**Introduction**

PQI- Performance and Quality Improvement- is an integral part of our organization. We strive to create a culture of continuous improvement, to streamline service delivery, administrative functions, and better serve survivors and our community.

An important function of this report is to provide information to our stakeholders about strengths and opportunities for growth. As an agency, as we have grown in size and scope, we have also been presented with opportunities to grow in our policies, procedures, and methods of operation. As you will see throughout this report, we sometimes fall short of our goals and targets. When this is the case, we will always have a plan of action to address these challenges. PQI is a continuous process, and we strive to apply new and bold strategies to improve in all that we do.

**Section 1 – Strategic Organizational Goals**

This section looks at overarching goals related to accessibility, safety and rights of persons served, risk prevention, and financial strength that are intrinsic and necessary for sustainability of the organization.

1. Long Term Goals and Objectives:
2. Increase discretionary funds:
   1. Increase discretionary funds: Goal = 10% increase in first time donors

Result: 10%

Total Donors This Period = 184 Total First Time Donors This Period = 7

* 1. Increase Principal Balance in the Margarite Morris / PW Endowment with the Springfield Foundation by 5% annually.

Result: 0% [*pandemic impact on budget did not allow for reinvestment of reserve funds]*

1. Engage Volunteers:
   1. Short-term Goal #1: Increase program focused volunteer hours by 25% [212 hours]

Result: 24% *Current period should be 50% of goal.*

Total Hours This Period (FY21Q1&2) = 104 Total Hours Last Period (FY20) = 851

*\*pandemic measures including social distancing and other efforts to reduce contagion have limited program focused volunteer opportunities.*

1. Staff Retention:
   1. Increase employee long-term commitment to the agency by implementing professional development plans.

Goal: 75% of staff will achieve all stated goals within one year of plan development.

Timeline: June 2021

Result: *Staff evaluations are in process and due by May 31, 2021 for management review.*

* 1. Reduce short term turnover rate by improving on-boarding experience.

Goal: 80% of all new-hire staff will report positive experience and satisfaction with orientation to their job at 30 and 90 day survey.

Timeline: December 2020

Result: *pending – SHRM has recommended placing performance evaluations on hold during the course of the pandemic due to increased workplace and life stressors.*

[Ref. Turnover Report]

Project Woman has contracted with local temporary agencies to ensure required staff/facility ratios are maintained due to lowered responses for open positions as a result of the pandemic.

1. Risk Prevention:
   1. Improve facility compliance:Through feedback from staff, community partners, volunteers and consumers we are aware that there is insufficient parking at our main office/service location. The distance to/from offices from the designated parking is a barrier for many survivors for reasons such as age, injury, and safety. There is not enough parking capacity in addition to the distance which causes the need to park even farther (opposite side of the campus) for many.

Goal: Project Woman in cooperation with the landowner will identify Accessible Parking accommodations at the E. Home Rd. location to be in compliance with ADA requirements.

Timeline: Spring 2018; January 2020; December 2020; December 2021

Result: Postponed *pending campus renovations by the Clark County Commission*

* 1. Security Information: *See Safety and Health Report section below.*
  2. Financial Stability:
     1. Increase Financial Reserves:

Goal: Project Woman will increase reserve funds (Money Market, other holdings) by 5%.

Timeline: September 2020; December 2021

Result: 0%: *pending PPP loan forgiveness results – updated report will be provided.*

Interim Benchmark: Increase Cash on Hand to 90 days.

Result: 81% of goal

COH 105.41 [6-2020 unaudited] COH 73.24 [12-2020 unaudited]

**Section 2-Outputs**

This section looks at Project Woman’s outputs. Outputs are measurements of productivity. The outputs focus on what we are doing, rather than how what we are doing is helping our clients. Later in this report we will look at outcomes and discuss how clients have benefitted from our services.

All Programs:

Project Woman will meet funder defined outcomes and outputs with integrity for all programs and operational areas. % of deficiency in meeting funder requirements will be reported monthly, quarterly and annually to ensure continuous improvement strategies are timely.

Goal/Standard for compliance = 100%

Timeline: December 2019 and ongoing

Result: 100% Compliant with funders 0% Non-compliant with funders

100% Compliant [6-30-2020]

*Two local funders have asked for additional clarification related to shelter stay tracking by county and/or clarification of funds use for the program. Additional reporting measures have been put in place to meet this request. Non-compliance has not been specifically identified, however, for the purpose of this report and assurance of continuous improvement efforts these are reported as need for improvement.*

93% Compliant with funders [2/28] 7% Need for Improvement

Community Advocacy & Education

Output #1: Provide student engagement on campus 10 times in the academic year

Result: Q1: 2; Q2: 3; Total = 5

50% of annual goal *\*on track for Mid-term period*

Output #2:  Attend/lead 36 community events/meetings in the fiscal year

Result:  Q1: 3;   Q2:8; Total = 9

25% of annual goal *\*pandemic measures have limited events/meeting attendance*

Behavioral Health Program

Output #1: Meet Utilization of 60% for Community Psychiatric Support Treatment

Result: 35%

Improvement Strategy:

1. Adjust staff positions related to cost and ability to produce units within the Medicaid Redesign constructs
2. Initiate and/or follow through with staff performance evaluations including corrective action when warranted.

*Pandemic measures impacted 4th quarter performance. Delay in billing due to transition to telehealth services is one factor. Updates to this period results are pending after reconciliation of billing through the Clearinghouse and Medicaid Portals.*

Output #2: Meet Utilization of 50% for Individual Counseling

Result: 66%

Transitional and Supportive Housing Program

Output #1: Meet Utilization of 50% for Transitions Case Management

Result: 35%

Improvement Strategy:

1. See above strategies for CPST
2. Restructure supportive housing program to delegate CM and Advocacy duties to other staff vs. a designated housing specialist to reduce redundancy, overlap, and inefficiency.

**Section 3- Outcomes**

This section looks at how our survivors/clients are being impacted as a result of our services. Client outcomes can be difficult to measure in our area of service. For this reason, Project Woman has decided to focus on how our clients perceive they have been impacted. Our services help survivors to begin a journey that they will continue on at their own pace. It is our responsibility to ensure that our services are delivered in accordance with our mission:

*“Project Woman is dedicated to ending domestic violence and sexual assault by providing services and programs that protect, educate, and empower members of the community.”*

Outcomes have been chosen based on surveys provided by the Ohio Attorney General’s office, as well as past studies conducted of similar information.

Advocacy Program

Outcome #1: 85% of survivors surveyed report knowing more about VINE and VOCA Compensation Funds. \**New Measure*

Result: 56%

Current Period: Q4 = 56% \*noting a significant reduction from 100% in the previous period.

Improvement Strategy:

1. Create VINE and VOCA information packets as handouts at all points of entry to the agency. All subsequent providers will offer review of this information and provide education on how these programs may meet the needs of survivors.
2. Staff training/remediation about VINE and VOCA compensation will be provided across all programs.
3. Advocacy staff performance evaluations will be conducted and offer options for improvement to meet this program goal.

Outcome #2: 95% of survivors surveyed report knowing more ways to plan for safety

Result: 97%

Improvement Strategy: Update – *strategy has had a positive impact*.

1. Surveys will be distributed by the advocacy program at more frequent intervals throughout survivor engagement in the program.
2. The Shelter program will engage victim advocacy and safety planning in more frequent ways within the program.

Behavioral Health Program

Outcome #1: 80% of survivors surveyed who report knowing more about community resources/services available to assist them

Result: 100%

Outcome #2: 90% of survivors surveyed who report feeling that their counselor understood what they are going through at the time they presented for care

Result: 100%

Outcome #3: 85% of survivors surveyed who report that they understand they are not responsible for the abuse they experienced

Result: 98%

Community Advocacy & Education Program

Outcome #1: 85% of students with correct post survey answers

Result: 89%

*\*pandemic related closures of schools have resulted in reduction in participation*

Transitional and Supportive Housing Program

Outcome #1: 85% of survivor/tenants report knowing more community resources/services available

Result: 100%

Outcome #2: 85% of survivor/tenants report more focus to maintain or increasing independence

Result: 83%

Improvement Strategy: Updated – *some positive impact noted*

1. Identified lead staff (Housing Advocate) will provide intensive support to ensure engagement in Empowerment Education programming for all tenant/survivors enrolled in the supportive housing programs.
2. Empowerment Education calendar/schedule will be published to all tenants/clients monthly to encourage participation in programs.

Emergency Shelter and Safe House Program

Outcome #1: 85% of survivors will enter safe housing within 60 days of entering shelter

Result: 59%

Interim Benchmark: Achieve and maintain 45 day average LOS

Current Period: 83 days Previous Period: 78 days

*\*Impacts of the pandemic included higher barriers to moving from shelter to safe/affordable housing solutions.*

Improvement Strategy:

1. Realign program focus to Housing Advocacy and dovetail supportive housing solutions with overall safety and relocation strategies.
2. Retrain all staff in the Coordinated Entry process and engage with the local Continuum of Care to ensure access to funding for housing solutions.

**Section 4- Case Record Review**

Project Woman conducts a quarterly Case Record Review by area of service. Charts are selected randomly, and no identifying information is recorded as a part of the review. The intent is to ensure that client records contain all necessary information to be compliant with regulations. Our target for accuracy is 80% across all areas of service. For programs of service that fall below this target, an improvement plan will be required. Please review Section 6 of this report for all improvement plans.

Goal/Standard of compliance – 100% for all programs.

Result: 98%  *Consistent performance*

Improvement Strategy:

1. Engage a volunteer(s) to assist in administrative functions of the supportive housing program to bring files and database entry into compliance.

Timeline: April 2020 - Completed

1. Reconfigure central filing process to ensure chart elements are clearly segregated and all redundancy removed.

Timeline: April 2020 - Completed

**Section 5- Client Comments**

Some of the most valuable information that we receive is in the form of client comments and feedback. In this section, you will find examples of what our clients are saying about our agency and services. (All identifying information has been removed.)

“I feel like you [PW] saved my life. I will forever be grateful.” - Survivor

“Nisa is amazing.” - Survivor

“Programs should work better together.” - Survivor

“I went from totally dependent to independent!! Thank you!” - Survivor

“I don’t understand VINE funds; it was explained to me but it is still confusing. “ - Survivor

“I may have given up if it weren’t for calling because you just listened and then I realized it would be okay.” – Crisis Line Caller

“Thank you for making the time to figure out what was needed to help this person. During the ‘shut down’ it was hard to know how to make things happen.” – Referral Partner

“Thank you for putting in the “donation drop” to make it easy to put in things you need and be quick in/out since we are being careful to be socially distant!” - Donor

**Section 6- Improvement Plans**

Improvement plans have been implemented to address any areas that fall short of goals. A brief synopsis of the work we have been doing to improve is located in this section.

Utilization Improvement: behavioral health and advocacy staff have the ratio of direct/indirect time calculated monthly.

CPST Annual Total: 47% of Goal *\*some improvement noted over mid-year report (35%)*

Next Steps:

1. Corrective Actions for staff who have not achieved and/or maintained utilization requirements will be completed.

Individual Counseling Annual Total: 72% of Goal *Improvement noted over year-end report (66%)*

Next Steps: Monitor No-Show rate and adjust scheduling strategies accordingly

Next Steps: Track # of individuals who are ineligible for Medicaid and/or have private insurance access.

Advocacy Annual Total: 92% of Goal

Next Steps: Hire open position [1FTE] – units could not be delivered due to short staff capacity

Shelter Annual Total: 154% of Goal

Next Steps: Review funding options for more shelter capacity including off-site shelter/hotel stay and modification of space at shelter facility to accommodate additional beds.

**Section 7- Recognition**

Project Woman recognizes members of the team who exhibit excellence, show great improvement, go above and beyond for individuals and for the mission, etc. This section highlights outstanding team members and accomplishments.

Shout out for Nisa! – Received the Chrysalis Award for excellent services as an Advocate [18 years!!]

Shout out for Mahdaja – Met personal Utilization Goals 3 periods in a row!

Shout out for Audrey – Ensured CAP Model fidelity for the team!

**Section 8- Miscellaneous Information**

1. Compliance with Database Solutions (PIMSY and OSNIUM):

Improvement Strategy:

1. Establish a schedule of training for all levels of staff to build efficiency in user entry and report processing.

Timeline: September 2020 (delays due to COVID19 limitations on in-person training and backlog for online/conferencing with the database provider.)

Completed: December 2020

* Staff have been trained in routine data entry and report functions.
* Program leadership will receive updated training in administrative functions for either/both systems to ensure responsiveness and ability to configure varying reports to meet funding and regulatory requirements.
* Direct Service / Intake staff will receive a “Deep Dive” training as part of on-boarding and annual requirements to ensure ongoing efficiency and compliance with use of the database solutions.

1. Realign staff duties to maximize expertise in Medicaid billing and database management by CPST staff (Kenisha) and reduce her caseload demand accordingly.

Completed: April 2020

**MUI & Grievance Report:**

Grievances Filed: 2

Substantiated: 1

Allegation of Clients Rights Violation: confidentiality, privacy, and professional boundaries.

1. Review conducted by the CRO: 1 staff was found to have violated professional boundaries by sending/receiving texts with a survivor on personal device [even though company equipment was issued and is available for use]; violation of confidentiality by speaking about survivors to others without authorization (this includes other survivors receiving services).

Unsubstantiated: 1

Allegation of Clients Rights Violation: being treated with respect, ethical behavior, professionalism.

1. Review completed; indicating survivor’s rights were not violated. Recommendations for program improvement include remediation and retraining of shelter staff regarding crisis intervention strategies, UI/MUI reporting requirements, and effective communication during conflict. Additional recommendation includes review and revision to inventory controls and communications across programs at point of exit from shelter.

Issues/Trends:

1. Client Rights related to staff violation of client confidentiality.

Recommendations/Actions Taken:

1. Staff remediation where necessary and appropriate.
2. Staff training for program areas to ensure understanding of professionalism, boundaries, confidentiality and privacy rights assured for survivors under VAWA.
3. Staff correction up to and including termination where necessary and appropriate.

Incident Reports Filed: 151

Issues/Trends: [See attached quarterly reports]

**Safety & Health Report:**

The Safety and Health Committee conducts a quarterly review of all issues regarding employee and client/survivor safety by focusing on facilities and risk management. The Committee utilizes representatives from across all programs and administration of the agency. The Committee has identified the following safety issues along with recommendations and results over the past year:

1. Safety and Security:
   1. **Technology:** 
      1. Security cameras are in use at all facility locations including both shelters, Chrysalis Manor, and the administrative/program offices. All locations are monitored with a variety of camera views.
         1. Currently in process of upgrade at the Springfield Shelter to mirror the newer technology installed at the Champaign County facility. Completed: December 2020
         2. Currently reviewing options of upgrade to the security system and camera monitoring at Chrysalis Manor to increase panoramic view and garden location with greater magnification.

Pending secured funding;

Timeline: May 2021

* + 1. Alarms (Security) are installed on all entrances and windows in each shelter location.
    2. Each facility location (Shelters, Chrysalis, and Admin/Program Offices) have camera surveillance.
       1. Springfield Shelter have had additional exterior cameras installed to increase view and monitoring capability for parking lot, fence line at property perimeter and street view.

Completed: April 2020

* 1. **Other Safety and Security**:
     1. Fence at Springfield Shelter is scheduled to be removed from its current location and adjusted to include the perimeter of the property down to and including the 12-step configuration at the bottom of the yard/parking lot.

Timeline: November 2020 [Completed]

* + 1. Lighting at the Springfield Shelter is not sufficient in the parking and street access areas causing concern for safety.
       1. Submitted request to maintenance (to landlord) for estimates and work orders.
       2. Trees and brush that were obstructing the current lighting were removed. Some increased visibility noted.

Timeline: April 2020 [Completed]

* + 1. Property Line Delineation and Privacy Fence is necessary at Chrysalis Manor due to increased report of trespassing and vandalism across property boundaries.

Timeline: May 2021

1. Health and Safety**:**

Safety and Health inspections are conducted monthly (per shift at shelter locations) which includes a review of all fire extinguishers, fire safety plans, lighting and other systems. Preventative and other maintenance requests are submitted as needed and the appropriate maintenance completed as soon as possible once the need is established.

* 1. Project Woman established a Wellness Committee to serve as a subcommittee of the Safety and Health Committee. Priorities accomplished this year include:
     1. Engaging volunteers to provide reflexology and seated massage for staff once quarterly.
     2. KUDOS program: 71 “kudos” were given to staff by their peers in celebration of helpfulness, going above and beyond, and other ways that they have stood out to each other in the course of doing their jobs for the mission of Project Woman.
  2. Staff identified interest in participating in an Active Shooter training.

[ON HOLD due to the Pandemic – social distancing requirements]

**Section 9- Future plans:**

*Status from Year-End Report:*

1. Lower Level completion will allow moving forward with storage and inventory of donations, marketing and outreach materials, general supplies, and usable project-based space for activities.
   1. Engage volunteers routinely to assist in processing donations and materials.

(On-Going)

* 1. Additional strategy implemented: hired a part-time Reception Specialist in order share some of the increased reception duties [related to COVID19] and to ensure appropriate inventory and use of donations across all programs.

*This position was temporary and is currently being filled by a routine volunteer.*

1. Determine logistics of the front reception area and intake offices and reorganize as needed to optimize the flow of services and ensure the highest level of trauma-informed environment possible given structural constraints.

(Target Date for Completion: *ON HOLD – pending feedback from the County/Landlord and review of optional solutions)*

1. Establish a training series for Administrative and Leadership staff to ensure ability to operate all functions of database solutions (PIMSY, Osnium) and use of the billing clearing house (Trizetto).

Completed. See above

1. Review budget and funding options to revise the table of organization to include a Director of Operations in order to intentionally coordinate all programs.

(Target Date for Implementation: May/June 2021)

1. Allocate resources either through new funds or revised use of existing funds for a data entry position to meet the goal of data quality and timeliness of reporting as a subset of Section 2: Outputs: All Programs “Be 100% compliant with all funders / grant programs.”

Timeline: On Hold pending other priorities due to Ongoing Pandemic Measures.

1. Preparations for Re-accreditation through Council on Accreditation and increased demand and workflow make necessary a temporary [or temp/perm] hire of an Executive Assistant to focus on records and policy/standards review and work in concert with the Executive Director and Leadership Team.

Timeline: May 2021 – December 2021

1. Update shelter facility capacity to meet demand for service including on-site, off-site options and review feasibility of Safe House networks with community partners.
   1. Revise unused office spaces for temporary overflow shelter accommodations using Cares Act funding as available.

Timeline: May 2021

* 1. Consider capital options for renovation or new build locations to ensure sufficient emergency shelter and supportive housing solutions to meet demands.

Timeline: January 2021 – ongoing

1. Establish a facilities committee to determine feasibility