

2010 - 2011

Women In Distress of Broward County, Inc. Performance (Continuous) Quality Improvement Plan

Women In Distress of Broward County, Inc. (WID) was founded in July 1974. WID began as Broward County's first refuge for homeless women in a modest four bedroom home on Sistrunk Boulevard until a local tragedy brought light to the need for shelter for women and children in danger. After enduring a brutal beating at the hands of her spouse, a young Broward mother sought sanctuary at WID. At the time, WID was not licensed to accept children and the woman's two children were placed in temporary foster care while she stayed at the shelter. The separation from her children proved unbearable for the young mother, and soon thereafter she return home with her little ones in tow. Just one week later she was shot and brutally murdered by her spouse, as her children witnessed this unspeakable act of violence. Shortly after this tragedy, the agency's founders were able to purchase the current 54 bed shelter with generous donations. For the first time, WID was able to offer crisis shelter and support to victims of domestic violence and their children, as well as homeless women. In November 1995, the doors of the Jim & Jan Moran Family Center opened. The Family Center instantly increased WID's visibility, accessibility and capacity to serve more families. In 1999 we opened the door to Lorraine's House, an 8 bed Safe Home in Hollywood, to address the growing need for emergency shelter space. The Lorraine House was subsequently sold in December 2009, as we plan to relocate to a consolidated campus.

In December 2008, the Board approved the purchase of a 6 acre site with a complex of buildings in Deerfield Beach. After extensive renovations, this will become the new consolidated Jim and Jan Moran Family Center Campus of Women In Distress of Broward County, Inc., with the move projected in late 2010. It will house all of our operations – administrative, outreach, counseling, and more importantly, provide more emergency shelter beds in one secure location

Women In Distress has 36 years of experience serving the needs of domestic violence victims and their families in Broward County. We are currently the only nationally accredited, state-certified, full service domestic violence center serving Broward County. Our mission is *to provide victims of domestic violence with safe shelter, crisis intervention and resources and to educate the community in order to Stop Abuse for Everyone (SAFE) through Intervention, Education and Advocacy.* We strive to accomplish our mission by offering 24-hour crisis intervention services through our hotline and crisis shelter facility, counseling for domestic violence victims and their children at various locations throughout Broward County, support services such as food, clothing and household items, and community education and professional trainings on domestic violence and related topics.

We believe that each survivor of domestic violence has the right to a safe secure home and the capability to self-determine his/her violence free future. That is why we center

our efforts on providing an environment that will help victims recover from the traumatic effects of victimization and develop an understanding and awareness of the dynamics of domestic violence – empowering them to gain independence and self-sufficiency.

Philosophy of PQI

In an effort to provide the highest quality care for the families we serve, Women in Distress of Broward County is committed to a plan for continuous quality/performance improvement. This plan is designed to systematically gather information from all stakeholders, for the purposes of planning and assessing the efficiency and effectiveness of service delivery and customer satisfaction. An effective quality/performance management system also ensures that administrative and support divisions (financial, HR, IT, facilities, administration, safety and security) serve the needs of program managers to, in turn, meet the needs of the agency's strategic plan and annual goals. The processes are strength based, and allow and encourage managers and their staff to operate their programs in ways that maximize performance while minimizing costs. The goals are to determine causes and provide solutions, towards eliminating or reducing identified problems when data reveals issues of concern. In addition, this process provides for the development and/or replicating best practice models. Corrective action is integral to the plan, with identified staff responsibilities and timeframes for implementation. Each quarterly meeting begins with progress on items for corrective action or implementation. Tracking continues until successful completion or resolution.

The Board of Directors has delegated responsibility for the implementation of the plan to the Chief Executive Officer and the management team of the organization. The plan is reviewed and updated on an annual basis by the management team and the Board of Directors. The Board will review the data generated by the Performance & Quality Improvement process on at least an annual basis for the use of developing a long-range organizational plan. In addition, reports are distributed to the board for their review and input. Policies and procedures, personnel assignments, staff training, contracts and programs are revised as a result of the PQI process when warranted.

Critical to this plan is the involvement of all stakeholders of the organization, to include, but not limited to: the families in service, the Board of Directors, staff, volunteers, funding sources and community organizations. Stakeholder input is solicited through on-going consumer satisfaction surveys, annual staff and volunteer satisfaction surveys, board involvement, surveys of funding sources and community organizations. Ongoing suggestions are encouraged from staff and families in service with suggestion boxes at all locations, which are incorporated into the PQI program. Feedback regarding the PQI plan and processes is provided to all stakeholders through a variety of methods: A quarterly and annual summary of PQI activity provided to the staff and volunteers; The board also receives reports and information via the CEO report; and PQI information is included in the agency's Annual Report which available to all stakeholders.

The PQI process involves staff at all levels of the organization. Directors and supervisors are responsible to gather data and report at the quarterly committee level.

The PQI Coordinator is responsible for the overall coordination of PQI activities. This responsibility can be delegated when necessary. Supervisors and managers are trained in data driven management, with each department reporting to a PQI subcommittee. Subcommittees meet on a quarterly basis to review data, discuss trends, develop and monitor corrective action plans and review progress. The subcommittees are task oriented, with their information being forwarded for the larger PQI meeting. The PQI meeting reviews progress and established mechanisms for providing feedback to all stakeholders.

The program addresses the following elements:

- Long-term planning
- Short term planning
- Internal quality monitoring
- Records review
- Outcomes measurement
- Measurement of consumer satisfaction
- Feedback mechanisms
- Information management
- Corrective action

Long term planning: The Board of Directors is responsible for long term planning for the organization, with input from the Chief Executive Officer and staff. This process takes place at a minimum, every four years. The development of the organization's long-term plan includes a review of the mission and vision of the organization. This process results in goals and objectives that flow from the mission and mandated responsibilities of the organization. The planning process assesses strengths, weaknesses, opportunities, threats and human resource needs. From this process, strategies for meeting the identified goals are developed.

Long term planning includes an assessment of community needs, which examine services offered by other providers in the community, gaps in the organizational continuum of care, accessibility and the need to redirect or expand services in response to changing needs of the community. Demographic data is developed and reviewed in relation to the makeup of the community, the organizational staffing and the population we serve. Specific data to be assessed includes: annual household income, gender, age, racial/ethnic composition, religious affiliation and language of choice.

Short term planning, which is departmental and staff driven is conducted annually to operationalize the goals and objectives of the organization's long term strategic plan. This process encompasses the data resulting from the performance & quality improvement process and permits flexibility to respond to changing organizational and community needs. Short-term goals and objectives are assessed and developed, with specific time frames, budgetary objectives and the delineation of staff responsibilities.

Methods of assessing progress toward goals and objectives are specified at that time. On an annual basis the organization examines outreach, intake, assessment and service delivery processes, to identify barriers and opportunities to serving any group within its defined service population, human resources deployment, training and supervision. A risk management assessment is conducted to review the overall risk to the organization, in relation to the review of research and legal requirements, inclusive of licensing and mandatory reporting laws. Findings from external review processes such as audits and accreditation activities are addressed as well.

Internal quality monitoring consists of gathering data from all areas of the organization, which is used in the management of efficiency, effectiveness and customer satisfaction. Subcommittees have been developed to manage the data, assess trends and provide feedback for the quality improvement process. The following is a brief description of each review process and review forms are attached to the plan.

Quarterly case record review is conducted with randomly selected open and recently closed cases, as well as high volume/high risk participants will be reviewed by the case review team on a quarterly basis. This review will be in addition to clinical supervision and will be completed by someone other than the assigned staff member or their supervisor. A minimum of 25 cases will be reviewed from each program. Data will be used to identify trends and ensure clinical and administrative compliance. Charts in need of corrective action will be checked for compliance in the following review.

- Specific points for review include, but are not limited to:
 - Quality of the documentation
 - Screening and assessment
 - Service planning
 - Services provided
 - Appropriateness of service in relation to need
 - Case notes
 - Outcome of the case – service goal attainment
 - Safety planning
 - Administrative review for paperwork and signatures
 - Legal requirements –confidentiality forms, consents and contracts

Participant satisfaction data is gathered on an ongoing basis from individuals and families in service. Monthly, participant satisfaction information from all departments

and points of service will be compiled in a report and presented at the PQI meeting. Surveys are anonymous and may include basic demographics. This report will include aggregate data in a quantifiable format. Recommendations for improved satisfaction will be presented, as well as recommendations for increased participant input.

Staff satisfaction is assessed on an annual basis. Anonymous surveys are distributed to all staff and information is aggregated and presented at the department head and the board of directors meetings . Areas of dissatisfaction are assessed and suggestions for increased satisfaction are incorporated into the PQI process.

Outcome measurement is performed for each service program with regard to individual participant progress and aggregated to assess program effectiveness. In an effort to individualize service planning, each program reviews achievement of individual service plan goals at case closing, in relation to the number of goals set. Changes in clinical and or functional status are assessed based on progress toward service goals. Each service has established outcome expectations, which are compared to actual outcome data. Service areas and training also incorporate pre and post testing to assess effectiveness of the intervention. Program modifications are made in response to findings.

Facilities and physical plants are inspected on a weekly basis, generating monthly information related to facilities and physical plant needs including information from maintenance requests, completion of same and presented to the PQI committee

Grievance and Serious Incident reports are gathered on a monthly basis and all participant grievances and serious incidents are reviewed. This data is addressed at quarterly Risk management meetings and is used to determine trends, environmental risks, areas of concern and to make recommendations for improved service delivery and customer satisfaction.

Contract/grant compliance is assessed on a monthly basis, with each department reporting on compliance with outcome measures and progress toward annual goals. Areas not performing to standard will submit a plan of action for correction.

Human Resources aggregate data from exit interviews with recommendations, which is presented quarterly. Annually a report is generated, to include turnover rate and trend analysis. The results of annual employee satisfaction surveys provide the basis for an annual action plan, with the goal of improving employee satisfaction. Personnel file reviews will ensure compliance of legal and funder requirements.

Training and Development aggregates data from all internal and external training sessions and provides recommendations at the monthly meeting. Compliance with mandatory training is coordinated and monitored. Staff lacking required training will be identified and compliance will be ensured

Staff training needs assessments/satisfaction are performed quarterly, with results driving the training calendar for the next 3-6 months. An annual training calendar with

mandatory training scheduled is developed with an alternative plan for those unable to attend the two scheduled trainings (i.e.: video, external sources, etc.). Quarterly clinical in-service training is driven by staff need.

Information Technology has written procedures, which govern the management of information and ensure adequate systems to support operations, planning and evaluation activities. Procedures govern the electronic collection and transfer of sensitive data. Fundamental to this system is dependability, confidentiality and rapid access to information. Consistent formats and methods are used for reporting and disseminating data. All computers have viable anti-virus protection; security measures to limit access and are backed up daily.

In an effort to ensure the dependability of the information technology program, daily checks and assessments are in place, which are monitored and adjusted according to need. Issues and trends are identified and action is taken to increase efficiency, effectiveness or user satisfaction, which is incorporated into the PQI program.

Finance utilizes data driven management to ensure compliance with federal, state and local mandates, as well as the efficiency of systems for daily operations. Quarterly reporting of these systems and additional areas of concern are presented. Annually the findings of the audit are integrated into the PQI process.

Development reviews special event and mailing information, in terms of return on investment and areas for improvement. In addition, daily systems are assessed for efficiency and effectiveness, which are processed through the PQI process.

Thrift Store sales and administrative issues are included in the PQI process, with emphasis on increased sales and customer satisfaction. Quarterly reports will be conducted for satisfaction surveys made available to patrons, this information used to increase satisfaction and sales. Administrative issues are also presented as applicable.

Additional items from each department are presented at the PQI subcommittee or general meetings as applicable.

The Performance & Quality Improvement Cycle

WID performance & quality improvement efforts are based on the Quality Improvement Cycle. Requests for quality measurements and recommendations may come from anywhere in the Agency or from external stakeholders. These requests will be directed to the supervisor of the specific department, who may then bring to the applicable Performance and Quality Improvement (PQI) Committee. The committee will follow the process to gather and analyze data, recommend changes, if needed, based on the data, measure the results of the changes and report results of the process.

Planning for Quality Improvement

The “Quality Improvement Cycle” is a never ending process that is anchored in planning. Every set of changes and their analysis leads to another round of planning. The agency’s Strategic Plan, is established by the Board of Directors and is based on input from community stakeholders, staff members at all levels, participants and funders. This provides the foundation for quality improvement planning. Meetings of the Board of Directors, senior management, program staff meetings, meetings with referring authorities and funders all factor in to the planning process.

Inputs

Issues that are to be studied and improved are called inputs. Usually, the determination of which issues require attention is based upon the planning process or previous quality improvement cycles. Some examples of inputs are:

- Analysis of customer satisfaction surveys (program participants, employees, recipients of trainings, customers at the agency’s thrift store)
- Requests for analysis from senior management
- Reports from funders/monitors
- Results of internal and external program audits
- Contract requirements
- Items identified by employees

The Performance & Quality Improvement Committees will review all possible problem areas and determine which are recommended for inclusion in the “formal” annual PQI process for new input tracking. Supervisors of specific departments then assign individuals or teams for data collection and analysis.

Data Collection

Once we identify an input as an important issue, we must collect data. The data informs us how we currently operate and may take the form of surveys, file reviews, aggregation of data contained in existing reports and direct observation. In most cases, an effective improvement cycle will include the collection of both quantitative (numeric) and qualitative (anecdotal) data.

Data Analysis

The data is examined and used to determine whether the problem is, in reality, a real problem. Data analysis is the process of turning data into useful information. It involves using the data to provide answers to the questions that are asked in the input process. Some examples may include:

- Is there an actual or perceived problem?
- Is the problem limited to certain programs or does it affect the entire agency?

Data is analyzed by a combination of individuals with knowledge of the subject being studied and individuals with expertise in analyzing data who have little or no knowledge of the specific subject. Data analysis should take place immediately after it's collected to ensure the relevance of the information.

Findings & Conclusions

Data analysis leads to findings and conclusions. Findings and conclusions should point to the root causes of the issues identified in the planning process or as inputs to the PQI process. It's also possible that data analysis may lead to the conclusion that more data needs to be gathered. Findings and conclusions should be completed as soon after data gathering and analysis as possible.

Often the findings and conclusions will point us to areas of strength. If this is found to be the case, the item is tracked departmentally as Quality Assurance for continued monitoring. This is done for a minimum of two reasons: one, it may be a grant objective that we want to ensure compliance with by vigil monitoring and data tracking or two, it may have been an area of concern in the past but data tracking has shown a period of success. It is moved to QA and then monitored for consistency within the relevant department before removing from the PQI process altogether. All areas are subject to returning as a new input.

Recommended Changes

Most findings and conclusions that identify the root cause of problems should lead to recommended changes. Based on the severity of the problem, these changes may be minor or they may fundamentally change the way we do business.

Implementation & Monitoring

The key to any improvement cycle is implementation. Successful implementation means that we're open to change even if we're not sure that the change will achieve the desired results. It also requires the support of all levels of management. People have to know and believe that they can make changes without fear of reprisal and that the changes are not punitive.

Once changes have been made, they have to be monitored for their outcomes. Changes that have negative effects should be revisited and those that have positive effects should be implemented in other areas where necessary.

Outputs

Once changes have been made and their impact monitored, we must report on the results. These reports should be prepared as soon as possible after the changes have been implemented and monitored. Outputs are made available to the board of directors, senior

management, program participants, referring authorities, community leaders and funders. This can be achieved through direct mail, email, and the agency's website, www.womenindistress.org.

Completing the Cycle

By reporting the outputs of the quality cycle, we'll automatically begin the process again. Some people will read the reports and begin the planning process again, either on the same topics (if root causes aren't identified and fixed) or on different topics. Additional people will see the success of the quality improvement process and suggest new inputs. By instilling this culture in our leaders and stakeholders, performance and quality improvement becomes a never ending process that continuously benefits our participants, our agency and our community.

Measurements & Outcomes

Throughout the cycle, measurement techniques and outputs from each department are analyzed. During quarterly Performance Quality Improvement meetings, discussions include the process of quantitatively comparing results with identified benchmarks. The impact of outputs are analyzed and provide the basis for activities to reach the target goal or outcome. Below are several outcomes which have been incorporated as a result of the PQI process.

- *Reduction in participants' wait time. Having an extended registration wait time means a longer period families have to wait to obtain domestic violence services. This could include important safety measures, educational information, links to referrals in the community, counseling, or even emergency shelter services. Although we can see walk-ins without a registration for emergency shelter services, there may be those who do not state their emergency needs and leave because of the wait time.
Outcome: By reducing the registration wait time, we are able to serve people faster which ultimately means providing options sooner to those affected by domestic violence. Safety, shelter, and advocacy needs are addressed without delay.*
- *Increase in number of post tests. Children are given a pre-test when they come in for services and are later measured with a post test that shows information learned about domestic violence. Without getting a sufficient number of post tests returned, we are not able to measure whether our programs are providing information that can make an impact on a child's daily life. We are also not able to provide data to many of our funders who expect these outcomes.
Outcome: By increasing the number of post tests returned, we are able to show data that our child participants have gained knowledge about safety planning and domestic violence. This knowledge will give these children tools how to be safe*

and information on what a healthy relationship looks like. These are the tools that will help them to develop their own healthy relationships later in life.

- Reduction in the amount of and simplifying participants' paperwork at orientation, resulting in increase in receipt of post tests.
Outcome: Results of post-tests provide information to evaluate the effectiveness of our orientation program.
- Reallocation of resources to improve cleanliness of participants' living quarters.
Results of resident satisfaction surveys revealed the need for improvement in living conditions. A maintenance person is now based at the residential facility and cleaning and maintenance of vacant apartments have been added to the job description.
Outcome: This has resulted in better maintained apartments and is a work in progress.
- Improved employee communication and recognition. *Results of the annual employee satisfaction survey indicated that communication from management and across departments needed improvement. An action plan was formulated, with input from line staff, supervisors and managers, which specified techniques to foster improved communication. Although this is a work in progress, feedback from employees indicates improvement. The survey results also revealed that employee recognition could be improved and actions are in place to increase opportunities for both peer recognition and recognition by supervisors.*
Outcome: Although this is a work-in progress, turnover in 2009 (25%) is 5% lower than turnover in 2008 (30%).
- Late receipt of department reports. *Monthly reports from each department are included in the information packet which is distributed to members of the Board of Directors prior to the monthly Board meeting. The reports convey, by department, both programmatic and administrative activities throughout the past month. This problem was made a PQI performance indicator, benchmark date due was established and measures were incorporated by each department to gather and submit report by the designated date.*
Outcome: Reports have been submitted on time resulting in the Board receipt of current information.
- Improved equipment. *Results of satisfaction surveys indicated that printers have been out of commission frequently and present an obstacle to timely and quality work.*
Outcome: The contract with the provider of the equipment has been re-negotiated and copier/printers have been upgraded.
- *Creation of development department goals surrounding increasing supporters and improving tracking systems.*

- *Creation of goals and development of an action plan for 2010 to increase employee satisfaction*

Operational Procedures

The PQI process doesn't end with data collection. Once data is collected, it is turned into useful information, presented in a meaningful way, analyzed and used to recommend and implement changes. In addition, the changes are tracked and the process started over again. Finally, any Women In Distress stakeholder may present a potential input idea to the PQI Committee for discussion and tracking.

Reporting

The cornerstone of the reporting process is an annual report summarizing all the quality improvement activities taking place throughout the agency. This report is made available to the board of directors, senior management, families served and external stakeholders such as funding sources and community partners. It is also available to the general public via www.womenindistress.org. In addition to the annual report, Women in Distress will prepare and distribute ad hoc reports on specific performance and quality improvement topics throughout the year. These reports may be used for internal purposes only or they may be released to the public.

Review of the Process

On an annual basis, the PQI Committees will review the work from the previous year and determine what re-work needs to be done on the process. This work may include: Identifying problems, adding and changing measurements, adding and changing benchmarks, assessing the Committee's strengths and weaknesses and identifying those barriers that stand in the way of the Committee doing its best possible work for the Agency.

In order to do this in the best possible way, the Committee will reach out to the following broad spectrum of stakeholders for feedback: community partners, participants, Women in Distress Board of Directors and Women in Distress staff.

