Performance and Quality Improvement

Annual Impact Plan & Report

Fiscal Year 2023-2024

OUR MISSION

Providing nurturing care and life-changing services for youth and families in need.

OUR VISION

To be a community leader that exceeds industry standards of care, pursues innovative practices, and equips youth and families to achieve healthy independence and sustainable success.

The Children's Attention Home is a 501(c)3, tax exempt organization, Federal ID: 57-0527092.
attentionhome.org • 803-328-8871 • P.O. Box 2912, Rock Hill, SC 29732 • @childrensattentionhome

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About the Children's Attention Home

Established in 1970 by the community and for the community, the Children's Attention Home has served nearly 9,000 children through its residential program. Today, the Home serves up to 40 youth and young adults daily, providing comprehensive care through both its residential and day services programs. From providing basic needs, medical and mental healthcare to educational support, workforce preparedness, and life skill training, each child receives individualized support as they pursue their goals and aspirations.

PQI Program Overview

The Performance and Quality Improvement Program (PQI) at the Children's Attention Home is a structured system of processes to help measure and improve overall organizational health, using data to compare actual performance to clearly defined goals. By tracking and aggregating data and setting specific outcome-based goals, the Home is able to impact overall quality in line with strategic goals and objectives of the organization. To read the full plan, refer to the Children's Attention Home's PQI Plan.

Stakeholder Involvement

Stakeholder involvement and feedback is instrumental to the development and implementation of the PQI process. CAH defines stakeholders as any person, group, or organization that has a vested interest in the services provided by the organization. CAH's key stakeholders share the aspirations to achieve organizational excellence. CAH teammates and board members play vital roles in the PQI success, and new teammates are introduced to the PQI during orientation.

CAH organizational stakeholders include:

- Program Participants
- Board of Directors
- Director Team
- CAH Teammates
- Volunteers
- Community Partners
- Funders/Major Donors

Impact Report Overview

This impact report consists of the annual PQI plan and progress tracking throughout the year. Information is updated throughout the year to provide progress reports and identify opportunities for improvement. The main sections of this report include:

Program Outputs: This section provides an overview of key metrics of program productivity. While these numbers do not show programmatic improvement or change, these indicators provide valuable information understanding the scope of service provided by the Children's Attention Home.

Performance & Quality Improvement Scorecard: This section provides a summary snapshot of the program outcome goals and progress. Further detail for each outcome is provided in the Program Outcomes section.

Program Outcomes: This section provides expanded information on sustainable change that is being achieved across the organization. Specific goals in all areas of the organization are identified each year as opportunities for improvement. Data visualization, detailed information on these measurements, and notes for improvement are included in each section.

For questions about any information included in this report, please contact info@attentionhome.org.

Organizational Outputs

This section provides an overview of key metrics of program productivity. While these numbers do not show programmatic improvement or change, these indicators provide valuable information understanding the scope of service provided by the Children's Attention Home. These numbers are updated monthly, with quarterly updates indicated where appropriate.

Programs

Day Services Program

# of participants	# Days of Service	# Meals provided	# Mental Health appointments	# assistance with transportation	# Educational support
166	846	1692	58	29	53

All Residential Programs

	# of participants served	# of participants served in >1 program	# Days of Service
Total	62	9	7,619

Enhanced Care	Total
# of participants served	26
# Days of Service	2,491
Avg Length of Stay *(in days)*	96

Development Progression *(% of youth who reached various levels by tier)*	Level 1	Level 2	Level 3	Level 4
Tier 1- **Immediate Needs** *(food, clothing, etc.)*	100%			
Tier 2- **Basic Needs** *(med exams, birth certificate, social security card, etc.)*	100%	29%		
Tier 3- **Education** *(enrolling in school, college, tours, basic computer skills, etc.)*	88%	18%		
Tier 4- **Independent Living** *(coping skills, reading a recipe, using an alarm clock, etc.)*	88%	47%	6%	
Tier 5- **Employment** *(applying and maintaining a job, resume, career planning, etc.)*	29%	29%		
Tier 6- **Transitional** *(driver's license, credit, vehicle purchasing, apartment)*	12%			

Moderate Care	Total
# of participants served	15
# Days of Service	2,274
Avg Length of Stay *(in days)*	152

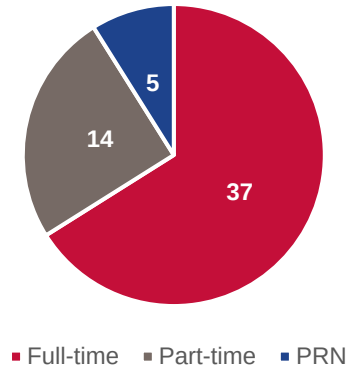
Development Progression *(% of youth who reached various levels by tier)*	Level 1	Level 2	Level 3	Level 4
Tier 1- **Immediate Needs** *(food, clothing, etc.)*	100%			
Tier 2- **Basic Needs** *(med exams, birth certificate, social security card, etc.)*	100%	31%		
Tier 3- **Education** *(enrolling in school, college, tours, basic computer skills, etc.)*	85%	8%		
Tier 4- **Independent Living** *(coping skills, reading a recipe, using an alarm clock, etc.)*	100%	62%		
Tier 5- **Employment** *(applying and maintaining a job, resume, career planning, etc.)*	15%	15%		
Tier 6- **Transitional** *(driver's license, credit, vehicle purchasing, apartment)*	15%			

Transitional Care	Total
# of participants served	21
# Days of Service	2,854
Avg Length of Stay *(in days)*	135

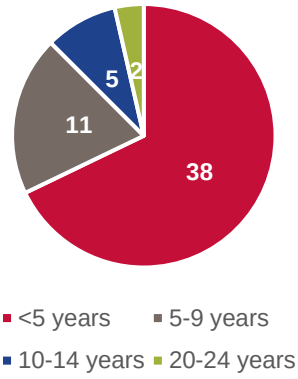
Development Progression *(% of youth who reached various levels by tier)*	Level 1	Level 2	Level 3	Level 4
Tier 1- **Immediate Needs** *(food, clothing, etc.)*	100%			
Tier 2- **Basic Needs** *(med exams, birth certificate, social security card, etc.)*	100%	83%		
Tier 3- **Education** *(enrolling in school, college, tours, basic computer skills, etc.)*	100%	44%	17%	
Tier 4- **Independent Living** *(coping skills, reading a recipe, using an alarm clock, etc.)*	100%	83%	33%	17%
Tier 5- **Employment** *(applying and maintaining a job, resume, career planning, etc.)*	100%	94%	28%	
Tier 6- **Transitional** *(driver's license, credit, vehicle purchasing, apartment)*	89%	17%	11%	

Teammates

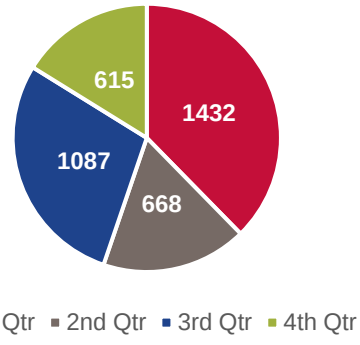
Employment Category



Employee Tenure



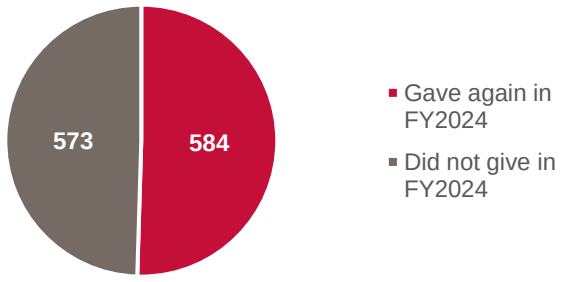
Training Hours
(Total: 3,802)



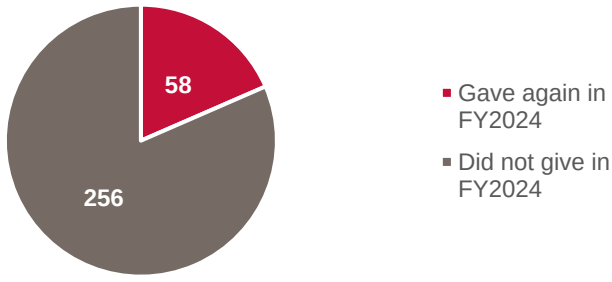
Community Outreach & Support

	Total	Speaking Engagements	Community Events	Campus Tours
# of events	**74**	32	18	24
# of people reached	**2715**	2081	482	151

Donor Retention Rate: 50.4%
Total Donors FY2023: 1,157
Total Donors FY2024: 1,097



First-time Donor Retention Rate: 18.5%
First-time Donors FY2023: 314
First-time Donors FY2024: 285



See annual and financial reports for additional info at attentionhome.org/annualreports.

Performance & Quality Improvement Scorecard

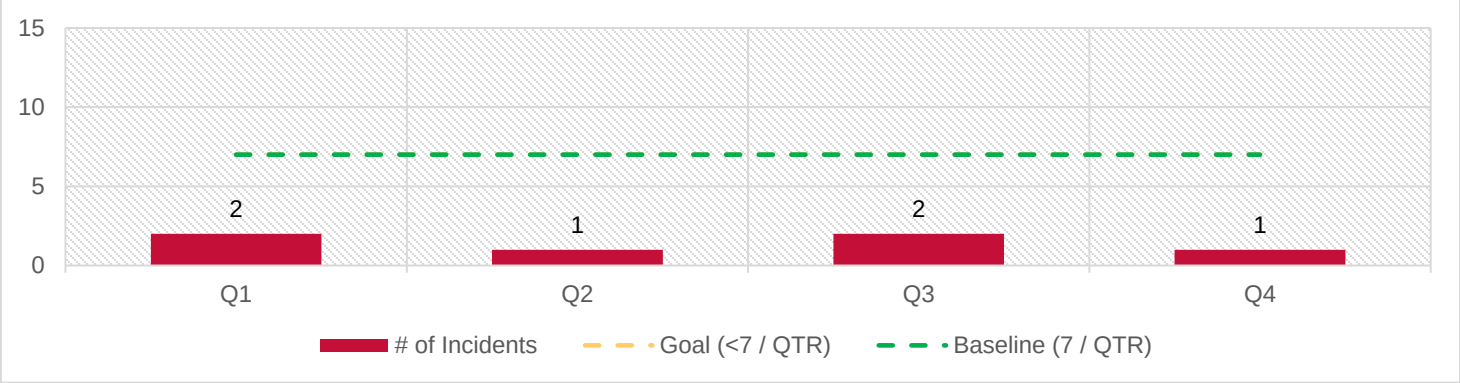
Quality Measure	Goal Statement	Baseline	Q1	Q2	Q3	Q4
Critical Incidents	Reduction in mental health incidents	7 per quarter (26 total for FY23)	2 (resulted in inpatient treatment)	1 (resulted in inpatient treatment)	2 (resulted in inpatient treatment)	1 (resulted in inpatient treatment)
Comprehensive Care Plan	80% of audited care plans will be in compliance	N/A	25% (4 /16)	38% (10/26)	39% (7/18)	50% (8/16)
Assessment Review Process	90% of eligible residents receive a CANS Assessment Review	70% (36/51 in FY 23)	62% (8/13)	32% (6/19)	74% (14/19)	33% (2/6)
Supervision	90% of supervision audits are compliant	N/A	83%	82%	67%	67%
Basic Needs, Day Services	80% of identified needs are met	N/A	37%	43%	86%	80%
Training	10% increase in provided trainings based on identified needs	93 per year (FY23)	54	40 (Total: 94)	56 (Total: 150)	39 (Total: 189)
Orientation	80% of new teammates complete full orientation process	65% (11/17 in FY23)	78% (7/9)	100% (2/2)	100% (4/4)	100% (8/8)
Facility Maintenance	10% increase in properly communicated maintenance requests	244 (FY23)	83	92 (Total: 175)	105 (Total: 280)	68 (Total: 348)
Supporter Stewardship	80% of first-time donors receive personalized follow up in 20 business days	16% thanked in 5 business days in FY23	Q1: 15% (4/26) Annual: 15% (4/26)	Q2: 61% (42/68) Annual: 49% (46/94)	76% (49/59) Annual: 62% (95/153)	Q4: 99% (64/65) Annual: 73% (159/218)
Board Attendance	80% of Board meetings and applicable committee meetings are attended by Board members	69% attendance at Board meetings in FY23	67%	82%	83%	78%
Board Giving	100% of Board members will individually contribute financially during the fiscal year*	76% (FY23)	38% (6/16)	66% (10/15)	93% (13/14)	100% (13/13)

Program Outcomes

This section provides expanded information on sustainable change that is being achieved across the organization. Specific goals in all areas of the organization are identified each year as opportunities for improvement. Data visualization, detailed information on these measurements, and notes for improvement are included in each section. Information for this section is updated on a quarterly or annual basis, depending on the nature of the measurement.

Critical Incidents

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Reduction in mental health incidents	7 per quarter (26 total for FY23)	2 (resulted in inpatient treatment)	1 (resulted in inpatient treatment)	2 (resulted in inpatient treatment)	1 (resulted in inpatient treatment)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Reduce the number of mental health incidents that result in emergency services.
2. The number of mental health critical incidents has reduced from previous years but still remained higher than desired. Due to changes in the program, the expectation is that more resources and training should result in prevention of critical incidents taking place.
3. Success will be determined by the number of mental health criticals resulting in emergency services being reduced.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Filled Clinical social worker position	ED	Staff	Jun ‘23	Aug ‘23	Hired and trained in Aug ‘23
Continue CARE implementation	ED / TC	Staff	Jul ‘23 – Jun ‘24	Jul ‘23 – Jun ‘24	Hosted three CARE TA visits; trained all new staff on CARE; developed CARE refreshers
Host grief and loss program for residents & staff training	SW / ED	Staff, paid facilitators	Jun ‘23 – Jun ‘24	Jun ‘23 – May ‘24	Hosted biweekly grief and loss groups for residents through May 2024; hosted monthly trainings for staff through Dec 2024
Host series of suicide prevention trainings (Q1)	TC	Staff, paid facilitators	Jun ’23 – Jul ‘23	Sept 30, ‘23	Hosted training series to equip staff to prevent suicidal and self-harm behaviors and incidents
Equip staff with mental health hotline (Q2)	DRS	Staff	Aug ‘23	Sept 30, ‘23	Worked with Catawba Mental Health to educate team on mental health hotline and other sources

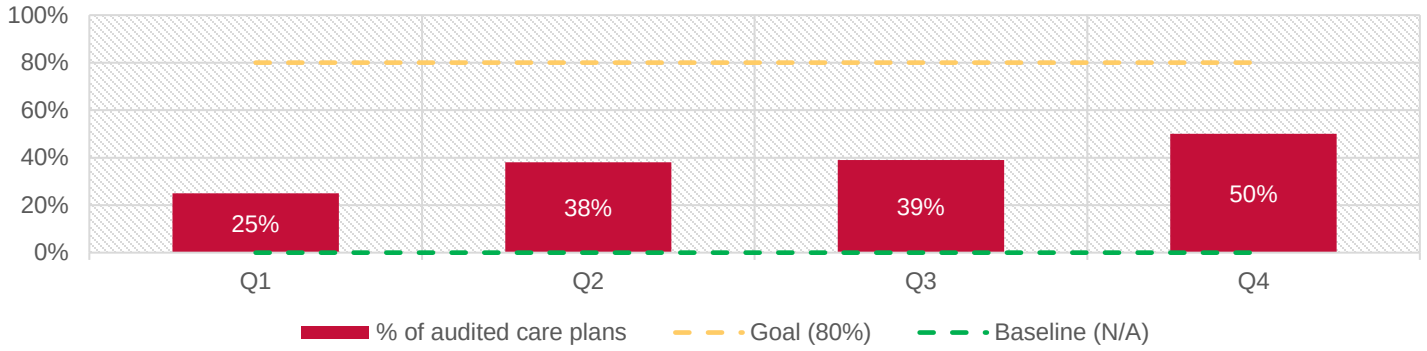
Host training for Holiday Awareness	SW	Staff	Nov, 2023	Nov, 2023	Social workers put together training to equip staff
Host mental health first aid training (Q2)	TC	Staff, paid facilitators	Dec 31, 2023	Nov, 2023	Hosted mental health first aid training for staff and open to community members

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Results indicate effectiveness in equipping staff to prevent mental health critical incidents requiring emergency services. Providing preventative resources, such as the mental health hotline, suicide prevention, and mental health first aid equipped staff to be prepared to support residents appropriately and as needed.
2. Finding training times that aligned with staff availability continues to be a challenge, which is under evaluation for the coming year.
3. Future trainings surrounding mental health related topics will be regularly incorporated into staff training plans as appropriate, including the continued implementation of the CARE program.

Comprehensive Care Plan

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of audited care plans will be in compliance	N/A	25% (4/16)	38% (10/26)	39% (7/18)	50% (8/16)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Comprehensive care plan compliance needs to be improved.
2. It was identified that there was a reduction in compliance rates during random chart audits for comprehensive care plans. Two correction action plans were received from DSS. Care plans were not being developed and updated in a timely manner to make improvements to their goals.
3. Plan to hold more random chart audits to test compliance, invite caseworkers and other appropriate parties to plan review meetings, fill necessary case management positions, and finish implementation of new software program.

Do:

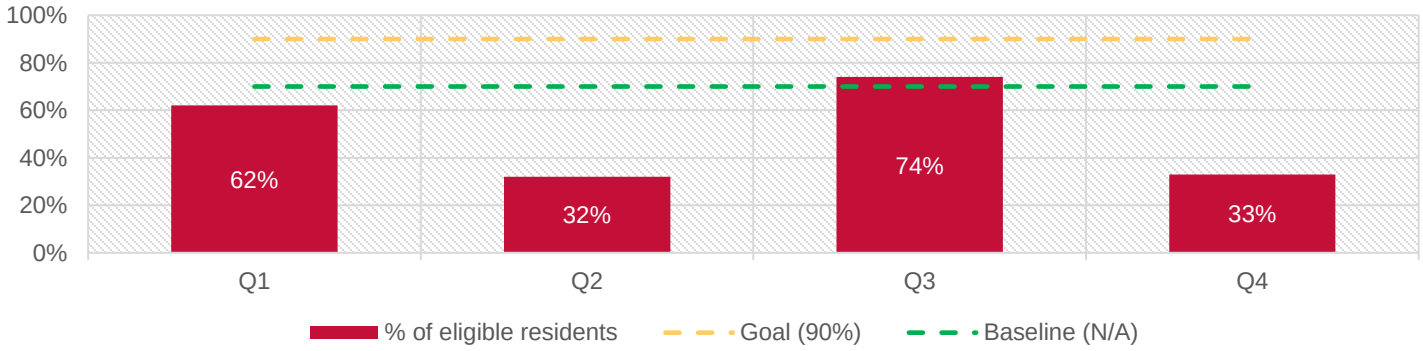
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Hire residential services director and fill two care coordinator positions	DRS / ED	Staff	Nov '23	Jan '24	RSD hired and started early Aug, ILC hired in Nov, CC hired in Jan '24
Complete migration from Kaleidacare to ExtendedReach	DP / ED	Staff	Jul '23	Dec '23	Due to technical issues, full migration wasn't completed until Q2
Training held for staff	DRS / ED	Staff	Mar '24	May '24	Staff trained on completion of care plans in eR Q3 and DSS came to review care plan completion in Q4

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. The migration process with new software (extendedReach) took significantly longer than anticipated due to software company's technical issues. This led to care plans being completed offline, and therefore entered and tracked inconsistently.
2. The software system was finally fully migrated in Q2.
3. Continued audits will be held and monitored in the coming year. Relevant staff to be trained in audit practice to ensure compliance going forward.

Assessment Review Process

Goal Statement	Baseline	Q1	Q2	Q3	Q4
90% of eligible residents receive a CANS Assessment Review	70% (36/51 in FY 23)	62% (8/13)	32% (6/19)	74% (14/19)	33% (2/6)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Follow up CANS assessments need to be completed to assist in comprehensive care planning for residents.
2. It was determined that the follow up assessments would be beneficial to reassess every 90 days to ensure care plans were being developed based on current information regarding the resident's needs and strengths.
3. That are assessments are completed and incorporated into the care planning process.

Do:

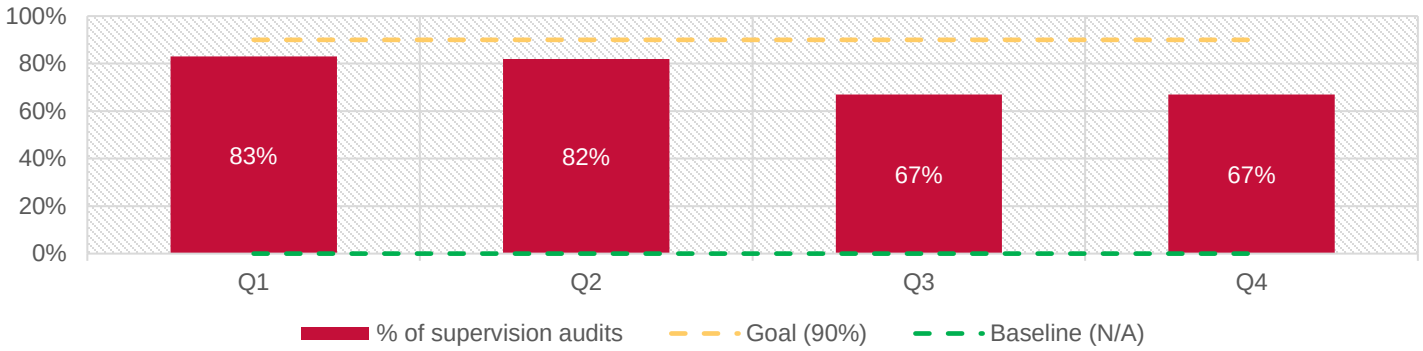
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Identify and train additional staff to complete CANS assessments	DRS	Staff	Sept '23	Sept '23	Seven staff were trained or recertified in CANS
Shifting responsibilities for CANS assessments to Care Coordinator	DP	Staff		Jun '24	

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Initially assigned to the clinical social worker, then expanded to programs social worker, and then expanded for all care coordinators and social workers to be trained in completing the assessments.
2. During periods of time while filling positions for care coordinators and software migration, assessments were completed inconsistently.
3. Throughout the year, it was determined that more individuals need to be able to complete assessments to ensure completion. DSS is now providing more initial assessments in Q4, so CAH teammates are more often responsible for follow up instead of initial and follow up.
4. Continued evaluation has been incorporated in the coming year goal in comprehensive care plan compliance and review.

Supervision

Goal Statement	Baseline	Q1	Q2	Q3	Q4
90% of supervision audits are compliant	N/A	83%	82%	67%	67%



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Random checks indicated lack of compliance in the area of supervision.
2. Increased randomized checks for supervision compliance will be held.

Do:

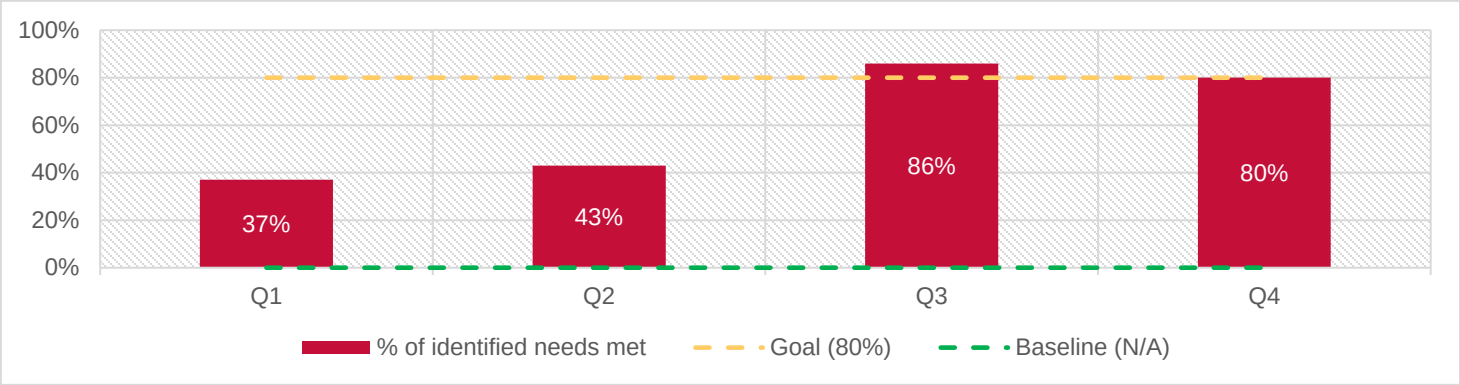
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Identifying issues for targeted training and hiring	DRS	Staff	Sept '23	Jan '24	Continued hiring for supervisors, care coordinators, and pinpointing specific topics in need of refreshers for staff
Retrain staff on Resident Supervision Policy	DRS	Staff	Mar '24	May '24	All residential program staff retrained in Q3
Restructured residential program staffing	ED / PD	Staff	May '24	Ongoing	New positions in recruitment and hiring process

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Staff were not executing line-of-sight expectations. Due to staffing challenges in leadership and oversight, holding staff accountable to expectations consistently proved challenging.
2. Schedule adjustments occurred to ensure staffing coverage and support was adequately present.
3. This area will continue to be monitored in the coming year. Additional randomized checks will be completed. The residential program staffing was restructured to address staffing concerns and provide better oversight and support within programs.

Basic Needs, Day Services

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of identified needs are met	N/A	37%	43%	86%	80%



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. As a new program, this goal was established to evaluate the effectiveness of the day services in meeting basic needs.
2. No previous data has been recorded. This year's goal is to establish a baseline.
3. For each child that comes in, staff does a needs assessment upon intake. A daily plan is developed based on identified needs, youth is connected with appropriate services, or the appropriate party is identified, and evaluated at the end of the day for completion.

Do:

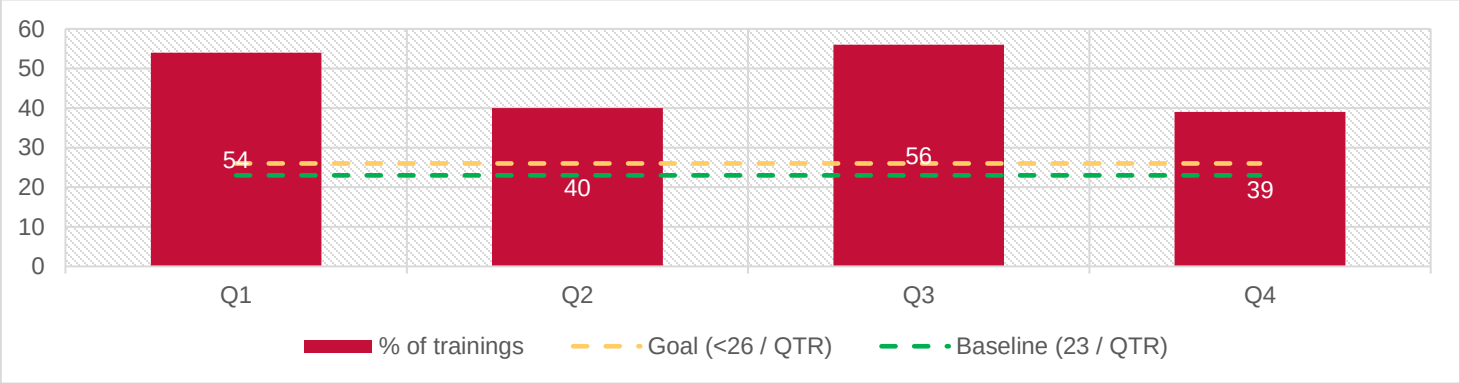
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Create tracking spreadsheet and train staff on	DP	Staff	Sept '23	Sept '23	Created by Day Services team to begin tracking program outcomes required by DSS
Needs assessment procedure was established	DP	Staff	Nov '23	Nov '23	An assessment was established by the team to identify and address needs. Staff was trained to execute, and spreadsheet was adapted to track new expectations.
Assessment was evaluated for accuracy and effectiveness	DP	Staff	Feb '24	Feb '24	Over time, assessment was evaluated for accuracy and effectiveness. Changes to assessment and tracking were made to improve this area.
Complete annual report for DSS	DP	Staff	Sept '24	Ongoing	Annual program report must be completed for DSS and the tracked needs that were met and unmet and the reasons will be shared for future program development.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. When starting, the goal only included basic needs (food, clothing, hygiene).
2. After Q2, the metric began to exclude needs identified that are beyond the Home's control to address. For example, when the team identified needs that DSS had to sign off on execution but didn't, the first two quarters captured this as an unmet need. From Q3 forward, only needs within the control of the Home to meet were measured for this goal. The unmet needs are tracked elsewhere.
3. In the program's annual report, we will be able to report the additional needs that could be met with their cooperation and support.

Training

Goal Statement	Baseline	Q1	Q2	Q3	Q4
10% increase in provided trainings based on identified needs	93 per year (FY23)	54	40 (Total: 94)	56 (Total: 150)	39 (Total 189)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. It was identified that additional training in specific topic areas were desired by our team to improve their effectiveness in their roles.
2. Due to the identified needs of the population, additional training was needed to equip staff to carry out job responsibilities and care effectively. It was also identified that training would impact several areas needing improvement and to meet annual organizational goals.
3. Training topics will be evaluated and trainings specific to relevant topics were established as the baseline for improvement.

Do:

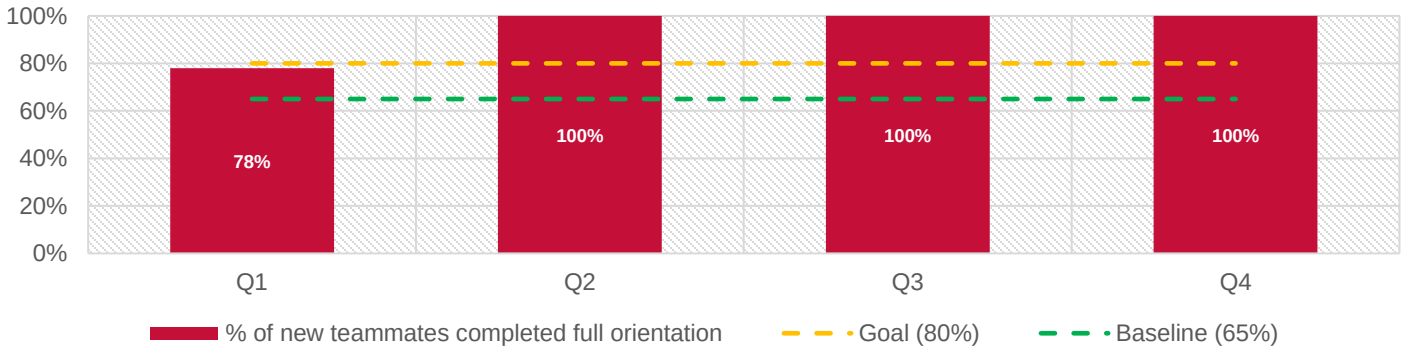
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Evaluate previous year's trainings for participation and relevance.	TC	Staff, software	June/July '23	July '23	TC pulled reports and information related to previous year's trainings to understand what topics were covered and relevant for current.
Identify training needs	ED	Staff	July '23	July '23	Directors had conversations with teams to identify needs, which were communicated to ED
Identify trainers and resources to cover topic areas and host trainings	TC	Staff, funding	Ongoing	Ongoing	Expert trainers and support were identified for specific topic areas to ensure best practices.
Host trainings regularly on relevant identified topics	TC	Staff	Ongoing	Ongoing	A variety of trainings were hosted throughout the year to address specific topics, such as those noted above in this report.
Develop and host CARE refreshers	TC	Staff	November '23	Ongoing	CARE refreshers were developed and hosted to reinforce initial CARE trainings. Participation was lower than expected and will be evaluated for future implementation.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Due to topic specific trainings, critical incidents were reduced, CARE principles were better executed according to feedback from residents in surveys, and additional topic areas for training and refreshers were identified.
2. With some trainings, scheduling to ensure participation of relevant staff continues to present a challenge. We are still evaluating and identifying opportunities to ensure staff are able to receive training relevant to their roles and responsibilities. Additionally, we are continuing to evaluate the best ways to ensure retention of information delivered during trainings and put it into practice, as this has also been a challenge.
3. Funds were received to continue development of trainings in specific areas to address needs of specific populations in the Home's care. Further development of training plans is underway to address specific needs by position and area. Topics identified last year as helpful are being incorporated in a regular rotation for ongoing development.

Orientation

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of new teammates complete full orientation process	65% (11/17 in FY23)	78% (7/9)	100% (2/2)	100% (4/4)	100% (8/8)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Identified that a consistent plan was not in place to ensure proper orientation of new residential program employees to the Home.
2. People were not performing consistently in areas that were considered basic expectations of positions.
3. New employees will be more extensively trained in roles and responsibilities, thoroughly evaluated

Do:

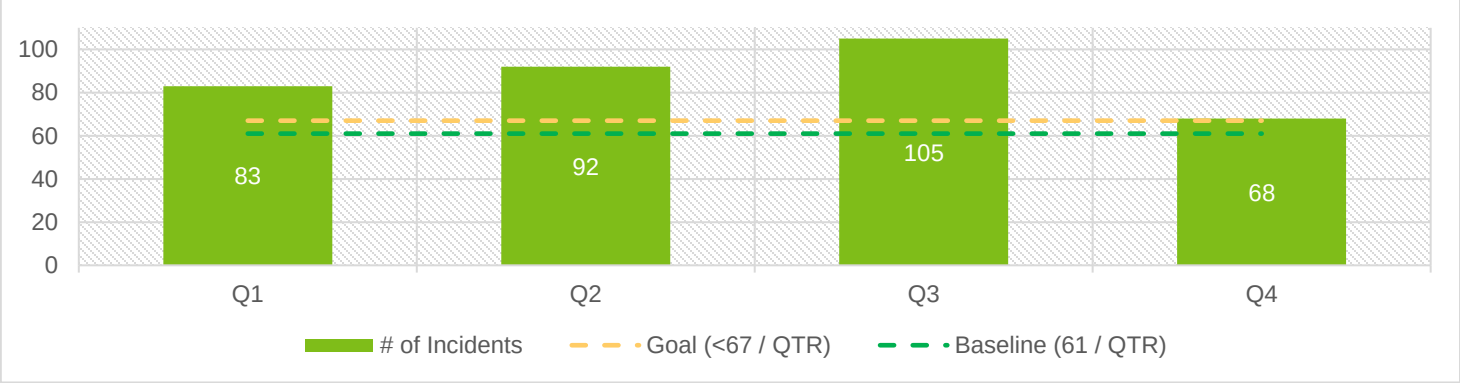
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Develop orientation training module in Relias	TC	Staff	Ongoing	Ongoing	Relevant trainings for initial training and orientation were compiled and put into a training module. The module is under continuous evaluation to ensure as additional trainings are identified as needed.
Establishing consistency in information delivery and training in first 90 days	ED	Staff	Ongoing	Ongoing	A checklist was developed to compile the various required trainings and area overviews.
Develop program specific orientation training	TC	Staff	June '24	Ongoing	Specific needs for certain roles were identified and incorporated into position specific orientation plans.
Incorporate more frequent check-ins and evaluation in orientation process	ED	Staff	August '23	Ongoing	Done
Develop individualized orientation schedules to address specific roles and responsibilities	ED	Staff	August '23	Ongoing	As new hires were onboarded, Directors were responsible for individual areas and ensuring new hires received relevant training and support.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Through this process, we identified where new employees may have opportunities for training earlier in the process, developed existing teammates as more effective trainers in specific areas and roles, and were able to identify early in orientation where new hires may not continue given the nature of the work.
2. Throughout the process, retention of information received during orientation training proved to be a challenge. Orientation was extended to improve this, and ongoing efforts to ensure information retention and practice are being evaluated.
3. As policies are evaluated during the coming year for reaccreditation and programmatic contract changes, additional trainings will be developed to help employees better retain, access, and practice the policy. Ongoing training plans for specific roles are also in development.

Facility Maintenance

Goal Statement	Baseline	Q1	Q2	Q3	Q4
10% increase in properly communicated maintenance requests	244 (FY23)	83	92 (Total: 175)	105 (Total: 280)	68 (Total 348)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. We had facility and maintenance issues that were not being properly reported to ensure problems were prioritized or addressed appropriately.
2. Feedback from visitors onsite identified problems that had not been reported through internal channels prior to visitor observation, and staff were reporting concerns in channels apart from the maintenance email as expected.
3. To remedy this discrepancy, a number of appropriately reported concerns will be tracked to encourage and ensure timely and appropriate response to concerns and issues.

Do:

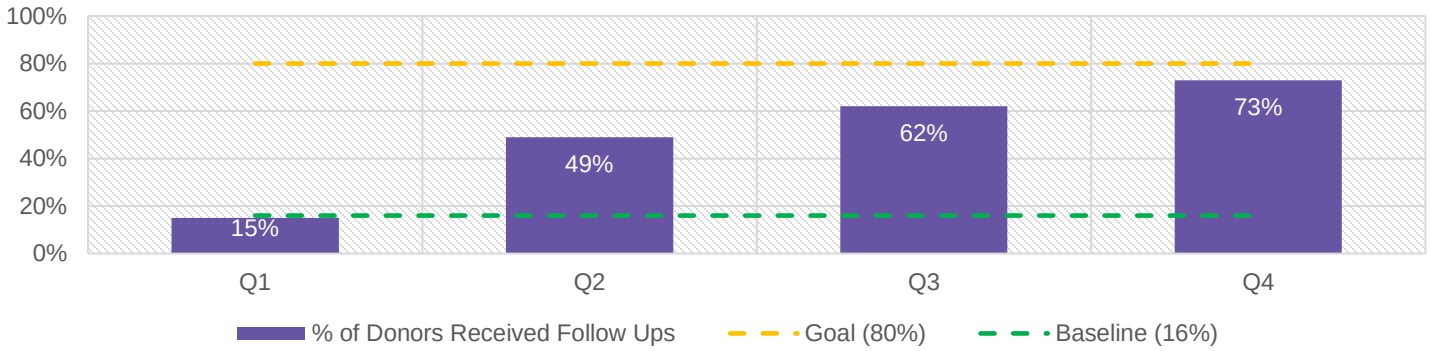
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Retrain staff on proper communication of maintenance concerns and issues	DFO	Staff	Sept ‘23	Ongoing	Regularly remind staff of proper maintenance communication practices in internal newsletter.
Revise monthly maintenance checklist	DFO	Staff, Regulatory Requirements	Oct ‘23	Oct ’23	Revised to include additional regulatory preventive maintenance items.
Incorporate areas contact education into orientation	ED	Staff	Jan ‘24	Jan ‘24	The sheet that included who to contact for issues was handed out to more staff and posted more publicly. This was identified as a helpful tool during the year and added to orientation.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. More emails and requests were received, and fewer problems were noticed by visitors as processes improved.
2. Prioritizing and addressing the volume of need for maintenance assistance continues to be a challenge. Developing a more effective tracking system is needed to ensure concerns don’t fall through the cracks.
3. In the coming year, responsibilities for oversight and reporting of problems have been assigned to relevant supervisory positions to assist in this effort. An improved tracking system is being evaluated.

Supporter Stewardship

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of first-time donors receive personalized follow up in 20 business days	16% thanked in 5 business days in FY23	Q1: 15% (4/26) Annual: 15% (4/26)	Q2: 61% (42/68) Annual: 49% (46/94)	Q3: 76% (49/59) Annual: 62% (95/153)	Q4: 99% (64/65) Annual: 73% (159/218)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. The completion of phone calls to donors within 5 days was not being done consistently, and it was determined an extended timeframe was needed.
2. This was identified through the reporting in Bloomerang of tasks completed for first time donor calls, research shows that this increases likelihood of second.
3. To allow for a realistic time for completion, the timeline for completion was extended to 20 business days.

Do:

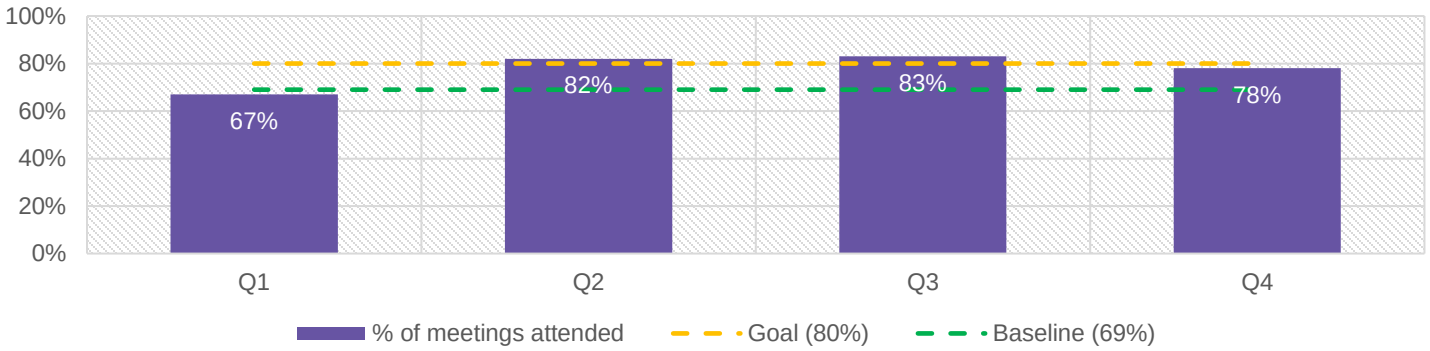
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Integrate this task into the weekly donation review	DDM	Staff	Sept '23	Oct '23	This process was handed off to new DS completely at the end of Q1.
Incorporate regular time for completing calls	DS	Staff	Jul '23	Oct '23	This task was able to be done consistently within the timeframe by the end of the year.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. This process was incorporated into the weekly donation process but was being assigned inconsistently. This was corrected when the position was filled later in the year.
2. Checking to ensure follow up was completed in the allotted timeframe was not happening, and so a review process was established to occur prior to the end of each month to ensure completion of follow up.
3. To improve consistency, DDM and DS worked together to ensure timely completion happened. Although annual percentages did not meet the goal, quarterly improvements demonstrate the improvements in execution. This will continue to be evaluated and tracked to ensure proper follow up.

Board Attendance

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of Board meetings and applicable committee meetings are attended by Board members	69% attendance at Board meetings in FY23	67%	82%	83%	78%



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. It was identified that attendance at called board meetings and assigned committee meetings fell below the required 80% collectively as laid out in board member expectations.
2. In evaluating the attendance records for the previous year of board meetings in FY2023, the attendance was measured at an average of 69%.
3. The metric is the average attendance at all called board meetings and applicable committee meetings, and cumulative attendance at all meetings over the course of the year is being evaluated.

Do:

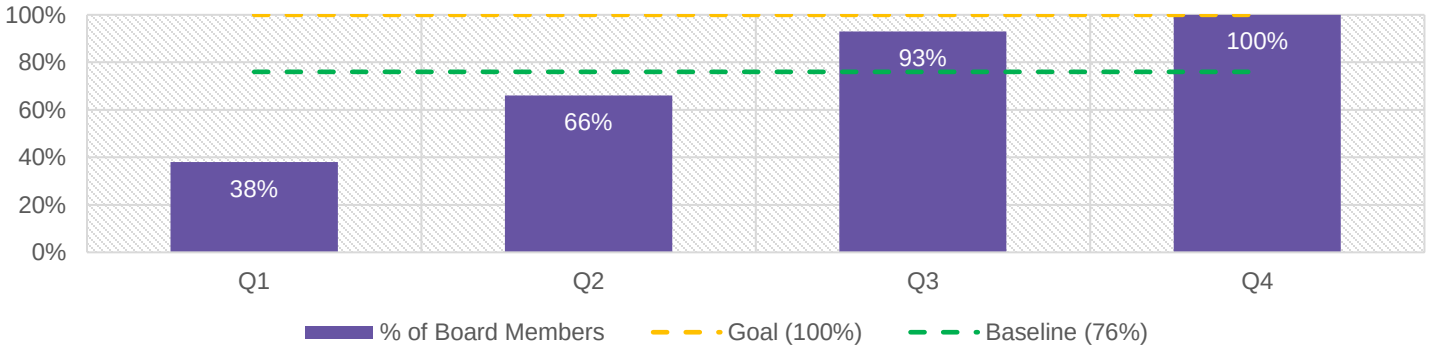
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Set up tracking sheet to track attendance at all board and committee meetings	DDM	Staff	Sept '23	Sept '23	Sheet created to track collective attendance for all board meetings included in metric.
Create set schedule for meetings going forward for each committee for the year	ED	Staff	Sept '23	Sept '23	Each committee established set meeting times with each committee to help committee members plan.
Communicate status of board attendance in board meetings on PQI updates	ED	Staff	Ongoing	Ongoing	The PQI scorecard with board attendance included was communicated quarterly.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. By incorporating the attendance at committee meetings and board meetings, it appeared attendance improved over the year.
2. While the goal is to have all board members meeting in person, having all members attend in person and avoid virtual attendance was a challenge.
3. Continued efforts to plan meeting schedules in advance to allow for prioritization of attendance will be encouraged.

Board Giving

Goal Statement	Baseline	Q1	Q2	Q3	Q4
100% of Board members will individually contribute financially during the fiscal year*	76% (FY23)	38% (6/16)	66% (10/15)	93% (13/14)	100% (13/13)



Plan: (1) Briefly describe opportunity for improvement, (2) What info and data that supports the need for this change, (3) Describe success indicators, how outcomes will be measured, and success will be determined.

1. Annually, there was not 100% personal giving from the board, therefore limiting funding opportunities for the Home.
2. Giving records and rejections from grantors indicated this needed to change.
3. This metric will be monitored over the course of the year, recorded, and updates given in board meetings to encourage board members to give. The development team will communicate throughout the year to board leadership.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Board giving tracking is incorporated into PQI scorecard	DDM	Staff	Jul '23	Sept '24	Updated quarterly with personal giving percentage updates.
Communication with board members who have not given	DDM / Board Chair	Staff / Board	Jul '23	Jun '24	Board received updated in board meetings and individuals were notified closer to the end of the fiscal year if they had not yet given.

Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Several board members signed up to be monthly donors and automate their giving. Others make their annual gift at annual fundraisers.
2. Educating board members on what was considered a personal gift (company giving did not count) was important in understanding the board giving expectation.
3. Annually, board members will receive individual follow-up in addition to collective reporting to ensure the expectation is completed.