** Request for assistance with out-of-home (OOH) support and additional resources to manage youth behavior, concerns include ongoing behavioral issues without services currently in place, the family also expressed frustration regarding excessive outreach during the youth's vacation, the family received a text message from the therapist that was meant for the Care Manager.	The **3** areas did not show significant trends or patterns. Key concerns included escalating behavioral and safety concerns, unmet service needs, and dissatisfaction with providers/services, including requests for higher levels of care or discontinuation of services.	Partners for kids and families reviewed the plan. **Yes = Green** **No = Red**

Partners for Kids and Families is committed to Wraparound Value of Youth/Family Voice and Choice. *Standard 1.M.5 Results for the Persons Served (effectiveness)*	**Metrics:** Monthly Family Quality Calls & Family Satisfaction Surveys **Measured**: Monthly Family Quality Calls (Monthly) & Family Satisfaction (Yearly) **Applied To:** Youth & Families	Calls made to families monthly. The Family Satisfaction survey are sent out to families via Tiger Connect, ResourceNet, and paper copy upon request. Results are analyzed for strengths and areas that need improvements.	**Quality Assurance; Quality Assurance Specialist & Program Coordinators**	Unanswered and unreciprocated phone calls, uncompleted survey responses.	**96%** PFKF families feel comfortable discussing their concerns with their Care Manager. **91%** PFKF families can manage their plan and are confident that their voice/choice is being heard. **94%** PFKF families report that they are satisfied with CMO services.	**98%** PFKF families feel comfortable discussing their concerns with their Care Manager. **99%** PFKF families can manage their plan and are confident that their voice/choice is being heard. **94%** PFKF families report that they are satisfied with CMO services.	**90%** of families participating in CMO will demonstrate their ability to manage their plan and feel confident that their voice and choice is included. **90%** of families will report that they are happy with CMO services. **≥ 90% = Green** **84% - 89% = Yellow** **<83% from Target = Red** **PRIORITY: HIGH**

Partners for Kids and Families will ensure that families are being seen in person or virtually by family's choice. *Standard 1.M.7 Results for the Persons Served (efficiency)*	**Metrics:** Monthly Progress Note Reporting/ Analysis System (monthly). The Director of Operations will follow up with staff on concerns that need to be addressed. **Measured**: Monthly **Applied To:** Care Management	Every month, Care Managers will offer and schedule Face to Face Meeting with Families.	**Care Management Operations; Care Manager Supervisors, Operation Managers & Director of Operations**	Family may request not to be seen for the month.	**94%** of families seen	**95%** of families seen	**95%** of youth and families will be seen by their assigned Care Manager at least once a month. **≥ 95% = Green** **89% - 94% = Yellow** **<88% from Target = Red** **PRIORITY: HIGH**

Children participating in the CMO will have Improved or Remained Stable in the Behavioral/Emotional Needs and Risk Behaviors domains. *Standard 1.M.4 Results for the Persons Served (effectiveness)*	**Metrics:** Cyber SNA Outcomes data and CMO dashboard. **Measured**: Quarterly **Applied To:** Youth & Families	Care Managers to update SNA every 75 to 90 days and reevaluate needs and plan strategies regularly. Quality Assurance Specialist reviews key areas where needs persist to identify barriers.	**Care Management Operations: Care Managers, Care Manager Supervisors, Operation Managers & Director of Operations, Quality Assurance**	Possible lack of resources in identified areas. Family and environmental factors outside Care Managers' control. Transition reasoning is unclear.	**81%** of youth improved or remained stable in Behavioral/Emotional Need. **95%** of youth improved or remained stable in Risk Behaviors. **71%** of transitions are planned and successful (Goals Met- Level of care not needed, transitioned to another service coordination entity, Moved out of State).	**81%** of youth improved or remained stable in Behavioral/Emotional Need. **95%** of youth improved or remained stable in Risk Behaviors. **78%** of transitions are planned and successful (Goals Met- Level of care not needed, transitioned to another service coordination entity, Moved out of State).	**75%** of our active youth between the 9 and 12-month interval will have improved or remained stable in the Behavioral/Emotional Needs domain. **90%** of our active youth between the 9- and 12-month interval will have improved or remained stable in the Risk Behaviors domain. At least **75%** of transitions will be considered planned and successful. **≥ 75% = Green** **69% - 74% = Yellow** **< 68% from Target = Red** **PRIORITY: HIGH**

Standard, Domain & Objective	Indicators, Data Source, Frequency & Applied to	Implementation Strategies	Person (s) Responsible	Identified Barriers	Contact Year (CY) 2024/2025	Contact Year (CY) 2025/2026	Target & Priority
CMO will be at or above the state average for youth and families who maintain stability and avoid reenrollment for 6 months following transition. *Standard 1.M.7 (Efficiency)*	**Metrics:** Power BI & Cyber CMO Dashboard, reenrollment report **Measured**: Quarterly **Applied To:** Youth & Families	Care Managers will have regular conversations about transition with CFT to ensure families are prepared and linked to appropriate services prior to transition. Discussions surrounding "Readiness" will occur during supervision. Review of previous services will occur at the time of reenrollment.	**Care Management Operations; Care Managers, Care Manager Supervisors, Operation Managers, Director of Operations, and Quality Assurance**	Change in family Circumstances. Diagnoses that are cyclical in nature. Lack of sustainable services to link families at transition.	In 2024, **12%** PFKF transitioned youth had reenrollments occur within 6 months after transitioning. In 2024, **15%** of all CMOs transitioned youth had reenrollments occur within 6 months after transitioning.	In 2025, **13%** PFKF transitioned youth had reenrollments occur within 6 months after transitioning. (families with no contact) In 2025, **14%** of all CMOs transitioned youth had reenrollments occur within 6 months after transitioning.	**At or below state average** **Yes = Green** **No= Red** **PRIORITY: HIGH**
At least 80% of youth with I/DD diagnoses will be successfully linked to DD eligibility through CSOC. *Standard 1.M.8 (Service Access)*	**Metrics:** Power BI (Cyber DiagTreatPlans/ CMO Dashboard; DD Eligible Population) **Measured**: Monthly **Applied To:** Care Management	Supervisors will work with the I/DD team liaison to facilitate DD eligibility application submission. Care Managers and Supervisors will work as the I/DD partner to facilitate DD eligibility application submission.	**Care Management Operations: Care Managers, Care Manager Supervisors, Operations Managers, Director of Operations & I/DD Teams, Resource Team**	Family choice to not apply. Lack of access to timely evaluations or assessments.	**57%** of youth with I/DD diagnoses have obtained DD eligibility.	**60%** of youth with I/DD diagnoses have obtained DD eligibility.	**70%** of youth with I/DD diagnosis will be successfully linked to DD eligibility. **≥ 70% = Green** **64% - 69% = Yellow** **< 53% from Target = Red** **PRIORITY: HIGH**

PFKF will work to keep at least 90% of youth in their home and community. *Standard 1.M.7 Resources used to achieve results for persons served (Efficiency)*	**Metrics:** Cyber CMO Dashboard; OOH Population, Power BI & OOH Report **Measured**: Quarterly **Applied To:** Care Management	When youth are in an OOH treatment facility, Care Managers will ensure conversations about transition homes occur at every meeting. Care Managers will ensure the plan is revised on a regular basis if progress is not being made. CFT will exhaust all community-based resources before moving to OOH treatment referral.	**Care Management Operations: Care Managers, Care Manager Supervisors, Operation Managers, Director of Operations & Quality Assurance**	Court Ordered OOH treatment. Permanency needs. Despite community-based support youth has intensive treatment needs that impact ability to succeed at home, in school and in the community. Increasing number of I/DD youth with persistent needs requiring OOH. Average length of stay in a Behavioral Health or Substance Abuse OOH treatment setting is 17 months.	As of July 2024-June 2025, **94%** of youth enrolled are in the community.	As of July 2025-June 2026, **94%** of youth enrolled are in the community.	**90%** of youth in their home and community. **≥ 90% = Green** **84% - 89% = Yellow** **< 83% from Target = Red** **PRIORITY: HIGH**

At least 95% of families (active and transitioned) will indicate that they are satisfied or very satisfied with the services provided to them by PFKF. *Standard 1.M.5 Feedback from persons served.*	**Metrics:** Family Satisfaction Active Youth Surveys Transition Survey Post Transition Survey **Measured**: Yearly **Applied To:** Youth & Families	Once a year, Surveys will be automatically sent to active families that have been enrolled for 1 year or more. Families are surveyed, 6 months post transition. Families are surveyed at the time of transition. Feedback (positive and negative) will be shared to improve practice and recognize staff. Provider surveys are also conducted yearly. Families are surveyed using these scales. 1= Strongly Agree 2= Agree 3=Neither Agree nor Disagree 4= Disagree 5=Strongly disagree	**Quality Assurance; Quality Assurance Director, Quality Assurance Manager, Quality Assurance Specialist & Program Coordinators**	Caregiver and Youth completion of survey.	**91%** of Caregivers and **96%** of Youth surveys completed had given a score of 4 or 5 for overall satisfaction rating with PFKF services from Family Satisfaction surveys (Caregiver response 321, youth response 91). **99%** of the Responses that were "All of the time" and "Most of the time" were represented in the Transition Survey (2024-2025). Post transition survey **41** Caregiver and **18** youth responses completed since July 2024. **95% overall percentage.** **Increased by 3% from previous year.**	**93%** of Caregivers and **87%** of Youth surveys completed had given a score of 4 or 5 for overall satisfaction rating with PFKF services from Family Satisfaction surveys (Caregiver response 210, youth response 23). **98%** of the Responses that were "All of the time" and "Most of the time" were represented in the Transition Survey (2025-2026). Post transition survey **70** Caregiver and **21** youth responses completed since July 2025. **93% overall percentage.**	At least **95%** of families will indicate that they are satisfied or very satisfied with the services provided to them by PFKF. **≥ 95% = Green** **89% - 94% = Yellow** **<88% from Target = Red** **PRIORITY: HIGH**

Standard, Domain & Objective	Indicators, & Data Source	Implementation Strategies	Person (s) Responsible	Identified Barriers	Contact Year (CY) 2024/2025	Contact Year (CY) 2025/2026	Target & Priority
PFKF will score at or above the state average on benchmarked family satisfaction measures. *Standard 1.M.5 Feedback from persons served.*	**Metrics:** Active and Transitioned Family Satisfaction Surveys State Report of Family Satisfaction Surveys **Measured**: Yearly **Applied To:** Youth and Families	Participating Care Management Organizations throughout the state will share data at regular intervals. State data will be compared with PFKF agency data.	**Quality Assurance Director, Quality Assurance Manager, Quality Assurance Specialist & Program Coordinators**	Consistent and timely collection of data among CMOs.	**Caregiver survey PFKF/State** Question 1. **98%** / 95% Question 2. **99%** / 96% Question 3. **97%** / 95% Question 4. **98%** / 95% Question 5. **97%** / 90% Question 6. **97%** / 93% **Youth survey PFKF/State** Question 1. **100%** / 96% Question 2. **100%**/ 96% Question 3. **99%** / 94% Question 4. **100%**/ 93% Question 5. **100%**/ 91% Question 6. **99%**/ 93%	**Caregiver survey PFKF/State** Question 1. 99% / 95% Question 2. 99% / 94% Question 3. 99% / 96% Question 4. 99% / 93% Question 5. 98% / 95% Question 6. 98% / 93% **Youth survey PFKF/State** Question 1. 87% / 95% Question 2. 92% / 95% Question 3. 99% / 92% Question 4. 100% / 94% Question 5. 100% / 92% Question 6. 97% / 92%	At or above the state average. **≥ State average = Green** **-5% State average = Yellow** **< -6% from State average = Red** **PRIORITY: MEDIUM**

Partners for Kids and Families 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 & Power BI **Measured**: Monthly **Applied To:** Care Management	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 in person or remotely with the family within 72 hours. Supervisors will review plans within 48 hours of receiving them and submit them to PerformCare for approval.	**Care Management Operations: Care Managers, Care Manager Supervisors, Operation Managers, Director of Operations & Quality Assurance**	Family requesting delay in scheduling CFT meeting (family choice).	PFKF average service plan compliance rate: **78%** Statewide CMO average service plan compliance rate: **73%**	PFKF average service plan compliance rate: **78%** Statewide CMO average service plan compliance rate: **74%**	At or above the state average. **Yes = Green** **No = Red** **PRIORITY: HIGH**

PFKF will review the agency's Cultural, Linguistic, and Diversity-related Accessibility Plan. *Standard 1.M.8 (Service access)* ***New in 2025- 2026**	**Metrics:** Cyber & Demographics report **Measured**: Annual **Applied To:** Care Management	Annual Data Collection occurs from July 1-September 1 of each year. Results are reviewed with Leadership and the Quality Assurance Committee.	**Quality Assurance Team & Care Management**	Available demographic information may be incomplete, and cultural or linguistic barriers may not always be consistently identified or tracked due to limitations in CYBER.	N/A New This Year	Missing Race: **41** Missing Ethnicity: **53** Missing Language: **0**	**Completed=Green** **In Progress=Yellow** **Not Completed=Red**
(a)PFKF will ensure 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 & Power BI **Measured**: Monthly **Applied To:** Care Management	TISPs will be submitted to the Operation Managers for Review and immediately forwarded to the Quality Assurance Specialist.	**Care Management Operation; Care Managers, Care Manager Supervisor, Operations Managers, Director of Operations & Quality Assurance Team**	Multiple layers of processing required for review, tracking and billing safeguard for monthly transitioned youth. Family requesting delay in scheduling CFT meeting (Family Choice).	PFKF average TISP submission rate: **78%** Statewide average TISP submission rate: **80%**	PFKF average TISP submission rate: **80%** Statewide average TISP submission rate: **80%**	At or above the state average. **Yes = Green** **No = Red** **PRIORITY: HIGH**

(b) PFKF will show improvement in its Monthly Record Analysis audit 'Score'. *Standard 1.M.7 Resources used to achieve results for the people served (Efficiency)*	**Metrics:** Record Reviews; Monthly Record Analysis **Measured**: Monthly **Applied To:** Care Management	Quality Assurance Team to complete the Monthly Record Review. The Quality Assurance Director and the Director of Operation will implement agreed upon improvement strategies for areas identified.	**Care Management Operations: Care Managers, Care Manager Supervisor, Operation Managers, Director of Operations & Quality Assurance**	Timely submission of plans to CSA. Initial meeting timeframes due to scheduling meeting conflicts. Incomplete consent forms.	**84%** of Chart audits reviewed met the goal of **75%** or above record completion. Top areas that need improvement found in the Record Reviews for Cyber and Global Search include: **35%** of CFT's are held within 75 days (The state requirement is every 90 days. We set a standard of every 75 days) of each other with ISP's submitted to the CSA within 7 days. **23%** of youth are seen within 72 hours of enrollment.	**74%** of Chart audits reviewed met the goal of **75%** or above record completion. Top areas that need improvement found in the Record Reviews for Cyber and Global Search include: **43%** of CFT's are held within 75 days (The state requirement is every 90 days. We set a standard of every 75 days) of each other with ISP's submitted to the CSA within 7 days. **26%** of youth are seen within 72 hours of enrollment.	Goal of **75%** of chart audits reviewed meet the goal of **75%** record completion. **≥ 75% = Green** **69% - 74% = Yellow** **<68% from Target = Red** **PRIORITY: HIGH**

(c) Initial consent forms will be signed and uploaded into global no later than 7 days of receiving the referral. *Standard 1.M.7 Resources used to achieve results for the people served (Efficiency)*	**Metrics:** Record Reviews: Monthly Record Analysis & Power Bi **Measured**: Monthly **Applied To:** Care Management	Initial Face-to-Face is scheduled within 72 hours of referral, and forms are completed at that time. E-forms are automatically uploaded into Global, and paper forms are filed by the Administrative Team within three days.	**Care Management Operations: Care Managers, Care Manager Supervisor, Operation Managers & Director of Operations, Quality Assurance**	Consistency in communication from orientation to individual supervision. Will be creating a process to track the 7-day time frame for uploaded forms.	Email and Text- **91%** ROI- **91%** Rights of Children Served **92%** HIPAA- **91%** Telehealth- **82%**	Email and Text- **93%** ROI- **80%** Rights of Children Served- **95%** HIPAA- **93%** Telehealth- **93%**	The goal of **95%** initial consent forms will be signed and uploaded into global. **≥ 95% =Green** **80% - 94%=Yellow** **<80% from Target=Red** **(PRIORITY: HIGH)**
(d) At least 95% of interpretive summaries will be completed within 30 days of enrollment. *Standard 1.M.7 Resources used to achieve results for the people served (Efficiency)*	**Metrics**: Interpretive Summary & Power BI Report **Measured**: Annually (*in 2026 this is be measured monthly) **Applied To:** Care Management	Upon receiving a new referral through CSA, the CSA progress note will be utilized by the Operations Administrator to complete the interpretive summary and upload into Global Search.	**Care Management Operations: Care Managers, Care Manager Supervisor, Operation Managers, Operation Administrator & Director of Operations**	When transitioned youth returns within 30 days of transition and no new interpretive summary is created.	**85.08%** of interpretive summaries were completed within 30 days of enrollment, or youth re-enrolled within 30 days of transitioning.	**93.65%** of interpretive summaries were completed within 30 days of enrollment, or youth re-enrolled within 30 days of transitioning.	**95%** of interpretive summaries will be completed with 30 days of enrollment. **≥ 95% =Green** **89% - 94%=Yellow** **<88% =Red** **PRIORITY: HIGH**
(e) 95% of Signature Sheets for ISP and	**Metrics**: Report from	Signature sheets are signed after	**Quality Assurance**	Technical Issues & Inaccurate data	Overall matches **79%** ISP matches **81%**	Overall matches **95%** ISP matches **96%**	**95%** of Signature Sheets for ISP and

face to face meetings will be submitted and uploaded into CYBER and global. *Standard 1.M.7 Resources used to achieve results for the people served (Efficiency)*	Global and Cyber **Measured**: Twice a week **Applied To:** Care Management	CFT and Face to face meetings. The administrative team uploads the form from Global into CYBER	**Director, Quality Assurance Manager, Quality Assurance Specialist & Program Coordinators**		Face to Face is **71%**	Face to Face is **95%**	face to face meetings will be submitted and uploaded into CYBER and global. **≥ 95% =Green** **89% - 94%=Yellow** **<88% from Target=Red** **PRIORITY: HIGH**

1. Desired Outcome: Implement all regulatory mandates and fulfill contractual obligations
2. Desired Outcome: Continue to implement Partners for Kids and Families Corporate Compliance Plan and Code of Conduct.

Compliance Goal: Partners for Kids and Families will ensure that all operational areas are 100% compliance with federal, state, and local statutory and regulatory requirements (including Medicaid, HIPAA, & Labor Laws) as well as conformance with CARF Accreditation Standards.							
Standard, Domain & Objective	Indicators, & Data Source	Implementation Strategies	Person (s) Responsible	Identified Barriers	Contract Year (CY) 2024/2025	Contract Year (CY) 2025/2026	Target & Priority Level

(a) PFKF will revise and update its employee handbook and ensure that policies and procedures are up to date and in compliance with appropriate standards. *Standard 1.M.9 (Business Functions)*	**Metrics**: Employee Handbook **Measured**: Annually **Applied To:** Care Management	A yearly review of policies and procedures will occur to ensure all are up to date.	**Executive Director, Corporate Compliance Officer & Human Resource Director**	System changes that impact internal procedures and policies.	Procedure for Annual Review of Policies and Procedures Document: Employee Handbook Last Review Date: 01/10/2025 Next Scheduled Review: 01/09/2026 .	Procedure for Annual Review of Policies and Procedures Document: Employee Handbook Last Review Date: 01/09/2026 Next Scheduled Review: 01/08/2027 .	All policies and procedures reviewed and signed yearly. **Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**

(b) On average, PFKF will bill for at least 95% of enrolled youth. *Standard 1.M.9 (Business Functions)*	**Metrics**: Progress Note Data; SharePoint, Monthly Record Analysis, Billing Analysis, Progress Note Data. Billing Analysis, Progress Note Data. **Measured**: Monthly **Applied To:** Care Management	Program Coordinators and Quality Assurance Team reviews monthly Care Management Activities as a safeguard for billing errors and to determine billing for the previous month. Sometimes the Program Coordinators meet with the Quality Assurance Manager, Quality Assurance Director and or the Executive Director and Director of Operations.	**Care Manager, Quality Assurance; Quality Assurance Analyst, Quality Assurance Manager, Quality Assurance Director, Program Coordinators, Accounting Administrator & Finance Director**	Reasons unable to bill: Timeframe, note type, note content, missing contact, missing duration and no documentation. Delays due to extenuating circumstances with families. Family declines completing the Medicaid application. No Authorization Number.	Billed for **96%** of youth.	Billed for **96.75%** of youth.	Billing goal: **95%** of youth **≥ 95% = Green** **89% - 94% = Yellow** **<88% from Target = Red** **PRIORITY: HIGH**
(c) PFKF will ensure compliance in Medicaid billing procedures. *Standard 1.M.9 (Business Functions)*	**Metrics**: Cyber Report, Global & Power BI **Measured**: Monthly **Applied To:** Quality Assurance	Program Coordinators and Quality Assurance Specialist complete monthly record and billing audits. Audit results are reviewed by Operations Managers.	**Quality Assurance; Quality Assurance Manager, Quality Assurance Director Program Coordinators Finance Director & Accounting Administrator**	Some billings were recalled this contract year.	Monthly chart/billing audits completed with no issues.	Monthly chart/billing audits completed with no issues.	No identified issues and/or identified issues rectified. **Completed = Green** **In Progress = Yellow** **Not Completed = Red** **PRIORITY: HIGH**

(d) PFKF will complete quarterly PERM audits & Quality proactive record audits to monitor compliance in Medicaid billing procedures & fraud prevention. Standard *Standard 1.M.9 (Business Functions)*	**Metrics:** EZ Claim Billing Report & Monthly Billing Process **Quarterly:** Medicaid Audit, Proactive Medicaid Audit Measured: Monthly & Quarterly **Applied To:** Quality Assurance	Quality Assurance Specialist randomly selects 30 youth (24 active and 6 transition) Quarterly and submits it to the finance Director for audit.	**Finance Director**	None at this time	Quarterly audits completed with no issues identified.	Quarterly audits completed. One missed billing from February 2026 was identified and submitted for payment after finding.	Quarterly PERM audits will be completed. **Completed = Green** **In Progress = Yellow** **Not Completed = Red** **PRIORITY: HIGH**
(e) PFKF will review the CARF CYS (Child and Youth Services) Standards Manual annually to assess for conformance to existing and updated standards. Standard 1.M.9 (Business Functions)	**Metrics**: Annual Review of updated Manual **Measured**: Annually **Applied To:** Directors	Establishment of a comprehensive process that remains individualized and functional.	**Executive Director, Director of Administration and IT and Director of Quality Assurance and Corporate Compliance Officer, Finance Director, Human Resource Director, Community Resource Director**		PFKF continues to review CARF CYS Standards annually to maintain conformance to existing and updated standards.	FKF continues to review CARF CYS Standards annually to maintain conformance to existing and updated standards.	CARF standards will be reviewed annually. **Completed = Green** **In Progress = Yellow** **Not Completed = Red** **PRIORITY: HIGH**

(f) 90% youth enrolled without Medicaid will complete the NJ Family Care application within 30 days. *Standard 1.M.8 (Service access)* Wendy	**Metrics**: Annual Review of updated Manual **Measured**: Monthly **Applied To:** Finance and Care Management	Upon enrollment Medicaid Specialist will review eligibility and communicate with CM staff. CMs will collaborate with Medicaid Specialist staff to ensure application is received at the initial FTF or initial CFT	**Medicaid Specialist, Care Manager Supervision, Care Manager.**	Delays in initial contact. Family does not complete the application.	92 % of youth enrolled with PFKF during CY 2024- 2025 completed the NJ Family Care application within 30 days.	91 % of youth enrolled with PFKF during CY 2025- 2026 completed the NJ Family Care application within 30 days.	**90%** of youth enrolled without Medicaid will complete the NJ Family Care application within 30 days. **≥ 90% = Green** **89% - 85% = Yellow** **<85% = Red** **PRIORITY: HIGH**
PFKF will ensure compliance in completion of DCF Unusual Incident Reports within the identified time frame. *Standard 1.M.7 Resources used to achieve results for the persons served (Efficiency)*	**Metrics**: SharePoint UIR data tracking **Measured**: Ongoing & Quarterly **Applied To:** Care Management Operations Quality Assurance (Q.A Director QA Specialist)	Care Managers and Supervisors will receive ongoing training on the UIR process. Care Managers or designee submits the UIR in a form on SharePoint.	**Quality Assurance; QA Director QA Specialist Care Management Operations Manager; Care Managers & Supervisors**	Continuous training on UIR codes	There were **125** UIRs submitted during CY 24-25. **53** PFKF employees submitted UIRs. Avg. # of days UIRs were submitted after being notified of incident was **0.5** days.	There were **78** UIRs submitted during CY 25-26. **43** PFKF employees submitted UIRs. Avg. # of days UIRs were submitted after being notified of incident was **1.41** days.	Level **A+** Incident UIR form completed immediately. Level **A** Incident from completed by end of workday Level **B** Incident by the end of the next workday. **UIRs submitted within 5 days or less** **>5 days = Green** **6-11 days = Yellow** **<12 days = Red** **PRIORITY: HIGH**

PFKF will review UIR submission trends and patterns quarterly to inform training curriculum. *Standard 1.M.7 Resources used to achieve results for the persons served (Efficiency)*	**Metrics**: SharePoint UIR data tracking State UIR report **Measured**: Ongoing & Quarterly **Applied To:** Care Management	**Quality Assurance Director, Quality Assurance Specialist and Quality Manager will review internal UIR submission**	Quality Assurance; Quality Assurance Director, Quality Assurance Specialist & Care Management Operations; Care Managers & Care Manager Supervisors	None at this time	The most common Incident Types reported were Elopement (**39** Incidents), Abuse (**28** incidents), Suicide Attempts (**28** incidents). Of the Levels reported, **40** were A+ Levels (the highest level), **28** were A Levels **84** were B Levels Level U (unknown) was entered **12** times by staff (*Note – for some UIRs there were more than one Incident Types reported.). There were '**14**' youth that required 2 or more UIRs during the period reviewed.	The most common Incident Types reported were Elopement (**19** Incidents), Abuse (**12** incidents), Suicide Attempts (**21** incidents). Of the Levels reported, **17** were A+ Levels (the highest level), **10** were A Levels **44** were B Levels Level U (unknown) was entered **7** times by staff (*Note – for some UIRs there were more than one Incident Types reported.). There were '**4**' youth that required 2 or more UIRs during the period reviewed.	UIR reviewed and utilized training curriculum **Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**

(a) PFKF will conduct a HIPAA annual security risk assessment to identify opportunities for security enhancement. *Standard 1.M.9 (Business Functions)*	**Metrics**: Risk Assessment Plan **Measured**: Yearly **Applied To:** Administrative Team **Areas of risk for breach**: Agency cell phones, Use of emails, Paper documents containing PHI taken out of the office, Agency laptops/Tablets, Agency server, Working from home, Videoconference with families via TEAMS or Zoom, Public access to the building; unauthorized access to building or PHI, Administrative functions, Access to and release of information, Use of social media, Property damage and natural disasters, Disposal of office equipment, Use of thumb drives or other portable storage devices, Electronic versions of PFKF forms.	Directors will review recommendations and changes will be implemented. An Annual HIPAA security Risk Assessment will be conducted. Additional assessments may occur based upon need.	**Executive Director, Director of Care Management , Director of Administration /IT & HIPAA Privacy Officer**	None identified	HIPAA annual security risk assessment to identify opportunities for security enhancement completed in February 2025.	HIPAA annual security risk assessment to identify opportunities for security enhancement completed in February 2026.	An annual risk assessment is conducted with members of management. PFKF is determined to be at "Moderate" for HIPAA breach. The Director of Quality Assurance and Corporate Compliance Officer conduct an annual HIPAA training for all Staff which includes privacy practices in the workplace. **Completed = Green** **In Progress = Yellow** **Not Completed =** **Red** **PRIORITY: HIGH**

(b) PFKF 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 **Applied To:** Human Resource Team & Quality Assurance Team	Director of Corporate Compliance will conduct orientation regarding Corporate Compliance. Yearly training will occur with all staff regarding Medicaid waste, abuse, and fraud and other aspects of compliance.	**Quality Assurance Specialist conducts the orientation training.** **The Director of Corporate Compliance Officer conducts the training Annually & ongoing**	None identified	PFKF continued to incorporate corporate compliance as a key component of orientation process. Corporate Compliance Week will start this year. 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.	PFKF continued to incorporate corporate compliance as a key component of orientation process. Corporate Compliance Week will start this year. 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.	PFKF will provide training on Corporate Compliance during orientation and annually for all staff. **Completed = Green** **In Progress = Yellow** **Not Completed = Red** **PRIORITY: HIGH**

(c) PFKF will maintain compliance with HIPAA privacy and security and investigate any/all reports of potential breaches. *Standard 1.M.9 (Business Functions)*	**Metrics:** HIPAA Log; Audits A log is kept of any potential HIPAA violations, report sent to Privacy Officer/ Legal Specialist Office of legal Affairs DCF **Measured:** Annually & Ongoing **Applied To:** Quality Assurance	The HIPAA Privacy Officer keeps a log of HIPAA violations and Quality Assurance Team members conduct random audits. Breaches will be addressed and reported as per guidelines.	**Director of Quality Assurance and Corporate Compliance Officer, Quality Assurance Manager and Quality Assurance Specialist**	None identified	There were **'8'** HIPAA and security incidents during the Contract Year. All incidents were deemed a "low risk" HIPAA breach. Incidents included email errors and plans sent to the wrong family. All violations were rectified.	There were **'8'** HIPAA and security incidents during the Contract Year. All incidents were deemed a "low risk" HIPAA breach. Incidents included email errors, plans sent to the wrong family, and a text thread with an unintended recipient. All violations were rectified.	No identified issues and/or identified issues are rectified. **No Identified Issues and/or Identified Issues Rectified = Green** **Issues identified and pending = Yellow** **Issues identified and not rectified = Red** **PRIORITY: HIGH**
(c) All staff will attest to the Code of Conduct annually. *Standard 1.M.9 (Business Functions)*	**Metrics**: Code of Conduct Attestation in Paychex **Measured**: Annually **Applied To:** Quality Assurance Team All Staff	The Executive Director will review and update the Code of Conduct to ensure all elements of the standards are included. The code will be reviewed by the board of trustees, and once approved, all staff will receive and attest to the code.	**Executive Director, Director of Quality Assurance and Corporate Compliance Officer**	None Identified	Executive Director facilitated Code of Conduct presentation 5/16/25. Policy emailed and staff acknowledged in Paychex 5/28/2025.	Follow up with Mike for 2026 review	**Completed = Green** **In Progress = Yellow** **Not Completed = Red**

							PRIORITY: HIGH
(e) PFKF will complete an annual review of the Risk Management plan. *Standard 1.M.9 (Business Functions)*	**Metrics**: Risk Management Plan **Measured**: Annually **Applied To:** All Staff	The Executive Director will review this plan with the Health and Safety committee annually.	**Executive Director, Director of Quality Assurance and Corporate Compliance Officer, Quality Assurance Specialist and Health and Safey Committee**	None Identified	Risk Management plan reviewed on April 15, 2025.	Risk Management plan reviewed on October 20, 2026.	Risk Management plan reviewed annually. **Completed = Green** **InProgress = Yellow** **Not Completed = Red**
PFKF will review and complete the Corporate Compliance Annual Work Plan. *Standard 1.M.9 (Business Functions)*	**Metrics**: Policy Review, Corporate Compliance Annual Work Plan **Measured**: Annually **Applied To:** Cathy Medlar Enma White Sarah Grant	The Director of Quality Assurance and Corporate Compliance Officer will review this plan annually. .	**Director of Administration and IT, Director of Quality Assurance and Corporate Compliance Officer, Human Resource Director and Finance Director**	None Identified	New This Year	Will be done by the time this plan is reviewed	**Completed = Green** **InProgress = Yellow** **Not Completed = Red**

1. Desired Outcome: Partners for Kids and Families will maintain high performance standards, offer comprehensive orientation and training, and provide clear expectations for job responsibilities with staff to achieve operational excellence.
2. Desired Outcome: Partners for Kids and families will maintain a safe and productive workplace with a strong focus on workforce retention and employee Satisfaction.

Workforce Goals: Partners for Kids and Families will attract, develop, and retain a motivated, satisfied, and well-qualified workforce.							
Standard, Domain & Objective	Indicators, & Data Source	Implementation Strategies	Person (s) Responsible	Identified Barriers	Contract Year (CY) 2025/2026	Contract Year (CY) 2025/2026	Target & Priority
PFKF aims to have the Care Manager to youth at a ratio of 1:14 /15 *Standard 1.M.9 (Business Functions)*	**Metrics**: Power Bi Finance Director Report Cyber **Measured**: Ongoing & Monthly **Applied To:** All Program	Daily Youth assignment meeting. We monitor our agency census and staffing needs during our weekly PFKF Directors meeting and hire as needed.	**Director of Operations, Finance Director, Quality Assurance Director, Human Resources Director**	Staff on leave – Scheduled or unscheduled. (PTO, medical, NJFLA) Staff turnover – resignations, terminations, retirements	1:14/15 *Recruitment is ongoing, we have hired 8 Care Managers during the 2024 – 2025 contract year	1:14/15 Recruitment is ongoing, we have hired 10 Care Managers during the 2025 – 2026 contract year	**1:14/15** ratio for youth **14/15=Green** **16/17=Yellow** **<18=Red** **PRIORITY: HIGH**

98% of staff will complete the required annual training. *Standard 1.M.9 (Business Functions)*	**Metrics**: Relias Training Report Paychex Acknowledgement **Measured**: Annually **Applied To:** All Program	The annual Training curriculum will be housed on SharePoint and in Relias. Relias and Paychex reminders. 2025 All training (Paychex, Live, Relias, Staff Meetings) to be updated in Relias, Reports in Relias can capture all training in one location. The HR Administrator will help with this strategy. Reminders to all staff to not wait until the end of the year to complete training.	**Supervisors, Human Resources Director / HR Administrator**	Competing priorities when youth assignments are high. Collecting attendance sheet after training. Staff are required to have all their training done by the end of the year. Staff on leave	**65.3%** Completed Trainings in Relias. Supervisor training and reminders to check Relias for uncompleted training.	100% complete Relias trainings 2025 90% Completed Annual Trainings Reminders from Supervisor and follow up on uncompleted training.	**Completed = Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**
100% of new staff will complete orientation within 90 days of hire and a copy will be provided of the orientation and training plans to HR. *Standard 1.M.9 (Business Functions)*	**Metrics**: Square 9 Filing system **Measured**: Ongoing & Monthly **Applied To:** All Program	Orientation and Job Specific training plans were created in March of 2022 for all incoming staff. Copies of orientation & training plans will be submitted by supervisor with an employee's 90-day performance appraisal. This information is also updated in Relias for 2024-2025.	**Supervisors, Human Resources Director**	Collecting all Signature sheets during orientation. Prioritizing training curriculum for 90-day yearly appraisal.	100% completion of new staff orientation within 90 days of hire for 2024-2025 review period.	100% completion of new staff orientation within 90-days of hire for 2025-2026 review period.	**≥ 100% =Green** **94% - 99%=Yellow** **<93% from Target=Red** **PRIORITY: HIGH**

PFKF will monitor the effectiveness and efficiency of the newly revised and updated Performance Evaluations. *Standard 1.M.9 (Business Functions)*	**Metrics**: Performance Appraisal **Measured**: Ongoing **Applied To:** All Program	All supervisors have been trained on the Performance Appraisal form. Performance appraisal must be reviewed and approved before being reviewed by the employee.	**All Supervisors**	Continued training and support are provided to emphasize the importance of the performance reviews and to ensure staff are confident and effective in using the performance review to its fullest potential.	Partners continues to use the current Performance Appraisal system. Job description is also reviewed during the annual review. The adding of electronic signature has helped for full WFH staff.	Partners continues to use the current Performance Appraisal system. Job description is also reviewed during the annual review.	All Supervisors will utilize the newly developed form for their employees' Performance Appraisal. **Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**
100% of active employees will have current performance reviews completed according to agency timelines (90-day and Annual). *Standard 1.M.9 (Business Functions)*	**Metrics**: Square 9 Filing system HR reports **Measured**: Ongoing **Applied To:** All Program	90- day and yearly performance appraisal will be completed by Supervisors. To support timely completion of performance reviews, the HR Director will send out reminders to staff prior to upcoming due dates. In addition, Directors and Managers are expected to follow up with their teams to ensure reviews are completed on time. If a review remains incomplete after 90 days, an email will be sent to the responsible	**All Supervisors** **Human Resources Director**	Staff on Leave. Scheduling conflict.	Partners achieved a 89.6% on-time completion rate for annual and 90-day performance appraisals during the 2024-2025 review period. .	Partners achieved a 92% on-time completion rate for annual and 90-day performance appraisals during the 2025-2026 review period.	All staff will have a yearly Performance Appraisal completed. **≥ 100% =Green** **94% - 99%=Yellow** **<93% from Target=Red** **PRIORITY: HIGH**

		supervisor, as well as their direct supervisor, to reinforce accountability and prompt immediate action. **Reminder at first staff meeting in January 2025.**					

PFKF will maintain a 90% or above employee retention rate. *Standard 1.M.9 (Business Functions)*	**Metrics**: HR Reports Paychex **Measured**: Ongoing & Annually **Applied To:** All Program	Continuing review of Employee Satisfaction Survey. Exit interviews will be shared with the corresponding team(s). A debrief will be done if necessary. The Finance Director, Executive Director and Board will continue to review the Benefits package. Feedback from Quality Assurance Committee. Open door policy.	**Management Team** **Human Resources Director**	None Identified	Retention Rate for 2024-2025 is **92.5%**	Retention Rate for 2025-2026 is **94.2%**	**90%** or Above **≥ 90% =Green** **84% - 89%=Yellow** **<83% from Target=Red** **PRIORITY: HIGH**
PFKF will maintain a Health and Safety committee to spearhead wellness and safety initiatives for the agency. *Standard 1.M.9 (Business Functions)*	**Metrics**: Health and Safety Committee Meeting Minutes **Measured**: Monthly **Applied To:** All Program	PFKF will provide training on safety in the workplace. External Health/Safety Inspections will occur based upon regulatory requirements.	**Health and Safety committee** **Office Managers and Director of Administration/IT**	None Identified	All health and safety plans were reviewed and updated.	All health and safety plans were reviewed and updated.	Monthly meeting from January till October. Yearly Trainings. **Completed=Green** **In Progress=Yellow** **Not Completed=Red** **PRIORITY: HIGH**

Partners for Kids and Families will continue to implement established strategic plan. *Standard 1.M.9 (Business Functions)*	**Metrics**: Strategic Plan **Measured**: Ongoing & Annually **Applied To:** All Program	Annual Review of the plan by the board and staff. Continue to have strategic plan items included on leadership & Board agendas.	**All Directors**	None Identified	PFKF completed a full review of its strategic plan progress with the leadership team in February of 2025. The plan was approved by the Board of Trustees and Operationalized with timeframes and assignments.	PFKF completed a full review of its strategic plan progress with the leadership team in October of 2026. Looking to make a one-page version of the plan.	**PRIORITY: HIGH**

PFKF fosters a workplace that prioritizes health and safety both in the office and in the community, with a commitment to full compliance and a goal of maintaining zero OSHA violations. *Standard 1.M.9 (Business Functions)*	**Metrics:** HR Tracking Data **Measured:** Annually **Applied To:** All Program	PFKF will provide training on safety in the workplace. Additional trainings are conducted based on safety trends and patterns. External health/safety inspections are conducted based upon regulatory requirements.	**Director of Quality Assurance and Corporate Compliance Officer, Human Resource Director, Quality Assurance Specialist and Health and Safety Team**	None	OSHA 0 reportable accidents occurred during CY 2024 – 2025 Severity: 0 (nothing was reportable to OSHA) Medical Treatment: Yes (1) Lost Time: Yes (1)	OSHA 0 reportable accidents occurred during CY 2025 – 2026 Severity: 0	0 = Grean ≤ 2 = Yellow > 3 = Red **PRIORITY: HIGH**