Performance and Quality Improvement

Annual Impact Plan & Report

Fiscal Year 2024-2025

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 fiscal year (July 1 – June 30). 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
81	233	221	1	3	2

All Residential Programs

	# of participants served	# of participants served in >1 program	# Days of Service
Total	42	2	4,475

Enhanced Care	Total
# of participants served	19
# Days of Service	2,343
Avg Length of Stay *(in days)*	124

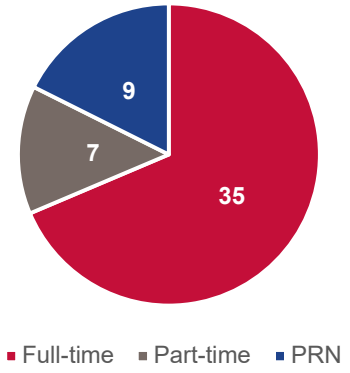
Development Progression *(% of youth who reached various levels by tier)*	Level 1	Level 2	Level 3	Level 4
Tier 1- **Immediate Needs** *(food, clothing, etc.)*	89%			
Tier 2- **Basic Needs** *(med exams, birth certificate, social security card, etc.)*	63%	21%	0%	0%
Tier 3- **Education** *(enrolling in school, college, tours, basic computer skills, etc.)*	63%	11%	0%	0%
Tier 4- **Independent Living** *(coping skills, reading a recipe, using an alarm clock, etc.)*	53%	16%	0%	0%
Tier 5- **Employment** *(applying and maintaining a job, resume, career planning, etc.)*	22%	14%	0%	0%
Tier 6- **Transitional** *(driver's license, credit, vehicle purchasing, apartment)*	14%	0%	0%	0%

Moderate Care	Total
# of participants served	25
# Days of Service	2,132
Avg Length of Stay *(in days)*	86

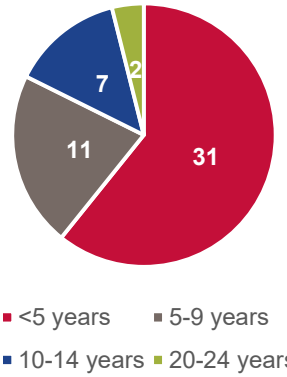
Development Progression *(% of youth who reached various levels by tier)*	Level 1	Level 2	Level 3	Level 4
Tier 1- **Immediate Needs** *(food, clothing, etc.)*	96%			
Tier 2- **Basic Needs** *(med exams, birth certificate, social security card, etc.)*	75%	13%	8%	0%
Tier 3- **Education** *(enrolling in school, college, tours, basic computer skills, etc.)*	25%	13%	13%	0%
Tier 4- **Independent Living** *(coping skills, reading a recipe, using an alarm clock, etc.)*	25%	8%	0%	21%
Tier 5- **Employment** *(applying and maintaining a job, resume, career planning, etc.)*	9%	9%	24%	0%
Tier 6- **Transitional** *(driver's license, credit, vehicle purchasing, apartment)*	13%	0%	25%	0%

Teammates

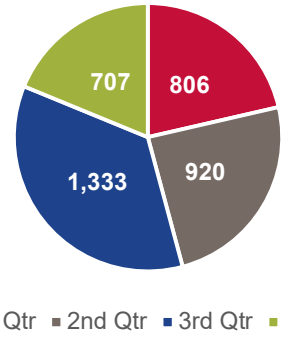
Employment Category



Employee Tenure



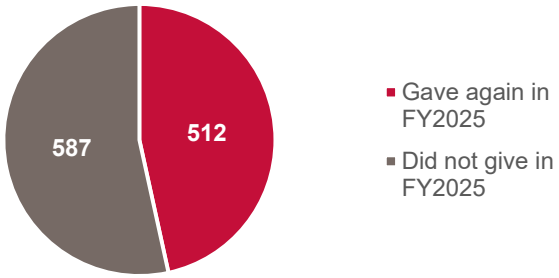
Training Hours
(Total: 3,766)



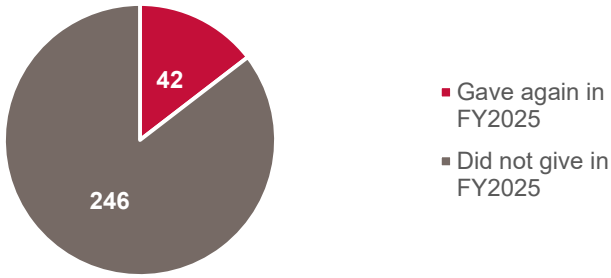
Community Outreach & Support

	Total	Speaking Engagements	Community Events	Campus Tours
# of events	**91**	23	27	41
# of people reached	**2,468**	1,105	1,257	106

Donor Retention Rate: 46.5%
Total Donors FY2024: 1,099
Total Donors FY2025: 892



First-time Donor Retention Rate: 14.6%
First-time Donors FY2024: 288
First-time Donors FY2025: 192



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

Performance & Quality Improvement Scorecard

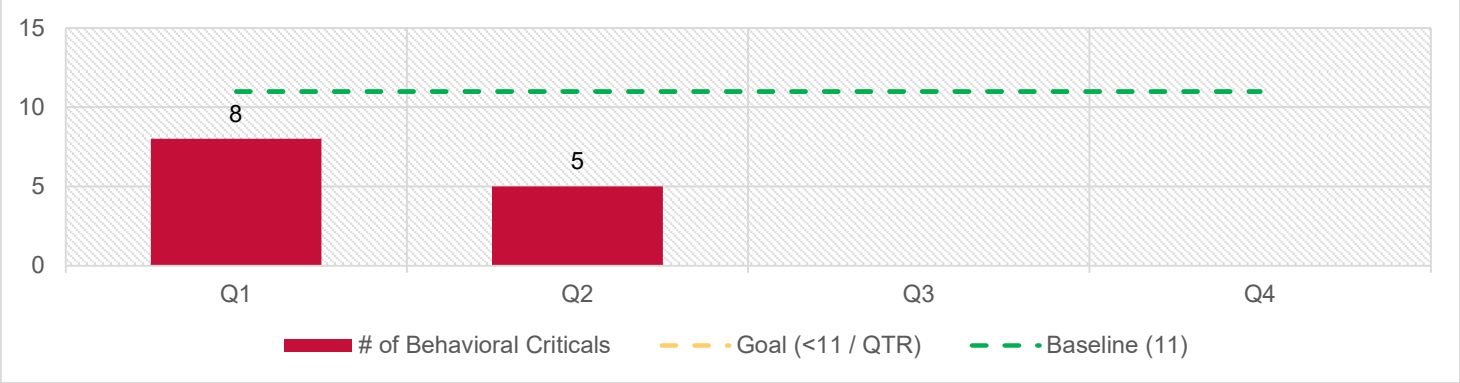
Quality Measure	Goal Statement	Baseline	Q1	Q2	Q3	Q4
Day Services Program	Reduce # of behavioral criticals in Day Services Program	11 per quarter (44 total for FY 24)	8	5		
Resident Files	80% of resident file audits are compliant	N/A	50%	11%	78%	39%
Supervision	90% of supervision audits are compliant	67%	75%	78%	81%	87%
Productive Time	80% of residents complete 40 hours of productive time	N/A	38%	68%	68%	83%
Food Services	70% of program participants participate in a nutritional/healthy eating activity 2x/month	N/A	67%	59%	65%	54%
Training	95% of teammates completed required training hours	87%	68%	68% (83% cumulative)	83% (98% cumulative)	100%
Development	Increase total annual fundraised support by 8%	FY2024 total fundraised support = $929,679	-2.3% FY25: $155,106.20 FY24: $158,764.94	7.7% FY25: $531,101.25 FY24: $493,253.68	2.2% FY25: $795,762.08 FY24: $778,762.08	-0.5% FY25: $914,351.08 FY24: $918,839.38
Board Education	All board members complete 3 hours of relevant training	N/A	31% (8 members at 1.5 hours)	45% (4 members completed 2.25 hours; 6 completed .75 hours)	77% (7 members at 3+ hrs; 2 members at 1.5-2.25)	78% (7 members at 3+ hrs; 2 members at 1.5-2.25)
Board Attendance	80% of Board meetings and applicable committee meetings are attended by Board members	78% attendance at Board meetings in FY24	82%	84%	85%	86%

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.

Day Services Program

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Reduce # of behavioral criticals in Day Services Program	11 per quarter (44 total for FY 24)	8	5		



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 law enforcement was being called too often for problems that the staff should be trained to handle.
2. Law enforcement provided recommended timelines for reporting certain incidents.
3. Success would look like fewer calls to law enforcement.

Do:

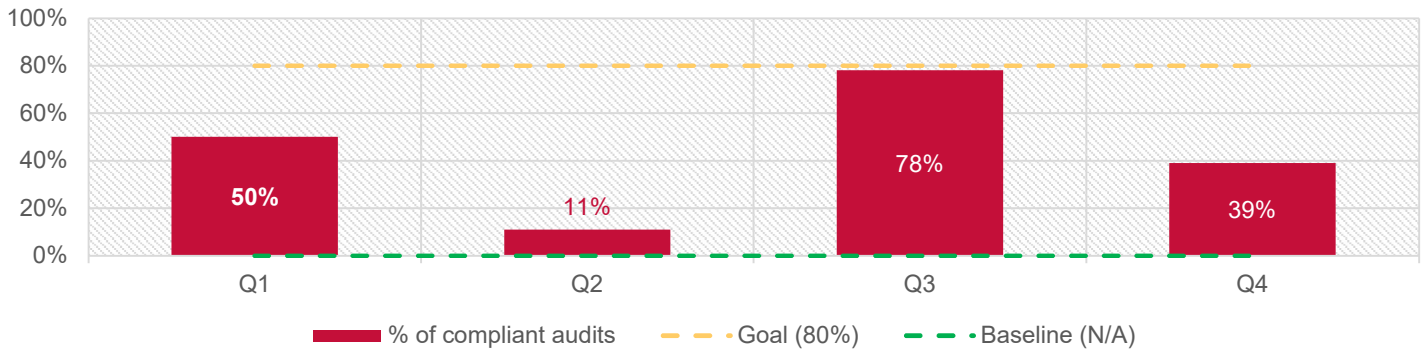
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Retrain staff on criticals	Alicia	Staff	Sept 30	Aug 6	Staff was retrained
Staff were retrained on CARE Model and de-escalation.	Alicia	Staff	Sept 30	Sept 30	Staff was retrained

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. Number of criticals involving law enforcement declined in second quarter.
2. Staff was concerned about timelines for law enforcement response for runaways specifically, but it proved accurate. This practice will be monitored going forward.
3. Program was sunset on Dec 20.

Resident Files

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of resident file audits are compliant	N/A	50%	11%	78%	39%



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. Resident files were audited and areas for improvement were identified.
2. A corrective action plan was put in place by DSS for chart compliance in Summer 2024.
3. Peer Care Coordinators will audit one another's resident files to ensure compliance.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Review two current resident files monthly	Alicia	Staff	Each month	Beg Jul '24	Following review, CC was notified of any discrepancies.
Spreadsheet for requirements from DSS created for Care Coordinator's (CC) to use for monitoring progress.	Alicia	Staff			
The worksheet for client chart audits was added to eR for centralized and easy access.	Alicia	Staff	July 30	June 30	These have been completed monthly and stored in eR. Alicia follows up after completion to review.
Added review of two current and two discharged resident files monthly	Alicia	Staff	Each month	Beg Oct '24	Ensured discharge summary was then being sent out in a timely manner.
Review transitioned from peer Care Coordinator to Programs Director at the beginning of Q3 during hiring of Residential Services Manager (RSM).	Alicia	Staff	Jan 30, '25	Beg Jan '25	Reviewer transitioned to provide more consistent oversight with the plan to transition to the RSM
Review transitioned to RSM	Alicia	Staff	Apr 30, '25		
Added review of all files from January-December 2024 to ensure they are in compliance	Alicia and Ashley	Staff	May 30,'25	In progress	

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. Discharge files were added to ensure further compliance with DSS.

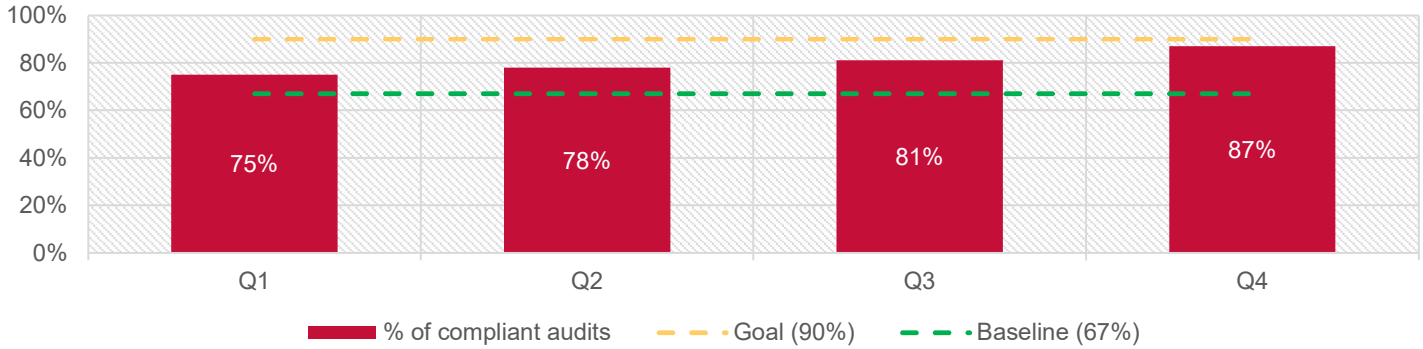
2. Worksheet was added to ensure compliance with accreditation standards.
3. Reviewer was changed to ensure more consistent oversight of file reviews.
4. CC shared they need an admin day to ensure all documentation is uploaded in a timely manner.
5. Additional reviews were unable to be completed due to position turnover and training of new staff.
6. Technical assistance visit with DSS was not completed until June to train CC's on what can be included in the charts.

Corrective Action Plan: When a goal is not met at the end of the fiscal year, a plan is determined to address deficiencies and improvements moving forward. If no corrective action is required, an explanation of specific reasons why will be included. The plan should include: plan/process to address and correct deficiency, who will own the CAP, date for completion, how the practice will be maintained, and where documentation is kept for review.

Corrective Action Item	Owner	Due Date	Comments
Use presentation from technical assistance to train Care Coordinators on resident file maintenance	Alicia	7/1/25	The training will be incorporated into CC orientation and CC's will receive training annually or more often as needed based on performance.
Implement monthly chart audits (two discharge & two current)	Alicia	7/1/25	Programs Director will complete and follow up with CC's regarding findings to ensure compliance and assign retraining as needed. CC's should make notes where deficiencies are outside of their control.
Incorporate documentation responsibilities into internship opportunities to add administrative support and relevant experience	Alicia	9/1/25	Internship opportunities are being expanded; interns will be trained during orientation on how to support in this area.

Supervision

Goal Statement	Baseline	Q1	Q2	Q3	Q4
90% of supervision audits are compliant	67%	75%	78%	81%	87%



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. Maintaining supervision expectations continued to be an area for improvement based on data from the previous fiscal year.
2. Staff restructuring will be done to ensure more supportive supervision in each cottage and increase oversight of this expectation.
3. Supervision audits will take place through both camera and in-person supervision weekly.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Staffing structure was changed to provide more supervision support in each cottage/program.	Tara	Staff, Funds	Sept 30	Oct 7	Restructuring was completed in September and put into effect on Oct 7.
Supervisors were sent to two-day supervisors training.	Alicia/Tara	Staff, Funds	Sept 30	Sept 20	Supervisors and CC's were all trained on foundational management and supervision practices.
Roles and responsibilities training was completed with leadership.	Alicia/Tara	Staff	Feb 28	Feb 13	Staff found it helpful and drove positive conversation and clarification.
Roles and responsibilities training was completed in teammate townhall, will be assigned in Relias in further detail with residential teammates, and incorporated into future cottage staff meetings.	Alicia/Tara	Staff	Mar 30	Mar 30	Training was completed with existing staff and incorporated as part of 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. In February leadership meeting, suggestions were:
    a. Reiterate expectations in upcoming staff meetings.
    b. Keep staff task-oriented to keep people focused on priority areas.

c. Pop up visits were suggested to encourage following of expectations.

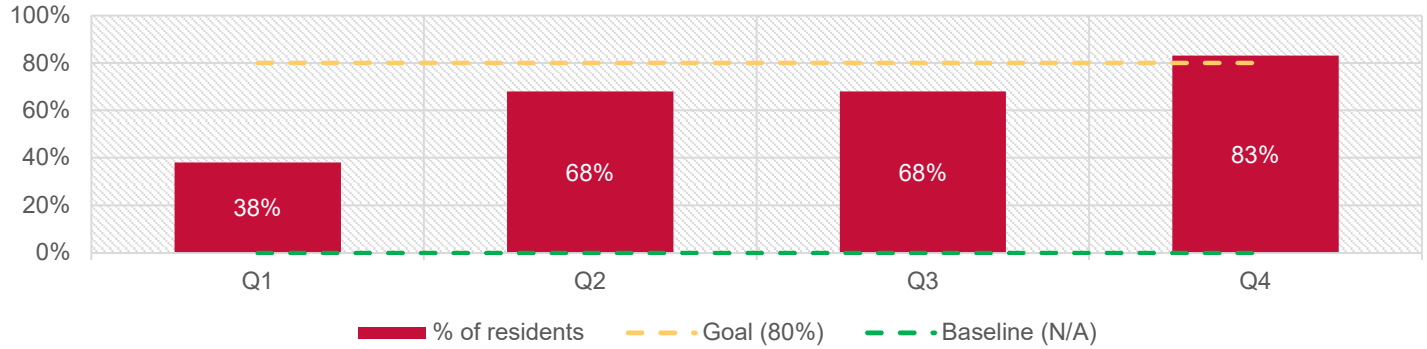
2. Roles and responsibilities training led to constructive conversation and suggestions from leadership were to incorporate scenarios for staff.
3. Back hall supervision continues to be an issue and is addressed in the corrective action plan.

Corrective Action Plan: When a goal is not met at the end of the fiscal year, a plan is determined to address deficiencies and improvements moving forward. If no corrective action is required, an explanation of specific reasons why will be included. The plan should include: plan/process to address and correct deficiency, who will own the CAP, date for completion, how the practice will be maintained, and where documentation is kept for review.

Corrective Action Item	Owner	Due Date	Comments
Evaluating implementation of documenting regular resident supervision checks 24/7 and rotation of supervision and engagement with residents.	Alicia	9/30/25	Talk with team to understand how this would work best with current environment and expectations.
Retraining teammates on resident supervision policy	Alicia	9/30/25	Host retraining to ensure teammates understand expectations in regard to specific programs
Move ownership of regular supervision checks to supervisors	Alicia	9/30/25	Begin to shift responsibility of regular supervision checks to supervisors to provide opportunity for accountability and feedback directly from supervisors to teammates.

Productive Time

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of residents complete 40 hours of productive time	N/A	38%	68%	68%	83%



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 many residents had completed school and needed additional activities for productively filling their time. CAH programs historically required 40 hours of productive time per week, and DSS requires 20 hours of productive time, consisting of school and work obligations.
2. Ensuring residents were meeting their goals and progressing developmentally was a primary focus of this metric.

Do:

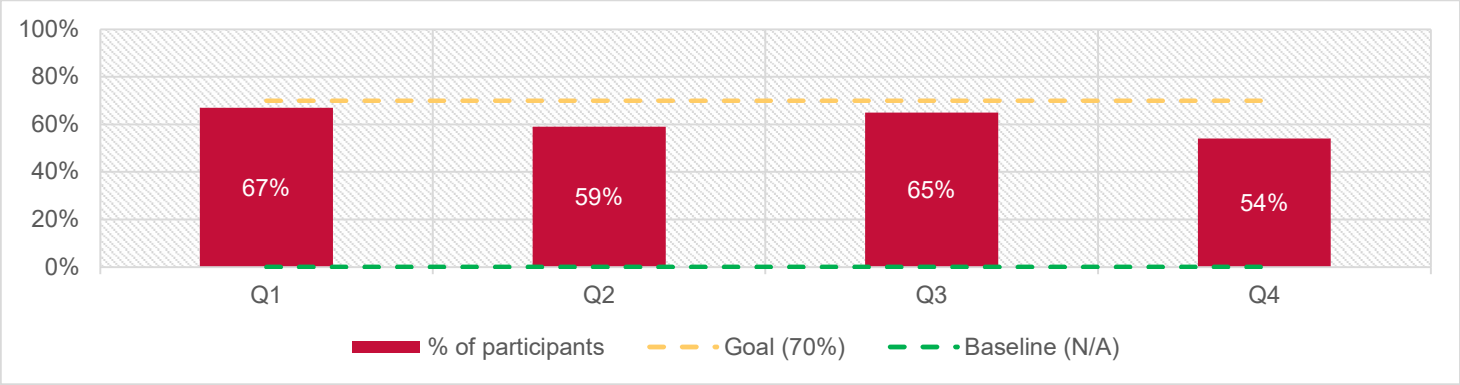
Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Clarification of what counted as productive hours	Alicia/Tara	Staff	Dec 31	Dec 5	Rate of hours tracked improved from Q1 to Q2
Clarification of tracking of these hours, including verification of activities (pay stubs, etc.)	Alicia/Tara	Staff	Dec 31	Dec 5	Rate of hours tracked improved from Q1 to Q2
Productive hours expectation reviewed with residents.	CC's	Staff	Oct 30	Oct 30	
Review of information and process with residential leadership	Alicia/Tara	Staff	Feb 13	Q3	Areas for improvement were identified
Productive hour expectations were reviewed with residents as part of the manual review.	CC's	Staff	Mar 30	Q3	Updated manuals were reviewed with residents during cottage meetings. Expectations are reviewed with all new residents.

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. Programs changed since measurement was put in place and will be evaluated for adjustment. Morris cottage was changed from independent living to moderate care and expectations were in process of being adjusted.
2. It was discussed how long before new residents would be held to these expectations.
3. It was identified that there were some challenges tracking the information. It was also discussed what was counted as productive time.
4. Peer influence was identified as a negative influence at times, even between different programs.
5. Productive hours were incorporated into the resident manuals.

Food Services

Goal Statement	Baseline	Q1	Q2	Q3	Q4
70% of program participants participate in a nutritional/healthy eating activity 2x/month	N/A	67%	59%	65%	54%



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 determined that nutritional education needed to be incorporated into the dining plan to ensure personal development in this area.
2. There was a noticeable increase in residents gaining weight and medical conditions that demonstrated the need for closer monitoring of diets and nutritional education.
3. Residents will be involved in the education planning and participating in the preparation of meals when possible.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
A dashboard was created to track residents helping in the kitchen.	Earl	Staff	July 30	July	It was determined this was not enough to meet the goal.
Residents were included in food selection and planning.	Alicia	Staff	July 30	June	
Create sufficient tracking methods for all staff.	Alicia	Staff, tech	Feb 28		

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.

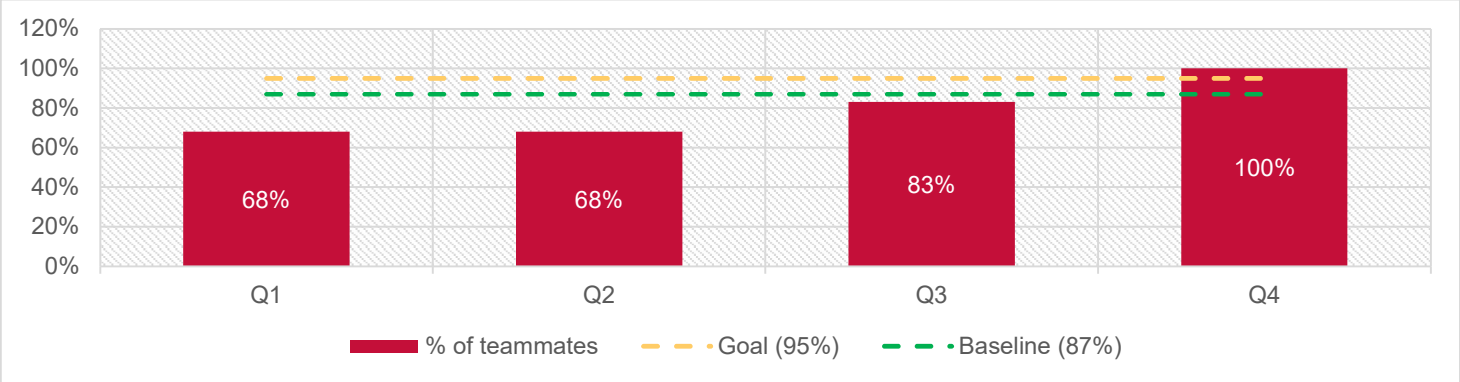
1. In the first quarter, Cathy and Earl were the primary drivers of activity for this area. This responsibility was spread out once staff restructuring took place.
2. Individual feedback has been provided by residents to leadership.
3. Residential leadership will be intentionally planning a cottage activity monthly. They had concerns about how to track these activities as well. It was also communicated that this metric is campus-wide versus each individual program.

Corrective Action Plan: When a goal is not met at the end of the fiscal year, a plan is determined to address deficiencies and improvements moving forward. If no corrective action is required, an explanation of specific reasons why will be included. The plan should include: plan/process to address and correct deficiency, who will own the CAP, date for completion, how the practice will be maintained, and where documentation is kept for review.

Corrective Action Item	Owner	Due Date	Comments
Reset expectations with opening new Enhanced Care Cottage	Alicia	9/30/25	As the cottage is reopening, the expectation will be to have an activity twice a month dedicated to healthy eating.
Programs will be assigned times to be in the kitchen for healthy eating activities	Alicia	9/30/25	Volunteers may be incorporated into activities for support.
Programs will be assigned one meal a month to prepare for the campus	Alicia	9/30/25	Volunteers may be incorporated into activities for support. Meal planning and grocery store trips incorporated for IL experience.
Build in external support for semi-annual nutrition-focused workshops	Alicia	9/30/25	Evaluate paid and unpaid support in this area.

Training

Goal Statement	Baseline	Q1	Q2	Q3	Q4
95% of teammates completed required training hours	87%	68%	68% (83% cumulative)	83% (98% cumulative)	100%



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. Ensuring staff had completed required training hours for licensing in a timely manner was a challenge. Additionally, staff were expressing they were ill-equipped to fulfill job expectations while simultaneously struggling to prioritize completing assigned trainings.
2. It was identified that staff were backloading training hours to Q3 and not completing training successfully as assigned throughout the year. In some cases, staff were not completing required trainings prior to requirements for licensing.
3. Completed trainings and training hours will be tracked and reported through Relias.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Training plans were adjusted to support more training taking place in the first two quarters.	Josh	Staff, tech	July 1	July 1	Relias training expectations were updated and assigned for all staff.
The CARE training was made mandatory for all teammates to complete within 6 months of hire or notice.	Tara	Staff, tech	June 30		Notification was sent to all teammates notifying that everyone has six months to complete CARE training as a job expectation. CARE training completion was also added to orientation.
Training modules were incorporated into orientation to ensure timely completion.	Alicia	Staff, tech	Jan 1	Jan 14	

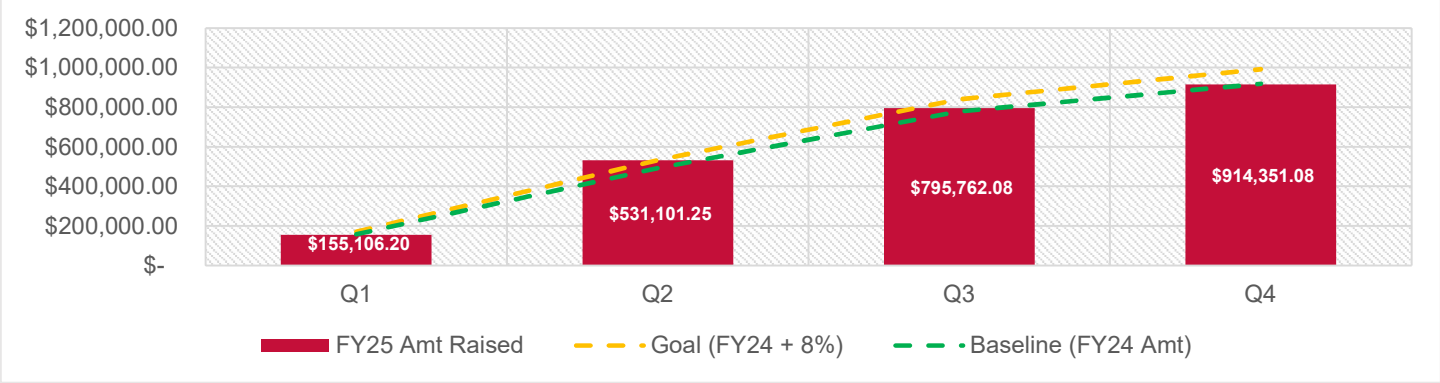
Check & Act: (1) Describe results & observations of improvement plan, (2) Describe challenges encountered during plan implementation, (3) Describe how completed plan will be integrated into regular practice.

1. Collectively, a greater portion of the team are on track with required trainings. However, there are still staff not completing assigned trainings in the assigned timeframes. These expectations were addressed individually.
2. It was identified that staff involved in critical incidents had not completed the CARE training. Going forward this will be a requirement and job expectation for all.

3. With new contracts came changes and new regulations for orientation of new residential teammates. With this, the orientation training schedule was adjusted to incorporate approximately a week of required trainings prior to engagement with residents, based on role and responsibilities.
4. Some teammates were not attending the mandatory NVCI training and had to be removed from the schedule due to being out of compliance. Training schedules were put in place at the end of May for the upcoming fiscal year to help teammates plan.

Development

Goal Statement	Baseline	Q1	Q2	Q3	Q4
Increase total annual fundraised support by 8%	FY2024 total fundraised support = $929,679	-2.3% FY25: $155,106.20 FY24: $158,764.94	7.7% FY25: $531,101.25 FY24: $493,253.68	2.2% FY25: $795,762.08 FY24: $778,762.08	-0.5% FY25: $914,351.08 FY24: $918,839.38



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. With growing expectations of staffing and programs, private annual support will need to grow to meet the need. With the capital campaign, there is the opportunity to leverage the excitement of future projects and growth for growth in annual dollars.
2. There was growth in private contributions in 2024, and with capital campaign activities and additional donor engagement, growth is anticipated to follow.
3. Funds raised will be measured cumulatively with benchmarks based on the same quarter of the previous year.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Establishing tracking for outreach activities and follow up.	Katy	Staff, tech	Sept 30	Sept 30	Outreach activity tracking procedures developed and documented.
More regular giving data will be incorporated into board activities.	Katy	Staff, tech	Quarterly	Jan 2025	Various fundraising data
Major gift and planned giving programs will be in place to support ongoing fundraising growth.	Katy	Staff, tech, Curtis Group	May 1		Practices for major gift and planned giving under development
Complete annual surveys for individual and organizational donors.	Katy	Staff, tech	Sept 30	Sept 30	Both surveys were completed and feedback incorporated into future projects.
Create annual partnership program for organizations.	Katy	Staff	Jan 1	Feb 28	Annual partnership opportunities were identified through
Hold donor engagement breakfast for donor stewardship.	Katy	Staff, funds	November	Nov 8	Second breakfast scheduled for Nov 7, 2025
Development dashboard created to track regular fund development activities.	Katy/Tara	Staff, tech	Apr 15		

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.

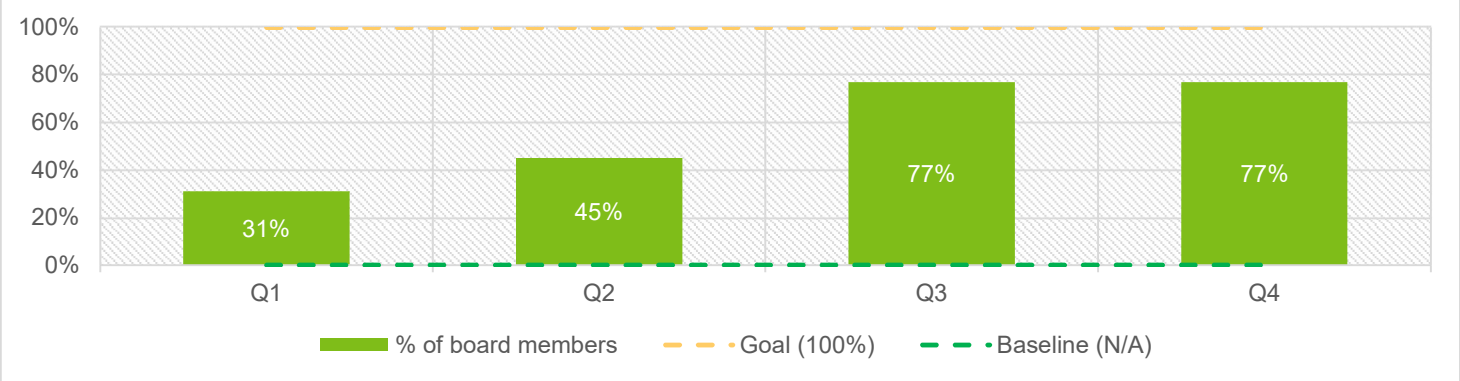
1. It was identified that outreach activity could use better tracking for follow up to encourage more people to take a next step.
2. Additional stewardship and cultivation strategies are in the process of being developed in conjunction with capital campaign activities, including major gifts and planned giving. Both are regularly reviewed with the Curtis Group.
3. Feedback from donor surveys was received and incorporated into future development plans.
4. The development team evaluated some of the follow up processes and identified opportunities for more extensive follow up and engagement. These will be developed for implementation in Q4 (email series, additional outreach follow-up, improved first-time donor follow up).

Corrective Action Plan: When a goal is not met at the end of the fiscal year, a plan is determined to address deficiencies and improvements moving forward. If no corrective action is required, an explanation of specific reasons why will be included. The plan should include: plan/process to address and correct deficiency, who will own the CAP, date for completion, how the practice will be maintained, and where documentation is kept for review.

Corrective Action Item	Owner	Due Date	Comments
Determine donor acquisition goals for the coming fiscal year	Katy	8/31/2025	Number of donors over the past three years has declined. Finding best ways to connect with new donors is needed.
Evaluate donor retention and lapsed donors for next steps	Katy	8/31/2025	Evaluate reasons for lapsed donors to identify trends to address; determine follow up needed for lapsed donors
Evaluate fundraising activity efforts for additional opportunities	Katy	9/30/2025	Update materials and promote opportunities for community members to assist with fundraiser support; evaluate annual spring fundraiser for opportunities to grow support
Continue development of annual partner, major gift, and planned giving recruitment and stewardship efforts	Katy	11/30/25	Finalize annual partner program, document practices for major gift and planned giving recruitment, stewardship, and recognition

Board Education

Goal Statement	Baseline	Q1	Q2	Q3	Q4
All board members complete 3 hours of relevant training	N/A	31% (8 members at 1.5 hours)	45% (4 members completed 2.24 hours; 6 completed .75 hours)	77% (7 members at 3+ hrs.; 2 members at 1.5-2.25)	77% (7 members at 3+ hrs.; 2 members at 1.5-2.25)



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. Board members shared a desire for more connection and understanding of programs and daily needs for the Home.
2. There was not enough allotted time in board meetings for programmatic trainings, and board members expressed challenges with attending trainings during the workday.
3. More training opportunities will be made available to board members and incorporated into board meetings.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Tracking in Bloomerang was established.	Katy		July 30		Tracking for training hours under volunteer activity was established for reporting.
Board self-eval results discussed by Board development for potential training topics.	Tara/Katy/ Board Dev. Comm.	Staff, Curtis Group			Board meeting time was evaluated for available time to dedicate to training opportunities.
Board meeting time was evaluated for available time to dedicate to training opportunities.	Tara/Adam		Bi-monthly		Board training needs were evaluated prior to each board meeting to ensure training relevancy
Training scheduled with Curtis Group for campaign updates and training	Katy/Tara	Staff			
Develop programmatic training for October board meeting.	Katy/Alicia				Board had positive feedback and asked for more information in the future.
CARE consultant Frank Kahn attended and provided training during board retreat.	Tara		Jan 30	Jan 25	Board had very positive feedback and wanted access to the CARE book.

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.

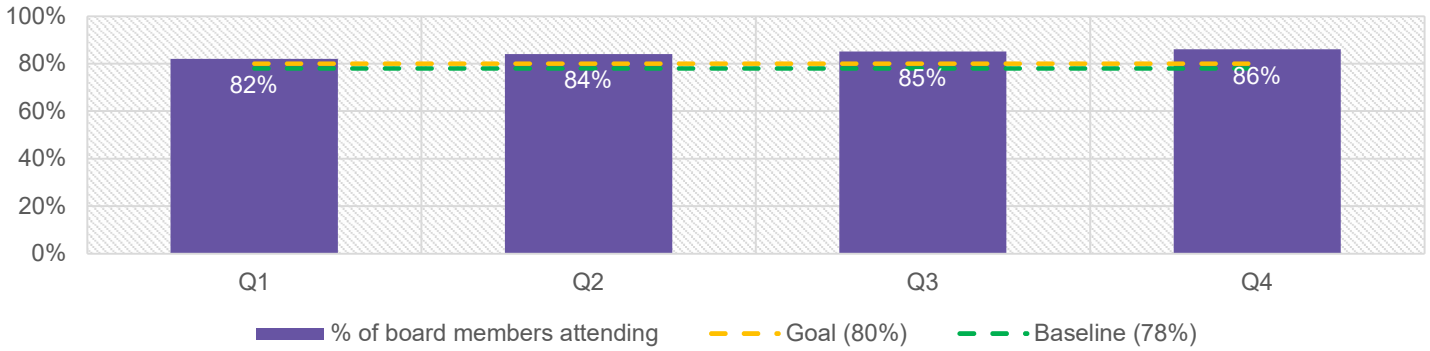
1. It was identified in Board Development that a programmatic training would be beneficial. This was incorporated into the October Board meeting. Frank with the CARE team was also incorporated into the board retreat.
2. Future connect to purpose time will be restructured to more transparent information about current residents and programmatic needs versus highlights.

Corrective Action Plan: When a goal is not met at the end of the fiscal year, a plan is determined to address deficiencies and improvements moving forward. If no corrective action is required, an explanation of specific reasons why will be included. The plan should include: plan/process to address and correct deficiency, who will own the CAP, date for completion, how the practice will be maintained, and where documentation is kept for review.

Corrective Action Item	Owner	Due Date	Comments
Incorporate into annual retreats	Tara	9/30/25	Build annual training topics into board retreats due to extended time available
Incorporate board feedback from board self-eval regarding training to Governance Committee meetings for follow up	Tara	9/30/2025	Use training feedback to build training plan for board for the year

Board Attendance

Goal Statement	Baseline	Q1	Q2	Q3	Q4
80% of Board meetings and applicable committee meetings are attended by Board members	78% attendance at Board meetings in FY24	82%	84%	85%	86%



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 board members struggled to regularly attend meetings and meetings had to be cancelled due to lack of attendance in FY2024.
2. Board attendance in the previous year proved a challenge in accomplishing necessary business for the organization.
3. Board attendance at regular meetings and committee meetings will be tracked to ensure adequate attendance and engagement with the collective board.

Do:

Action Item	Owner	Resources	Target Date	Actual Date	Progress Notes
Create a tracking system in Bloomerang for board member activity	Katy	Staff, tech	July 30	July 30	
Evaluate meeting structure (time of day, dates, in person vs. virtual, frequency)	Tara/Adam	Staff	Mar 30	Mar 30	Discussed in board retreat for implement
Restructure meeting schedule	Tara/Adam	Staff	Mar 30	April 30	Board meeting schedule was adjusted to be virtual, quarterly and shorter; a second Board retreat was added for additional in person; an annual calendar was put together for ease of planning for board members and increase engagement
Address attendance in recruitment	Tara/Katy	Staff	April 30	April 30	Board meeting schedule determined in advance of recruitment to ensure potential board members have availability to commit and attend.

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. In person meetings continued to be a challenge for some. Evening meetings also presented a challenge for some individuals.
2. It was highlighted that board calendars were not shared in the recruiting process and therefore made it difficult to understand the commitment involved. This was addressed at the board retreat through discussion with the plan for the board to schedule activities roughly 18 months in advance to prepare for board recruitment efforts.
3. Incorporating annual meeting schedule in board recruitment process was helpful in determining fit for potential board members and provided ability for current board members to determine ability to commit for the coming year and engage in other organizational activities.