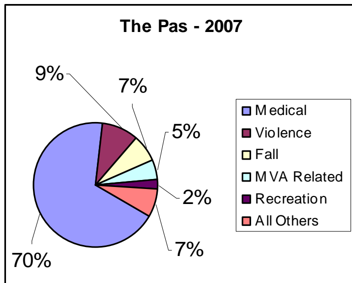
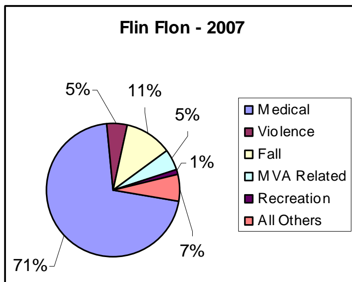
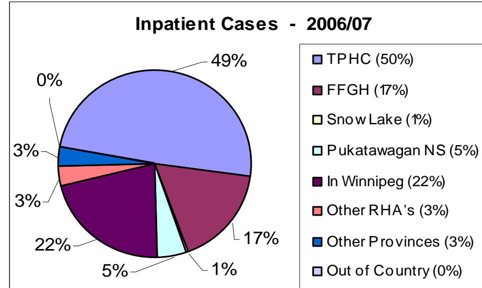
QUALITY SCORECARD
VITAL STATISTICS ON RESPONSIVENESS
September 2008

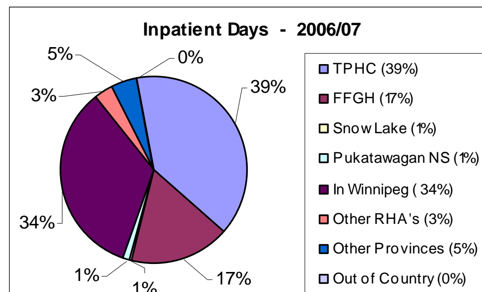
What EMS responded to?



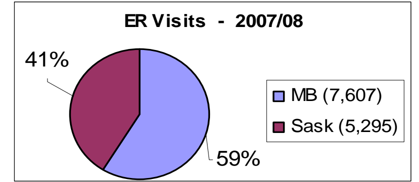


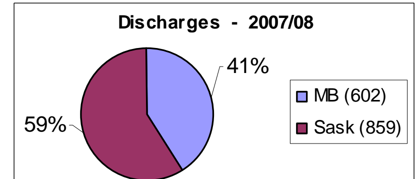
Where NOR-MAN Residents Access Hospital Services?

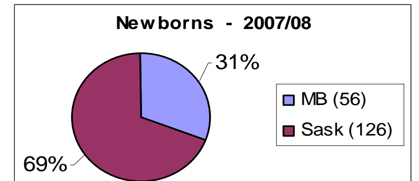


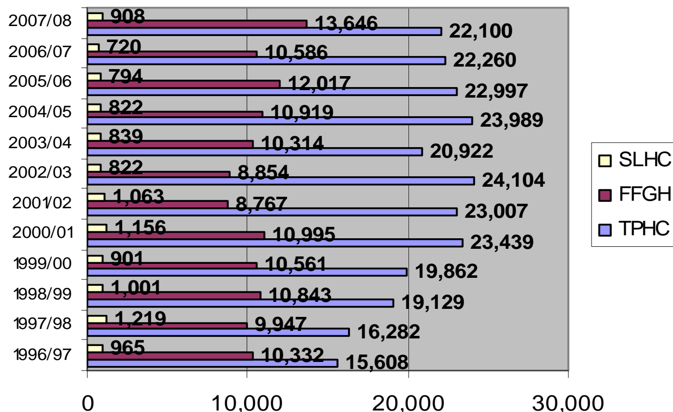


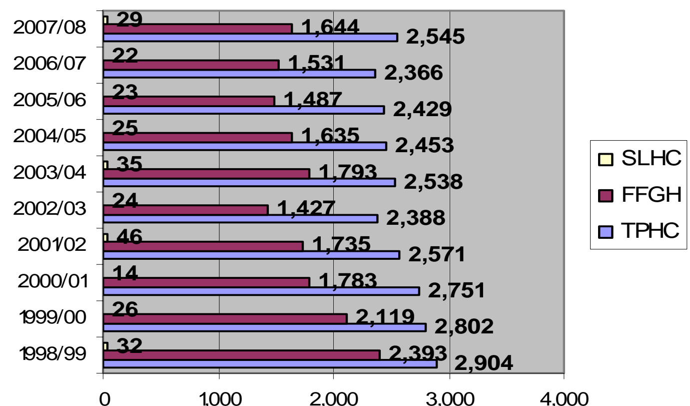
Saskatchewan Residents Use of FFGH – 2007-08

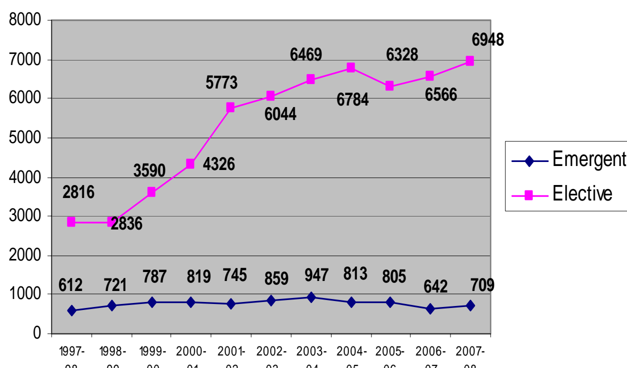












Newborn Bed Occupancy Rates

Years	FFGH	TPHC
2003/04	24%	24%
2004/05	17%	24%
2005/06	18%	24%
2006/07	18%	25%
2007/08	15%	27%

Hospital Bed Occupancy Rates

Years	FFGH	TPHC
2003/04	56%	63%
2004/05	47%	66%
2005/06	51%	62%
2006/07	39%	57%
2007/08	44%	60%

Quality Scorecard: Responsiveness
September 2008

Responsiveness

Client Satisfaction
- PCH Satisfaction
- Mental Health Satisfaction
- Acute Care Satisfaction
- Rosaire House Satisfaction
- Home Care Satisfaction
- Palliative Care Satisfaction
- Support Services Care Satisfaction
- Primary Health Care Satisfaction

Availability
- % Inpatient services provided in the region
- NPTP Travel by Physician Specialty
- NPTP Travel by Diagnostic Category
- Telehealth Unavailability
- % scheduled DER Client Days Cancelled
- % Attendance DER appointment/session

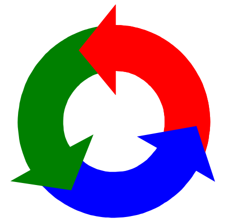
Accessibility
- % residents receiving Chemo in region
- % Home Care Requests
- CT Utilization
- Access to Dialysis in region
- Itinerant Clinic Days
- Retinal Screening Referrals

Timeliness
- Average Wait Times
- Rosaire House Utilization
- EMS Response Averages
- Average Length of Stay

Continuity
- Abstinence/Harm Reduction
- Improvement in Quality of Life
- Home Care On Call Stats
- Senior Management On Call
- % Clients Breastfeeding at 4 months

NOR-MAN Regional Health Authority Quality Scorecard: Worklife

Colour Codes: Optimal Good/ Ongoing CQI Warning/Room for Improvement Trouble/ Extensive Work Req'd In Development



NOR-MAN REGIONAL HEALTH AUTHORITY
QUALITY SCORECARD
"RESPONSIVENESS"

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension: Board End:	August 2008	**Reporter/ Source:**	Long Term Care CQI Team
Reporting Period:	December 2006		

Indicator Name: **Resident Satisfaction with Experience in Personal Care Home**

Definition: Resident Satisfaction Survey Selected Results

Results: Interpretation: The last Resident Satisfaction Survey was completed in December 2006. 124 Resident Satisfaction Surveys were distributed throughout our LTC facilities. Of the 124 distributed, 39 were returned (response Rate = 31%)

Rating: Good

- 92% were satisfied with the overall care they receive.
- 65% feel lonely, helpless and bored most of the time.
- 96% felt staff treated them with respect and kindness most of the time.
- 92% felt their privacy was respected most of the time.
- 85% were satisfied with the food.
- 82% were satisfied with the laundry services.
- 92% felt their home was clean.
- 85% were satisfied with recreational activities provided.
- 79% felt their spiritual needs were being met.
- 75% were satisfied with the pets that reside in their home.

Overall, the ratings were high as indicated by an "all of the time" response. The strengths were noted in the areas of:

- staff showing kindness and respect to the resident, their family and friends
- feeling their privacy is respected
- feeling safe
- staff taking time to include resident in conversations.

The weakness, indicated by a "never" response included:

- feelings of loneliness, boredom and helplessness

Residents were asked if they could change 3 things about the home they live in and their most common responses were:

- To improve upon the provision of recreational activities to include evenings and weekends
- To improve upon meals and snacks that are provided
- Variety of answers including need for more pets, less pets, more movies, repainting and more storage space.

Action Plan:

- Family and Resident Advisory Councils are in place and meet on a regular basis. This provides a forum to discuss and address ongoing concerns of residents/ families and to provide recommendations for improvements.
- The Long Term Care CQI Team continues to meet and identify opportunities for continuous quality improvements to improve resident's home environment.
- At present, we are only funded to have recreation staff to provide programming during the days Monday to Friday. A request has been submitted in our Health Plan for the past 2 years to provide funding to increase recreational staff for evenings and weekends
- Support Services conducts an ongoing resident satisfaction survey regarding housekeeping and dietary. See page 10 for results and action plan.
- Resident Care Audits continue to be done.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	**Reporter/ Source:**	Mental Health CQI Team
Board End:	Healthy People		

Reporting Period: December 2006 – December 2007

Indicator Name: **Community Mental Health Consumer Satisfaction Levels**

Definition:

1. Areas of Excellence: Items with >85% who Strongly Agree/ Agree
2. Things We Do Well: Items with 75% to 85% who Strongly Agree/ Agree
3. Areas of Improvement: Items <75% who Strongly Agree/ Agree

Results:
Interpretation:

Rating: Good

Areas of Excellent	
Staff encouraged me to take responsibility for how I live my life	98.0%
I like the services I receive here	96.2%
I would recommend this agency to a friend or family member	92.5%
I was able to get all services I thought I needed	92.4%
Staff here believe that I can grow, change and recover	88.8%
Staff returned my call in 24 hours	88.8%
If I had other choices, I would still get services from this agency	85.1%

Things Done Well	
Services were available at times that were good for me	84.65%
Staff were willing to see me as often as I felt it was necessary	81.4%
Staff were sensitive to my cultural background (race, religion, language, etc)	80.85%
The location of services was convenient (parking, public transportation, distance, etc)	77.7%
I felt comfortable asking about my treatment ad medication	77.7%
Staff respected my wishes about who is and who is not to be given information about my treatment	77.7%
Staff helped me obtain the information I needed so that I could take charge of managing my illness	77.7%
I am better able to control my life	75.25%

Areas for Improvement	
I do better in social situations	69.6%
I am better able to deal with crisis	69.6%
I was encouraged to use consumer-run programs	69.3%
I am getting along better with my family	67.26%
Staff told me what side effects to watch for	66.6%
I not staff, decided my treatment goals	66.6%
My symptoms are not bothering me as much	60.9%
I was given information about my rights	58.36%
I was able to see a psychiatrist when I wanted to	**51.8%**
I do better in school and / or work	47.85%
My housing situation has improved	34.8%

Adult Survey Response Rate = 19.7% (27/137 surveys)

We have shown improvements in the following three key areas since the December 2004 survey:

- staff here believe that I can grow, change and recover
- staff encourage me to take responsibility for my life
- the location of services is convenient

The first 2 indicators speak to the values of client empowerment and recovery, which were areas we targeted following the last survey. The 3rd indicator speaks to our new location in the Primary Health Care Centres.

Action Plan:	The Mental Health team in the Region will conduct the survey again in October and November 2008, at the same time as the other Regional health Authorities in the province. Results should be available in December 2008 and will be reported to Manitoba health and Healthy Living Mental health and Addictions Branch in February 2009. In the NOR-MAN Region we have developed actions plans that build on the survey indicators and are using those as part of the Quality Improvement process. We have goals in the following areas: 1. Suicide Prevention ✶ To raise awareness of issue in the region ✶ To develop inter-sectoral Suicide prevention Networks in the Region ✶ To offer ASIST workshops 4 times per year ✶ To study and implement Provincial Suicide prevention paper initiatives ✶ To study Aboriginal Suicide prevention data 2. Housing ✶ To assist clients living with severe and persistent mental illness to choose-get-keep appropriate housing in the community of their choice 3. Employee Mental Health ✶ To raise awareness of mental health issues in the NRHA staff group ✶ To offer educational opportunities to NRHA staff related to mental health issues in the workplace ✶ To promote mental wellness and emotional safety in the workplace.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension: **Board End:**	Satisfaction with Services Healthy People	**Reporter/ Source:**	Decision Support Acute Care CQI

Reporting Period: Data not available

Indicator Name: **Acute Care Client Satisfaction Levels**

- Ambulatory Care
- Emergency Department
- Inpatients

Definition: % Satisfied with experience in NRHA Acute Care facilities

Results: Interpretation:

During the past two years, there has been limited use of the 3 NRHA Client Surveys in place: the In-patients, Emergency, and Ambulatory Care. A new combined survey tool has been designed and pilot tested and will be introduced in the fall of 2008. The new distribution plans are as follows:

Rating:
In Development

- Chemo, Dialysis and In-patients will receive a survey as part of their discharge planning.
- The Emergency and Ambulatory Care surveys will be available at all times and posters describing the survey will be posted in emergency, day surgery, out-patient clients, OT, PT, lab, imaging and telehealth clinic rooms.

A marketing plan has been developed and will start in the fall of 2008 to ensure that all NOR-MAN residents know about the client satisfaction survey and the value of their comments to the NOR-MAN Regional Health Authority. Staff education sessions will also be given prior to the release of the survey tools and all staff will be asked to promote the completion of the survey to all clients.

Action Plan:

An Access database is being developed in conjunction with the newly purchased data capture software. The database is to be accessible to all acute care based Medical, Emergency, Operating Room and Obstetrics CQI Team members by a shared file with passwords. The new process will see all completed surveys sent to Decision Support for data entry, analysis and report generation. All survey information will be forwarded to Site Administrators for required action.

Each of the following acute based CQI teams - Medical, Emergency, Operating Room and Obstetrics will review survey reports, identify/discuss areas of concerns and bring recommendations forwarded to Quality Council.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Satisfaction with Services

Board End: Healthy People

Reporter/ Source: Addictions CQI Team

Reporting Period: April 1, 2007 to March 31, 2008

Indicator Name: **Client Satisfaction with Experience in Rosaire House**

Definition: % Satisfied with experience at Rosaire House

Results:

CRITERIA	06/07	07/08	Difference
Individual Counselling	96%	97%	+1%
Large Group Sessions	87%	88%	+1%
Small Group Work	90%	89%	-1%
Meals	81%	72%	-9%
Visiting Hours	80%	81%	+1%
Chores	88%	88%	0
Leisure Time	84%	87%	+3%
Room/ Private Space	90%	92%	+2%
Talking with staff	99%	99%	0
Treated with Dignity	99%	97%	-2%
Talking with Clients	96%	99%	+3%
Length of Stay	66%	73%	+7%
Feel Better about Self	100%	100%	0
Learned about Addiction	97%	99%	+2%
Overall Satisfaction	**90%**	**91%**	**+1%**

Interpretation:

2003/04: 93% reporting satisfaction
2004/05: 88% reporting satisfaction
2005/06: 91% reporting satisfaction

Clients continue to be satisfied with Rosaire House services and their learning opportunities. Areas of least satisfaction this year were: meals and the length of program. With the meals, we have conducted two audits this year and dietary has been most accommodating in trying new approaches. For the past 2 months, there has been a 4-week rotational meal plan and this seems to be working better.

Rating: **Good**

Action Plan: The Addictions CQI Team uses the information collected from surveys to guide Continuous Quality Improvement (CQI) efforts within Rosaire House. Over the past 5 years, although 28% of the clients have stated that the program should be longer, there are still no plans to lengthen the program, as there would still be a negative impact on the waiting list. Last year it was reported that the average number of clients on the wait list was 79 with a 11-week wait. This year it continues at the average of 79 but the length of time has gone down to 9 weeks. We continue to prioritize clients from the NOR-MAN region (up 8%) and pregnant women (up from 11% last year to 16% this year).

AREA OF ORIGIN	06/07	07/08	Difference
NOR-MAN RHA	56%	64%	+8%
Rest of northern Manitoba	25%	21%	-4%
South of 53rd parallel (Mb)	7%	11%	+4%
Saskatchewan (NRHA catchment)	12%	4%	-8%
Other	0	0	0

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Satisfaction with Services

Board End: Healthy People

Reporter/ Source: Decision Support Home Care CQI

Reporting Period: Data Not Available

Indicator Name: **Client Satisfaction Experience with Home Care**

Definition: % clients stating strongly agree, agree, neither agree or disagree, disagree or strongly disagree to selected questions on home care survey

Results: Interpretation: No new satisfaction surveying has been completed since the last scorecard. Data collection is continuing during the months of July, August and September 2008. Differing from the 2004 survey, all "home-based" Home Care clients that reside in the NOR-MAN region will be invited to participate and be interviewed in-person. Data analysis will be completed in the fall of 2008 and the Home Care CQI Team will use the information from the survey to ensure continuous quality improvements to their programs and services.

Rating: **In Development**

Action Plan: The Home Care CQI Team will use the results of the survey to help improve services for clients and guide continuous quality improvement initiatives.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	**Reporter/ Source:**	Palliative Care Program
Board End:	Healthy People		

Reporting Period: April – September 2007

Indicator Name: **Hospice and Palliative Care Family Satisfaction Survey Levels**

Definition:

1. **Areas of Excellence**: Items with >85% who were very satisfied/satisfied
2. **Things we do well**: Items with 75% to 85% who were very satisfied/ satisfied
3. **Areas of Improvement**: Items with <75% who were very satisfied/satisfied

Results:
Interpretation:

Rating: Green

Areas of Excellence	
How thoroughly the care team monitored your family member's symptoms	100%
Family conference held to discuss your family member's illness	91%
Information given by the care team about side effects of treatment	91%
Speed with which symptoms were treated	91%
Emotional support provided by the care team	91%
Would you recommend Palliative Care services to other people if they required these services	91%

Things We Do Well	
Family member died in the care setting of their choice	82%
Information provided by the care team about family member's condition and likely progress	82%
Care team's attention to family member's description of symptoms	82%
Opportunity to discuss spiritual matters	82%
The way the family was included in treatment and care decisions	82%
The way your family member's condition and likely progression was explained to you by the care team	82%
The way in which your family member's physical needs for comfort were met	82%
The ability of the care team to respond to changes in your family member's care needs	82%
The practical assistance provided by the care team	82%
Overall, how satisfied are you with Hospice and Palliative care services	82%

Areas for Improvement	
Your family member's pain relief	73%
The way in which admission to the hospital was handled	73%
The ability of the care team to provide care when needed	73%
Availability of the care team to the family	72%

2007 Survey Response Rate = 58% (11/19 surveys)

The term "Palliative Care Team for this survey refers to all staff (doctors, nurses, social workers, volunteers, pharmacists, health care aids, etc.) providing care to the client/patient during his or her illness.

Action Plan:	The NRHA Palliative Care team will continue to meet monthly to discuss and plan care delivery for all palliative clients in the NOR-MAN region. These team meetings provide a forum to discuss and address ongoing concerns of clients and their families; they also help to identify opportunities for continuous quality improvement to enhance service delivery. The key area for improvement from the 2007 survey is to enhance communications to clients and family members. Pain and symptom management education is a high priority for the teams. It is expected that the development and use of a palliative care resource manual would be beneficial to enhance clinical management practice. The Provincial Hospice and Palliative Care Family Satisfaction Survey will continue to be completed every two years.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Satisfaction with Services

Board End: Healthy People

Reporter/ Source: Support Services

Reporting Period: April 2007-March 2008

Indicator Name: **Support Services Client Satisfaction Acute Care**

Definition: Comparison of Scores (Actual Score for The Pas and Flin Flon vs. Aarmark Standard Score) on the following areas:

Results:

Interpretation:

Rating: Good

Warning in specific areas

Areas of Satisfaction	The Pas Actual Score	Flin Flon Actual Score	Aarmark Standard
Hot Food Temperature	**76.6**	**75.3**	85
Cold Food Temperature	**81.7**	89.7	85
Quality of Food	**69.2**	84.4	80
Server Courtesy	85.8	95.9	80
Overall Food Service Satisfaction	**89**	**96.4**	**85**
Room Cleanliness	**77.6**	92.6	80
Bathroom Cleanliness	81.7	93.6	80
Frequency of Room Cleaning	92	92.1	80
Timing of Room Cleaning	91.5	94.5	80
Cleaning Person Courtesy	83.1	91.2	81.8
Overall Housekeeping Satisfaction	**81.7**	89.7	85
Overall Average	**85.8**	**95.9**	**80**

Since last reporting period, we have implemented a new regional menu. We have issues regarding the hot food temperature satisfaction in both facilities. Investigation of the issue resulted in the problem being a combination of time trays sit on the floors prior to delivery, and some issues in the kitchen regarding heating of the bases. We will continue to monitor these issues. We struggle in The Pas to increase patient satisfaction regarding quality of food even though our regional menu is providing satisfied customers at the other sites. Our process for improvement is to visit the patient once a negative survey is sent in, and attempt to rectify the issue immediately. Satisfaction scores are monitored on a continual basis, and used as a tool for improvement.

Rosaire House client satisfaction has improved since we implemented the regional menu. Score in May 07 was 63.0%, and in May 08, the score was 78.6%

Action Plan: Continue to do temperature test audits on hot and cold food, and continue to respond to patient surveys as soon as negative results are known. Monitor scores.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Satisfaction with Services

Board End: Healthy People

Reporter/ Source: Support Services

Reporting Period: April 2007 to March 2008

Indicator Name: **Support Services Client Satisfaction Long Term Care**

Definition: Comparison of Scores (Actual Score for Long Term Care facilities vs. Aarmark Standard Score) on the following areas:

Results:

Interpretation:

Rating: Good

Warning in specific areas

Areas of Satisfaction	The Pas Actual Score	Flin Flon Actual Score	NLM Actual Score	Aarmark Standard
Hot Food Temperature	**82.3**	**72.4**	**73.4**	85
Cold Food Temperature	87.9	**73.7**	100	85
Quality of Food	**66.1**	**76.9**	95	80
Server Courtesy	94.6	92.3	100	80
Overall Food Service Satisfaction	**100**	**98.1**	**100**	**85**
Room Cleanliness	91.7	94.2	100	80
Bathroom Cleanliness	91.8	86.5	100	80
Frequency of Room Cleaning	95.9	94.2	100	80
Timing of Room Cleaning	95.9	96.2	100	80
Cleaning Person Courtesy	89.5	87.8	97.1	81.8
Overall Housekeeping Satisfaction	**87.9**	**73.7**	**100**	**85**
Overall Average	**94.6**	**92.3**	**100**	**80**

Overall Food Service satisfaction and Housekeeping satisfaction is above the Aarmark standard in all three Long Term Care Facilities. Areas ranked below the Aarmark standard were hot/cold temperature and quality of food in both the Flin Flon PCH and The Pas. While there have been improvements in these areas since last report, continued auditing is required. At all sites, the residents scored the overall satisfaction of food service above standards.
A new regional menu was implemented for this reporting period.

Action Plan: Continue to audit temperatures prior to meal service.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	**Reporter/ Source:**	Decision Support
Board End:	Healthy People		Community CQI

Reporting Period: Data not available

Indicator Name: **Primary Health Care Client Satisfaction Levels**

Definition: % clients stating strongly agree, agree, neither agree or disagree, disagree or strongly disagree to selected questions on Primary Health Care survey

Results: Interpretation:

To date, no client satisfaction surveying has been done. The Primary Health Care Client Satisfaction survey tool was designed and pilot tested in 2007 under the direction of the previous Community CQI Team. The piloted survey tool structure is currently being revised to allow for data capture software scanning to be used in conjunction with an Access database file.

The Primary Health Care Client Satisfaction Survey tool is to be offered to all clients accessing services through NRHA Primary Health Care Centres. Currently the distribution method is being reviewed and a second pilot test is scheduled for the fall of 2008.

Rating:
In development

Action Plan:

Distribution of the new Primary Health Care Client Satisfaction Survey is scheduled for the fall of 2008 as a revised pilot test with a commitment to review both the distribution method and the response rates to establish an ongoing distribution timeframe.

An Access database is being developed in conjunction with the newly purchased data capture software. The database is to be accessible to all Primary Health Care and Supportive/Specialty CQI Team members by a shared file with passwords. The new process will see all completed surveys sent to Decision Support for data entry, analysis and report generation. All survey information will then be forwarded to Primary Health Care Regional Care Advocates and the Long Term Care Regional Manager for required action.

Each of the Primary Health Care CQI Teams (Child/Youth, Maternal/Child, and the Chronically Ill) as well as the Supportive/Specialty CQI Teams (Home Care and Mental Health) will review survey reports, identify/discuss areas of concerns and bring recommendations forward to Quality Council.

Date: September 2008

Scorecard Area: Responsiveness

AIM Dimension: Availability

Board End: Optimal Recovery

Reporter/ Source: Decision Support Services
Manitoba Health
Table 19A

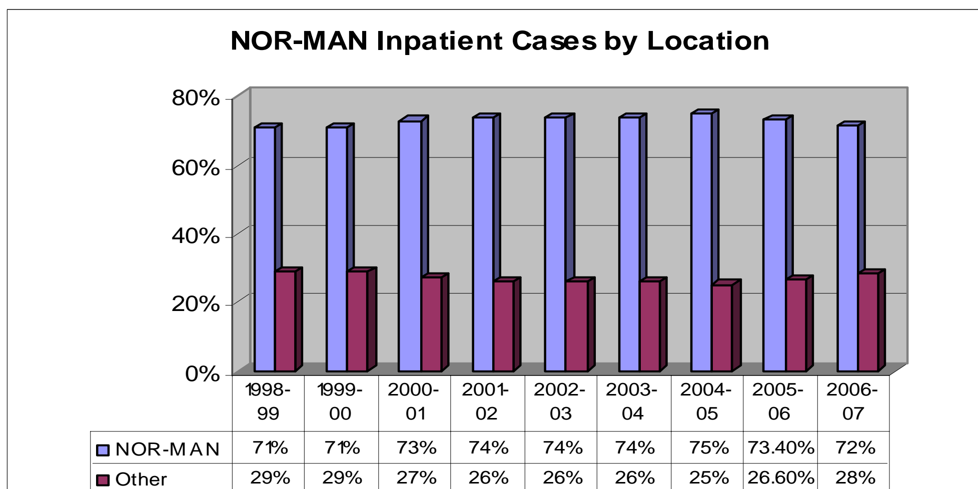
Reporting Period: Trend Analysis 1998-99 to 2006-07

Indicator Name: **% In-patient acute care services being provided in region for NOR-MAN residents**

Definition:
$$\frac{\text{Total \# acute care cases provided in region for residents of NOR-MAN}}{\text{Total \# acute care cases provided overall for residents of NOR-MAN}}$$

Results:
Interpretation:

Rating: **Good**



In 2006-07, 2,650 in-patient cases (71.6%) were provided within the region while 1,048 (28.34%) were provided out of the region. Of the 2,650 cases, 1,832 (69%) occurred at The Pas, 625 (24%) at Flin Flon, 20 (1%) at Snow Lake Health Centre and 173 (7%) at Pukatawagan Nursing Station. Of note, at Flin Flon General Hospital, there were an additional 683 non-resident cases of which 608 cases were for northeastern Saskatchewan residents which are not accounted for in the above graph.

Action Plan: We continue to review those services that residents of NOR-MAN receive outside the region. Each is evaluated as to whether it is feasible to provide within the region and the impact on existing resources (human & financial) of repatriating that service.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Availability	**Reporter/ Source:**	NPTP Program
Board End:	Optimal Access		

Reporting Period: Fiscal Year 2006/07 vs. 2007/08

Indicator Name: **Northern Patient Transportation Program (NPTP) travel by physician specialty**

Definition: Top 10 referrals for NPTP Travel by Physician Specialty by site

Results:
Interpretation:

Rating: Good

The Pas & Surrounding Area					
2006-07 Total Referrals: 3579			**2007-08** Total Referrals: 4532		
1.	Orthopedic	470 (13%)	1.	Internal Medicine	641 (14%)
2.	Ophthalmology	331 (9%)	2.	Orthopedic	572 (13%)
3.	Internal Medicine	310 (9%)	3.	Ophthalmology	438 (10%)
4.	Oncology	268 (7%)	4.	Oncology	338 (7%)
5.	Neurology	230 (6%)	5.	Surgery	332 (7%)
6.	Surgery	224 (6%)	6.	Cardiology	319 (7%)
7.	Cardiology	207 (6%)	7.	Neurology	268 (6%)
8.	Gynecology	201 (6%)	8.	Gynecology	240 (5%)
9.	Diagnostic	173 (5%)	9.	Endocrinology	198 (4%)
10.	Obstetrics	146 (4%)	10.	Respiratory	170 (4%)
Flin Flon & Surrounding Area					
2006-07 Total Referrals: 3975			**2007-08** Total Referrals: 4240		
1.	Orthopedics	662 (17%)	1.	Internal Medicine	682 (16%)
2.	Internal Medicine	425 (11%)	2.	Orthopedics	630 (15%)
3.	Oncology	314 (8%)	3.	Oncology	337 (8%)
4.	Ophthalmology	278 (7%)	4.	Renal	291 (7%)
5.	Cardiology	262 (7%)	5.	Cardiology	258 (6%)
6.	Diagnostic	222 (6%)	6.	Ophthalmology	237 (6%)
7.	Surgery	218 (5%)	7.	Diagnostics	237 (6%)
8.	Renal	182 (5%)	8.	Surgery	212 (5%)
9.	Neurology	152 (4%)	9.	Neurology	190 (4%)
10.	ENT	119 (3%)	10.	Gynecology	140 (3%)

In 2007-08, there were 8,772 NPTP referrals. This was a 14% increase in referrals from 2006-07 when there was 7,554 NPTP referrals. Overall, the top NPTP referrals in NOR-MAN for the two reporting periods was as follows:

1. Orthopedics (2334 or 14%)
2. Internal Medicine (2058 or 13%)
3. Ophthalmology (1283 or 8%)
4. Oncology (1257 or 8%)

Action Plan: Continue to monitor and investigate opportunities to provide itinerant specialty services in the region and/or telehealth opportunities for high demand areas.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Availability	**Reporter/ Source:**	NPTP Program
Board End:	Optimal Access		

Reporting Period: Fiscal Years 2006/07 vs. 2007/08

Indicator Name: **Northern Patient Transportation Program travel by Diagnostic Category**

Definition: Top 5 NPTP travel by Diagnostic Category by site

Results: Interpretation:

Rating: Good

The Pas & Surrounding Area			
2006-07 Total Referrals: 843		**2007-08** Total Referrals: 841	
1. Eye Pressures	124 (15%)	1. Eye Pressures	113 (13%)
2. Mammography	89 (11%)	2. MRI	92 (11%)
3. MRI	85 (10%)	3. Mammography	81 (10%)
4. Ultrasound	61 (7%)	4. Ultrasound	61 (7%)
5. Colonoscopy	58 (7%)	5. Colonoscopy	55 (7%)
Flin Flon & Surrounding Area			
2006-07 Total Referrals: 522		**2007-08** Total Referrals: 685	
1. CT Scan (TP)	163 (31%)	1. CT Scan (TP)	196 (29%)
2. MRI	58 (11%)	2. MRI	64 (9%)
3. Ultrasound	49 (9%)	3. Mammography	54 (8%)
4. Mammography	41 (8%)	4. Ultrasound	46 (7%)
5. Colonoscopy	28 (5%)	5. Colonoscopy	42 (6%)

Overall, in 2007-08, there was an 11% increase in number of referrals for diagnostic procedures from 2006-07. This increased was observed in the Flin Flon catchment area.

Prior to the CT Scanner in The Pas, CT scans were the top Diagnostic procedure for NPTP travel in NOR-MAN accounting for 24% of all warrants in 2002-03 in The Pas and 20% in Flin Flon. Referrals out of region for CT are now at 5% for The Pas and 3% in Flin Flon.

In Flin Flon, the highest diagnostic referral was for CT referrals to The Pas at 29% followed by MRI at 9%, Mammography at 8% and Ultrasound at 7%. In The Pas, the highest diagnostic referral was for eye pressures at 13% followed by MRI at 11%, Mammography at 10%, and Ultrasound and Colonoscopy at 7%.

Action Plan: From the data we have to date, it is clearly showing that the CT machine has had a large impact on NPTP travel. Continue to monitor and investigate potential opportunities to provide diagnostic services in the region where feasible.

Date: August 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Availability
Board End: Optimal Access

Reporter/ Source: MB Telehealth

Reporting Period: April 2007 to March 2008

Indicator Name: **Telehealth Network Unavailability**

Definition: Actual number of appropriate network bookings declined due to network unavailability, by reason (equipment, staffing or network limitations)

Results:
Interpretation:

Site	Equipment not available	MCU at Capacity	Staff not available	Other
Network overall	Network stats unavailable	0	0	0
Flin Flon	0	0	0	0
The Pas	0	0	0	1

Rating: Good

In February 2007, MBTelehealth installed a second telehealth codec at the Flin Flon General Hospital as recommended in the previous scorecard and the regional health plan. As a result, there was only 1 network unavailability occurrence in the most recent reporting period and it was due to network connectivity problems on the day of the event. It is anticipated that, at current levels of telehealth utilization, such occurrence will continue to be low to non-existent. There have, however, been several "near misses" but having 2 telehealth units in each of our larger sites has given us the flexibility to work around conflicts. Regional planning for steady growth of telehealth utilization and strategic acquisition of additional equipment and resources will help to ensure that reasonable access to the telehealth network is maintained.

Action Plan:

- Adding Telehealth capability in Primary Health Care Centres in The Pas and Flin Flon as part of a regional plan for expanding telehealth resources as well as replacing older equipment.
- Continued integration training with ongoing staff orientations to Telehealth equipment and processes as well as the new NOR-MAN online resource scheduling equipment
- Monitor and review network unavailability data for Flin Flon and The Pas and consider replacing this indicator with ones that reflect more recent challenges for the telehealth program in NOR-MAN Region
- Utilization for Snow Lake and Pukatawagan site is still quite low and access is good to optimal.

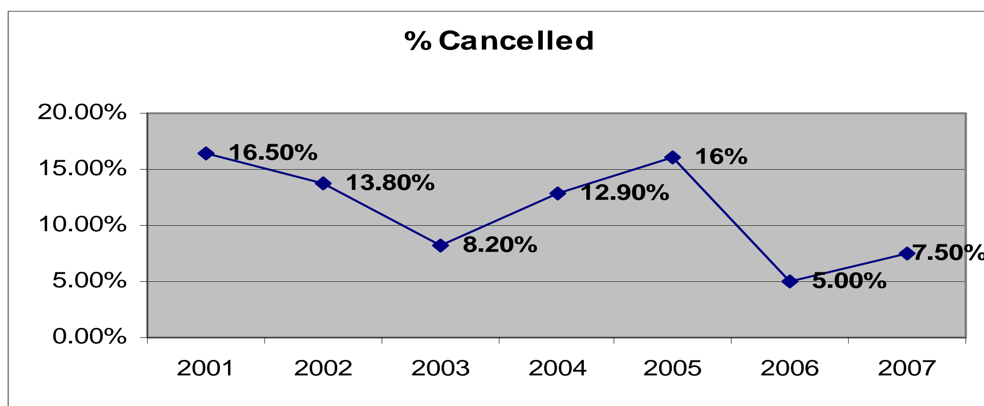
Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Availability	**Reporter/ Source:**	Diabetes Education
Board End:	Optimal Access		

Reporting Period: Trend Analysis 2001 - 2007

Indicator Name: **% of Scheduled Diabetes Education Resource (DER) Client Days in Outlying Areas cancelled; by reasons**

Definition: Total # of scheduled client days cancelled / Total # of scheduled client days & % by reason

Results: Interpretation:



Rating: Good

Reason	2003	2004	2005	2006	2007
Schedule conflicts	1	6	1	1	
Cancelled by Nursing Station – no clients	4	2	2	2	5
Nursing Station closed – funeral		1		1	
Staff Illness	1				
Weather/ Car	2	2	9		
Total Cancelled	**8**	**11**	**12**	**4**	**5**
Total Scheduled	**97**	**85**	**75**	**80**	**66**

There were 66 travel days scheduled, of which 5 (7.5%) were cancelled by the community nursing station or health centre. The only reason visits were cancelled was because there were no clients scheduled. In 2007, no travel days cancelled due to poor weather conditions

Action Plan: Continue to monitor. Continue to work with Nursing Stations and Health Centres to reduce the number of cancellations.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Availability

Board End: Optimal Access

Reporter/ Source: Diabetes Education Resource (DER)

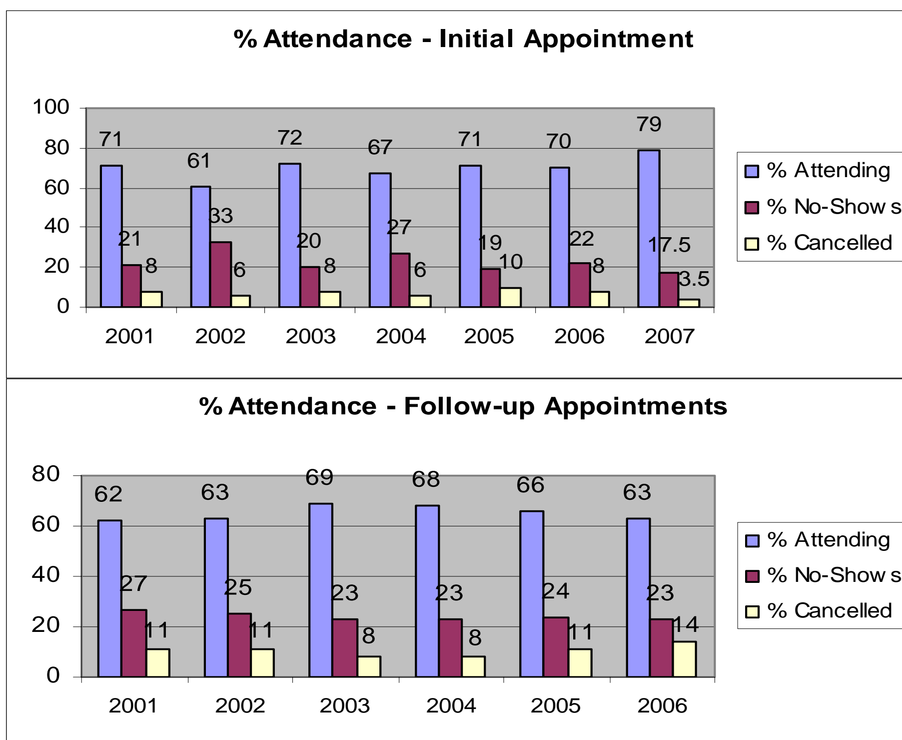
Reporting Period: Trend Analysis 2001 to 2007

Indicator Name: **% attendance, no-shows and cancelled appointments for Diabetes Education Resource (Initial and Follow-up)**

Definition: % attending = # attendance / total # booked   % no shows = # of no-shows / total # booked   % cancelled = # canceling / total # booked

Results: Interpretation:

Rating: **Good**



In 2007, there were 229 initial appointments and 643 follow-up appointments scheduled. Of those scheduled for initial appointments, 79% attended, 17.5% were no shows and 3.5% cancelled. Of those scheduled for follow-up appointments, 70.5% attended, 19.5% were no shows and 10% cancelled. The percentage of clients who attended an initial appointment with the Regional Diabetes Program (RDP) increased by 9% over the past year. For follow-up appointments, the percentage has increased over the past year. Wait times to see the Regional Diabetes Program is significantly less than in most other regions of the province. A total of 5 public education sessions were held.

Action Plan: Continue to work with communities and clients to increase percentage of clients attending initial appointments and education visits.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Accessibility	**Reporter/ Source:**	MB Cancer Care Registry Data
Board End:	Optimal Access		

Reporting Period: 1997- 2007

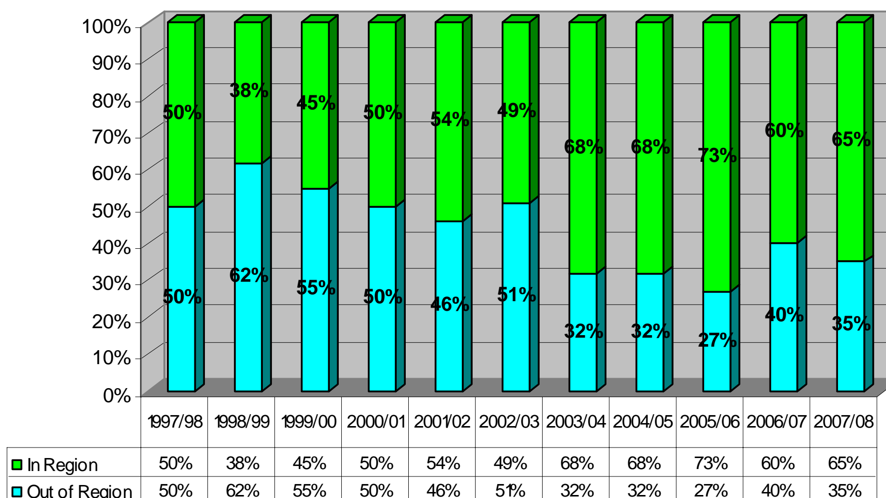
Indicator Name: **% of NOR-MAN residents receiving Cancer treatment in region**

Definition:

$$\frac{\text{Total \# of NOR-MAN Residents receiving Cancer treatment, in region}}{\text{Total \# of NOR-MAN Residents receiving Cancer treatment, any site}}$$

Results: Interpretation:

Rating: Good



	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08
In Region	50%	38%	45%	50%	54%	49%	68%	68%	73%	60%	65%
Out of Region	50%	62%	55%	50%	46%	51%	32%	32%	27%	40%	35%

Cancer Care Manitoba determines the feasibility of any resident receiving chemotherapy in their home region. It depends on the type of therapy, the patients overall condition, etc. The NRHA has a strong community-based Chemotherapy program in the region and where possible, residents of the region appreciate the opportunity to receive treatment without having to travel. During the 2007/08 fiscal year 102 IV Chemo sessions were provided in Flin Flon and 72 in The Pas.

Action Plan: To continue to monitor.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Accessibility

Reporter/ Source: Provincial Dialysis Program

Board End: Optimal Access

Reporting Period: As of June 2008

Indicator Name: **Access to Dialysis in region**

Definition: -# of individuals not able to receive treatment in requested NRHA location
-# of individuals from NRHA catchment area who are the “Conservative List” (people who are not receiving dialysis but are being followed by a Nephrologist and will need dialysis in the near future) by site

Results:

Interpretation:

	# NRHA Residents receiving treatment not in preferred location	# on conservative list
The Pas	8	6
Flin Flon	1	1

Rating: Warning

The Provincial Dialysis Program guarantees that a MB resident will receive dialysis in Manitoba but not necessarily at a local center in their region. Patients must meet certain criteria in order to be considered for a local center. As dialysis spots become open, each is filled based on the Nephrologist’s decision.
Construction began for The Pas Dialysis Capital Project in October 2007 with substantial completion March 17, 2008 and the first Dialysis day being April 14, 2008. The Dialysis department relocated to the third floor with the number of stations increased from 4 to 10 stations. Unfortunately, due to nursing shortages and the inability to recruit, we are only able to open 4 stations at this time.

Action Plan: Two staff (1 RN and 1 LPN) will be taking the Dialysis training in September 2008 and be back in the region by November, 2008 We are hopeful to expand from 16 patients (4 stations) to 24 patients (6 stations) by January 2009. We have secured 3 dialysis training spots for February 2009 and have 3 nurses interested in taking the training which will allow us to incrementally increase to 32 patients (8 stations). We are hoping to increase to 40 patients (10 stations) by June 2009.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Accessibility	**Reporter/ Source:**	Home Care CQI Team
Board End:	Optimal Access		

Reporting Period April 1, 2007 to March 31, 2008

Indicator Name: **% Home Care requests fielded in 48 hours (2 working days)**
% of Services implementations not completed within 48 hours

Definition:

$$\frac{\text{\# of new Home care referrals fielded in 48 hours}}{\text{Total \# of new Home Care referrals}} = \frac{181}{270} = 67\%$$

$$\frac{\text{\# of service implementations } \textbf{not} \text{ completed within 48 hours}}{\text{\# of new Home Care referrals fielded in 48 hours}} = \frac{41}{181} = 23\%$$

Results Interpretation: In 2007-08, 67% of Home Care requests were fielded in 48 hours, a decrease of 9% from 2006-07 (72%). Of the new Home Care referrals that were fielded with 48 hours, the percentage of Service Implementations not completed within 48 hours increased from 12% in 2006 to 23% in 2007. The difficulty that is being experienced by Home Care is the inability to recruit and retain Direct Service Workers despite ongoing recruitment attempts.

Rating: Warning

Action Plan: Continue to monitor. A memorandum of Agreement has been signed with the provincial bargaining unit and we are pleased to have implemented permanent status for our home care workers effective July 1, 2008. This transition for casual to permanent status of staff has been a work in progress for a number of years. We hope this significant change in status will enable us to recruit and retain staff and thus improve our ability to provide services. The Home Care CQI Team has an Employee Recruitment Retention and Conversion sub committee and they are looking at creative ways to recruit and retain staff.

Date: September 208

Scorecard Area: RESPONSIVENESS

AIM Dimension: Accessibility

Board End: Optimal Access

Reporter/ Source: NRHA

Reporting Period: 2006 vs. 2007

Indicator Name: **Itinerant Clinic Service Days**

Definition: # of itinerant clinic service days provided in region by clinic area, separated by physician & allied health professionals service days.

Results: Interpretation:

Rating: Good

Clinic	2006		2007	
	PD	AHD	PD	AHD
Orthotics (The Pas)	8	22	8	19
Psychology	12		8	
Psychiatry	42		31	
Breast Screening		48		36
Neurology (Flin Flon)	26		3	
Child Development (The Pas)	2		3	
Endoscopy (The Pas)	13			
Internal Medicine (Flin Flon)			15	

PD = Physician Days AHD = Allied Health Days

NRHA attempts to offer a number of itinerant clinics days in the region. The availability of these services in the region not only saves NPTP dollars, but also provides the opportunity for residents to access services locally which in the past they would have had to travel to obtain the required service.

The full-time Psychologist position was vacant over the past reporting period and as a result we had to depend on itinerant and telehealth consultations for psychology services. A new Psychologist has been hired and will start in the region (based out of Flin Flon) in September 2008.

Telehealth is also used as a clinical application for a number of areas including areas such as dermatology, wound care, pre and post surgical consultations, FAS/D diagnostic assessments, Mental Health and limited Pediatric Diabetes education and follow-up.

Action Plan: Continue to review those services that residents of NOR-MAN receive outside the region. These services need to be evaluated to determine whether it is feasible to provide within the region and the impact on existing resources (human & financial) of repatriating that service.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Accessibility

Board End: Optimal Access

Reporter/ Source: Diagnostic Imaging NRHA

Reporting Period: 2005-06 to 2007-08

Indicator Name: **CT Examinations Utilization by Category**

Definition: # and % of CT Examinations by Category by Month (In-Patients, Emergency, Referrals)

Results: Interpretation:

Year	In-Patients	Emergency	Referred In	Total
2005-06	169 (7%)	95 (4%)	2238 (89%)	2502
2006-07	151 (6%)	98 (4%)	2246 (90%)	2495
2007-08	199 (7%)	157 (6%)	2454 (87%)	2810

Rating: Good

There were 2810 CT examinations in 2007-08 which was an 11% increase from 2006-07. We increased our average of scans per month from 235 to 208. The majority of CT scans were by referrals at 89%.

At present, wait list for a CT is 3 weeks, which is well below the MB average of 8 weeks.

Action Plan: Continue to monitor.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Accessibility

Board End: Optimal Access

Reporter/ Source: Retinal Screening Vision Program

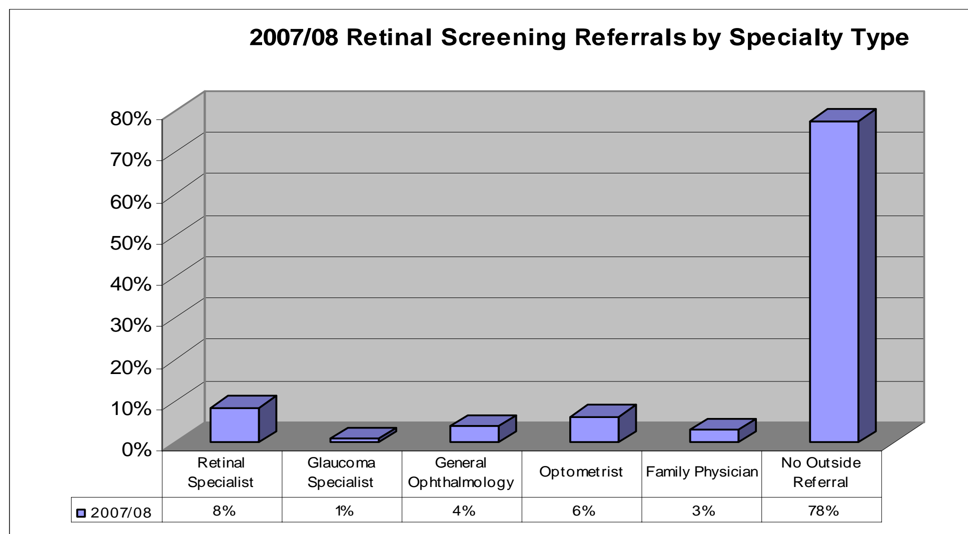
Reporting Period: April 2007 – March 2008

Indicator Name: **% of Retinal Screening Referrals by Referral Specialty Type**

Definition: Total # of NOR-MAN clients referred by type / Total # of NOR-MAN clients screened

Results: Interpretation:

Rating: Good



	Retinal Specialist	Glaucoma Specialist	General Ophthalmology	Optometrist	Family Physician	No Outside Referral
2007/08	8%	1%	4%	6%	3%	78%

In January 2007, the Manitoba Retinal Screening Vision Program, a wait time initiative was undertaken. The NRHA began screening clients on June 1, 2007. Of those clients screened in the 2007/08, 78% required no outside referral, while 22% of screened clients were referred to various specialists for further interventions.

During 2007/08, screening clinics occurred in the communities of The Pas, Flin Flon, Snow Lake, Cormorant, Cranberry Portage and Sherridon. Clients from Creighton and Denare Beach are also being seen.

Action Plan: Discussions with Easterville, Grand Rapids, Moose Lake and Pukatawagon for the hosting of community-based screening clinics to be held in 2008/09 are currently ongoing.

The Retinal Screening Nurse also works closely with both the NRHA Regional Diabetes Program and the Diabetes Integration Program (federal First nation program) to ensure comprehensive diabetes/chronic disease care for all clients.

During 2008/09, the Manitoba Retinal Screening Program will continue to educate both new and current retinal screening nurses in the province of Manitoba.

The NRHA needs to trend and monitor screening numbers to establish service delivery benchmarks.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Timeliness

Board End: Optimal Access

Reporter/ Source: Manitoba Wait Time Information Departments listed below

Reporting Period: As of August 2008

Indicator Name: **Average wait times and/or wait lists for specific departments**

Definition: Average wait time and wait list size for specific departments:

Results:

Interpretation:

Rating: **Good** **Warning**

Program Area		Wait Time
Physiotherapy (The Pas)	Priority Non-Urgent	55 people (21.5 days) 41 people (40.5 days)
Physiotherapy (Flin Flon)	Priority Non-Urgent	17 days 41 days
Audiology		Up to 1 week dependent upon which site client is being seen at.
Speech Language Pathology		1-2 weeks dependent upon which site client is being seen at.
DER	The Pas Flin Flon Snow Lake Outlying Communities	2 week 2 weeks or less 6 weeks or less 6 - 8 weeks or less
Mental Health	Children/Youth Adult	3-6 weeks 1 week
Rosaire House		79 on wait list - 9 week wait time (improvement of 2 weeks over 2006/07)
Home Care		0 on waitlist in The Pas 0 on waitlist in Flin Flon
CT Scan – The Pas		3 weeks (MB = 8 weeks)
Ultrasound –The Pas Ultrasound – Flin Flon		6 weeks (MB = 13 weeks) 2 weeks
X-Ray – The Pas X-Ray – Flin Flon		Same Day Same Day
Long Term Care (September 2008)		11 people - Flin Flon 5 people - The Pas

Departments where wait time is of concern are Mental Health (children/ youth), Rosaire House and Long Term Care

Action Plan: Recruitment of qualified allied health professionals continues to be a priority for the NRHA. The NRHA continues to seek out itinerant specialist and telehealth opportunities to assist in reducing waitlists where vacancies exist. Continue to monitor waitlists for selected program areas.

Areas of Note:

Physiotherapy – The waitlist in the Pas has reduced by half since last reporting period thanks to two new Physiotherapists who began employment in the fall of 2007. Wait times for Physiotherapy increased in Flin Flon from the last reporting period as we were short one Physiotherapist fro 3.5 months due to sick leave. Physiotherapy staff have all out-patients fill out a questionnaire upon receipt of their referrals. The questionnaires are scored and this decides which priority list they are placed on. Of note, all post fracture, surgical and those patients who are unable to work because or their injuries are automatically placed on the priority list.

Mental Health - The standard for Mental Health is that any new referral is seen within five working days. Our Adult population is within the acceptable standard. In terms of our child and youth populations, wait times have significantly increased due to the fact that we have been short two EFT, one in The Pas and one in Flin Flon, for an extended period. Additionally, alternate support services usually available through the school year are withdrawn in the summer and a large number of referrals come to Mental Health as default "back-up" service. An emerging trend that is adding to the wait time for service in Child and Adolescent Mental Health is new policy being implemented by child protection/social service agencies that requires referral for assessment by Mental Health services of all children evidencing high-risk ideation or behaviour e.g. voicing suicidal thoughts. While the safety and well-being of all children is paramount, it places enormous burden on already over-taxed resources.

Audiology – An audiometrist has been hired and trained. Since February she has been seeing clients for hearing screenings. Results of the screening have been reviewed by an audiologist in Brandon. At the end of September this contractual arrangement will end. Planning is currently underway to fill this required link for both the Parkland and Nor Man Regions. The program is in jeopardy if the support required for the audiometrist is not secured.

Speech Language – We have an active pre-school Speech Language therapy program in place. Wait times for services at this time of year is not a problem. Each spring a large proportion of the speech language pathologists' caseload is transferred to the school practitioners. In addition a large number of children receive services in the group format with the assistance of a summer student. Caseloads will grow exponentially in early fall with a caseload issue arising by December. The caseload averaged over the year is sufficient by national standards to require at least double the .8 E.F.T. position that is available. An adult/ geriatric Speech Language Pathologist position is still an area of need that we continue to identify as a new initiative.

Diabetes Education Resource – There have been a slight increase in wait times since the last scorecard in The Pas and in the outlying communities. Since there has been no Dietitian with the program for two years, some services have been curtailed. We have begun to address some of the wait times through the use of itinerant dietitian services and regular telehealth clinic dates with an itinerant dietitian. A Diabetes Assessment Nurse through our Risk Factor and Complications Assessment program has helped with keeping the" at risk" or " Pre-diabetes " wait times to a minimum.

Rosaire House – The wait list remained about the same during this past year but the length of time they had to wait was reduced by an average of 2 weeks. Much of this is due to aggressive follow-up by our team leader when clients do not show up or cancel.

Home Care – As of July 1, 2008 a variety of FTE's were created and implemented within the Direct Service Staff in the region. Thus resulting in a reduced wait list.

Long Term Care – In Flin Flon, a number of clients could be managed in the community versus a PCH placement if alternative housing with 24 hour Home Care support was made available. However, Home Care does not have the resources to provide 24 hour home care in individual homes. In The Pas, there are three empty beds which have remained closed due to chronic staffing shortages. These beds will remain closed until staffing is secured.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Accessibility

Board End: Optimal Access

Reporter/ Source: Rosaire House NRHA

Reporting Period: 2006-07 vs. 2007-08

Indicator Name: **Rosaire House Utilization Indicators**

Definition:
Occupancy Rate
# of new admissions
Of new admissions, % of admissions by various breakdowns
Average of clients

Results:

Interpretation:

Rating: Good

Rosaire House Utilization Indicators	06-07	07-08
Occupancy Rate	80%	80%
# of new admissions	200	207
# non-admissions	331	326
% not completing rehab	32%	24%
% of admissions female	51%	47%
% of female clients who are pregnant	11%	16%
% stating gambling dependency	25%	22%
% of CODI referrals	65%	61%
% of clients from NOR-MAN	56%	64%
% of clients from rest of northern MB	25%	21%
% of clients from south of 53rd	7%	11%
% of clients from Saskatchewan	12%	4%
Average age – male clients	33	36
Average age – female clients	32	31

This is a new indicator outlining utilization data for Rosaire House. The following is of note:

- 64% of clients are from NOR-MAN which increased by 8% from the last reporting period.
- The average of clients is 36 years of age for males and 31 for females.
- The occupancy rate has remained stable at 80%.
- The percentage of clients not completing rehab decreased by 8% over the two reporting periods.
- 47% of all clients are females of which, 16% were pregnant.
- The percentage of clients with co-occurring disorders was 61%.

Action Plan: Continue to monitor.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Timeliness

Board End: Quality of Care

Reporter/ Source: EMS

Reporting Period: 2005 - 2007

Indicator Name: **EMS Response Averages**

Definition: Average Dispatch to Enroute Time (mm:ss), in Town (First Unit & Second Unit)
Enroute to Arrival Time, In Town
Dispatch to Arrival Time, In Town
2nd Unit Response is the time the 2nd crew is paged at home till they are leaving the station to respond to the scene.

Results:

Interpretation:

Rating: Optimal

EMS Response Averages 2005	The Pas		Flin Flon	
	1st Unit	2nd Unit	1st Unit	2nd Unit
Dispatch to Enroute Time, In Town	01:50	05:59	02:26	07:40
Enroute to Arrival Time, In Town	02:48	N/A	04:37	N/A
Dispatch to Arrival Time, In Town	04:38	N/A	07:03	N/A
EMS Response Averages 2006	**The Pas**		**Flin Flon**	
	1st Unit	2nd Unit	1st Unit	2nd Unit
Dispatch to Enroute Time, In Town	01:56	06:38	01:41	11:43
Enroute to Arrival Time, In Town	02:57	N/A	04:22	N/A
Dispatch to Arrival Time, In Town	04:53	N/A	06:03	N/A
EMS Response Averages 2007	**The Pas**		**Flin Flon**	
	1st Unit	2nd Unit	1st Unit	2nd Unit
Dispatch to Enroute Time, In Town	01:47	06:56	01:47	04:59
Enroute to Arrival Time, In Town	03:18	N/A	05:03	N/A
Dispatch to Arrival Time, In Town	05:05	N/A	06:50	N/A

The goal in Manitoba for "Dispatch to Arrival Time, in Town limits" is arriving in 8 minutes, 90% of the time. The Pas & Flin Flon have both exceeded the provincial target. In The Pas, EMS responded to 1767 calls of which 1151 (65%) were primary calls and 616 were transfers. In Flin Flon, EMS responded to 1198 calls of which 508 (42%) were primary calls and 690 were transfers. The number of EMS calls increased in The Pas by 10% from 1602 in 2006 to 1767 in 2007. In Flin Flon, there was a slight increase (7%) in calls from 1112 in 2006 to 1198 in 2007.

Action Plan: Continue to monitor.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Timeliness	**Reporter/ Source:**	CIHI eCHAP CHAP 1 Report
Board End:			
Reporting Period:	Trend Analysis 2000/01 to 2006/07		

Indicator Name: **Average Length of Stay (ALOS) for NOR-MAN Acute Care Facilities**

- **Typical Case** - A patient who receives a course of treatment in a single institution and is discharged.
- **Average Typical LOS** - the average length of stay for all typical cases. The average is rounded to one decimal place. The calculation is: the sum of the total length of stay for typical cases/the count of typical cases with a valid length of stay
- **Average Typical ELOS** - the CIHI average Expected Length of Stay for all typical hospital cases. The average is rounded to one decimal place. The calculation is: the sum of the total ELOS for typical cases/total count of typical cases.

Results:

Interpretation:

Rating: Warning

Typical Cases	Snow Lake Health Centre		Flin Flon General Hospital		The Pas Health Complex	
	Avg	**Expected**	**Avg**	**Expected**	**Avg**	**Expected**
2001/02	3.2	4	3.2	3	2.8	3
2002/03	2.8	3.8	3.3	3	2.7	2.9
2003/04	4.6	4.1	3.2	3	3	3.3
2004/05	3.6	5.0	3.2	3.0	3.0	3.1
2005/06	10.0	5.8	5.0	3.4	3.8	3.5
2006/07	7.4	5.8	4.3	3.4	4.0	3.6

In the past two reporting periods, length of stay in NRHA facilities for acute admissions is higher then the expected Average Length of Stay.

Action Plan: This will be referred to the Regional Utilization committee for further analysis.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Continuity	**Reporter/**	Addictions CQI
Board End:	Healthy People	**Source:**	Rosaire House

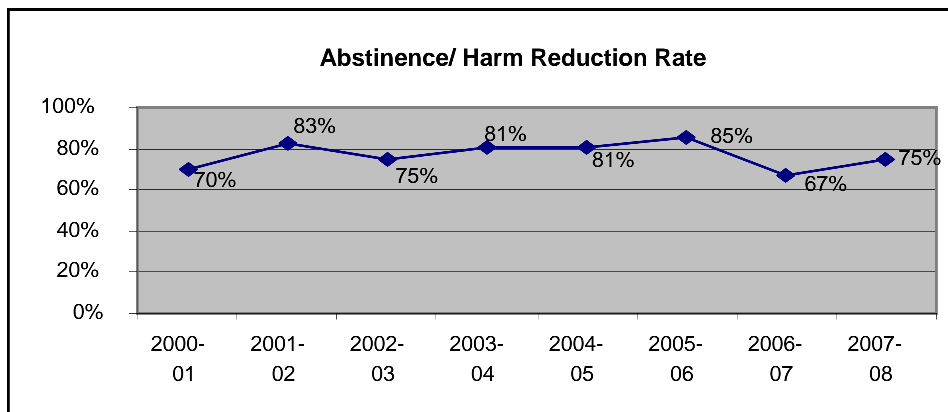
Reporting Period: Trend Analysis 2000-01 to 2007-08

Indicator Name: **Rosaire House One Month Follow-up Evaluation: Harm Reduction Rates**

Definition: % of clients who reported reduced intake level at one-month follow-up from Rosaire House treatment program

Results: Interpretation:

Rating: Good



The best practice philosophy for Addiction Services moved from abstinence to harm reduction in the early 1990's. This graph shows that during this time period, an average of 77% of Rosaire House clients have improved their relationships and general life performance by reducing their use of addictive substances or practices (eg. Gambling). Most of the clients who come here have lived in environments where addictive behaviours are the norm. They are learning more responsible ways in which to behave and more positive approaches to handling their problems. When the philosophy was 'abstinence only', there was only a pass/fail perspective and no smaller improvements were noted. Clients are feeling less guilty and more positive about their efforts with the changes that have taken place since 2000.

Action Plan:

The mandate of the centre is always to meet the client where he or she is at in their lives. Our vision statement flows from that of the Regional Health Authority. We no longer focus on whether or not clients have stopped their addiction, but whether or not they have found some skills, other than addictive behaviours, to improve their lives. .

Vision statement (what we see long range)

To be a warm, empathic service for those people with addiction and mental health challenges, providing skill development and ongoing support with the goal of strong and healthy individuals as foundations of strong and healthy communities

Mission statement (what we are doing now)

To assist people with addiction and mental health challenges accept and walk with their life events that cannot be changed by using their inner strengths and skills for healthy positive lifestyle choices.

With the best interest of the client in mind, Rosaire House staff work in partnership with community organizations to try and provide aftercare and follow-up support to our clients as staff resources permit.

Date:	September 2008	**Scorecard Area:**	RESPONSIVENESS
AIM Dimension:	Continuity	**Reporter/**	Addictions CQI
Board End:	Healthy People	**Source:**	Rosaire House

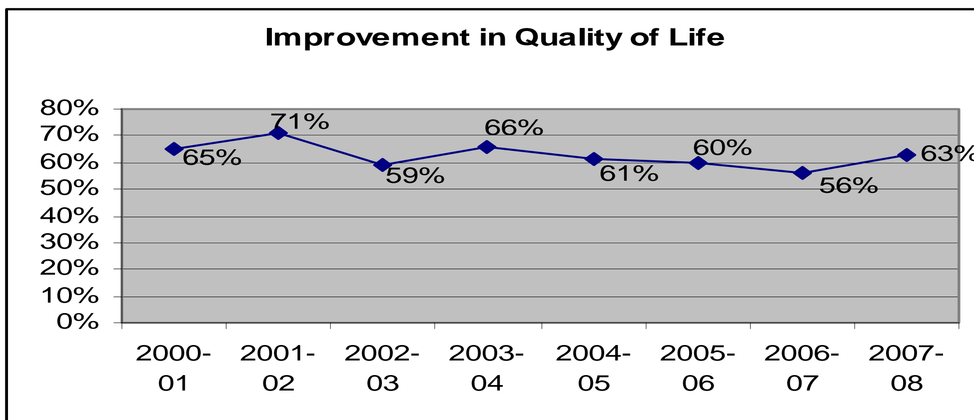
Reporting Period: Trend Analysis 2000-01 to 2007-08

Indicator Name: **Rosaire House One-month Follow-up Evaluation: Improvement in Quality of Life**

Definition: % of clients who reported improved quality of life at one-month follow-up from Rosaire House treatment program

Results: Interpretation:

Rating: **Warning**



The benchmark for this indicator since 2000 is 63%, meaning that 63% of clients completing the program should be reporting a more positive impact on quality of life at time of follow-up. In 2007-08, the rate was at the benchmark level, showing an improvement of 7%.

During the year, staff has continued to respond to requests for program changes to address needs clients are currently facing. Material for several sessions has been re-written and updated video resources brought in. This type of response to client suggestions is one of the foundations of this program.

Action Plan: See previous indicator for comments and action plan.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Continuity

Reporter/ Source: Home Care CQI Team

Board End:

Reporting Period: January to December 2007

Indicator Name: **Home Care On-Call Replacement Worker, % by reason**

Definition: # of Home Care on-call replacement calls by reason / Total # of on-call replacement calls

Results:

Interpretation:

Rating: Good

	The Pas	Flin Flon	Regional
Sick Replacement	54%	66%	59%
Call From Hospital Emergency Staff	0%	0%	0%
Family Sick/ Death/ Emergency	0%	8%	4%
Scheduling Error	1%	4%	2%
Clients Family Canceling	0%	2%	<1%
RN/LPN Canceling/Reinstating Service	0%	0%	0%
Other i.e. Wrong #/ Hang-ups	0%	2%	<1%
DSW not available	34%	10%	23%
DSW forgot to go to assignment	5%	3%	4%
Call for Direction	6%	3%	5%
Weather Conditions	0%	2%	<1%

Regionally, the on-call charts show that Sick Replacement has decreased by 13% to 59% in 2007 from 72% in 2006. Family Sick/ Death/ Emergency have increased to 23% in 2007 from 8% in 2006.

Action Plan: Effective July 1, 2008 FTE status has been implemented throughout the NOR-MAN region which includes Home Care Attendants, Home Support Workers, and Mental Health Proctors.

Continue to monitor.

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Board End: Continuity

Reporter/ Source: Senior Management On Call Database

Reporting Period: Feb. 1, 2006 to Jan. 31, 2007 vs. Feb. 1, 2007 to Jan. 31, 2008

Indicator Name: **Senior Management On-Call, % by reason, % by facility**

Definition: # of Senior Management on-call calls, by reason/ by facility
Total # of Senior Management on-call calls

Results: Interpretation:

Rating: Good

Calls by Subject	2006-07		2007-08	
	#	%	#	%
Staffing	112	61%	92	61%
Bed Availability	10	5%	14	9%
Physical Plant	6	3%	3	2%
Complaint	6	3%	1	1%
Physician Concern	4	2%	9	6%
Transportation	4	2%	3	2%
CI/CO	2	1%	0	0%
Shortage of Meds	1	1%	0	0%
IMS	1	1%	1	1%
Other	39	21%	27	18%
Total	**185**	**100%**	**150**	**100%**

Calls by Facility	2006-07		2007-08	
	#	%	#	%
St. Anthony's	111	60%	90	60%
FFGH	32	17%	22	15%
St. Paul's	22	12%	20	13%
PCH	11	6%	12	8%
SLHC	3	2%	3	2%
NLM	4	2%	0	0%
Other	2	2%	3	2%
Total	**185**	**100%**	**150**	**100%**

In March 2006, Senior Management instituted a Senior Management On-Call Rota to ensure that a member of the Senior Management Team was available 24 hours a day, seven days a week to respond to after hour emergencies. In 2007-08, there were 150 calls made to Senior Management, which was a 19% reduction in calls from the previous reporting period. The majority of calls by subject continue to be for staffing related issues at 61%. The majority of calls by facility continue to be from St. Anthony's at 60%.

Action Plan: Continue to monitor

Date: September 2008

Scorecard Area: RESPONSIVENESS

AIM Dimension: Continuity

Reporter/ Source: Infant/ Youth Health Team NRHA

Board End: Healthy People

Reporting Period: Audit for 6 months (January to June) each year 2001-2007

Indicator Name: **% mothers initiating and maintaining breastfeeding for 4 or more months, audit of client files (1st 6 months of each year)**

Definition:
% mothers initiating breastfeeding at discharge
% mothers maintaining breastfeeding at 4 months
Of those who initiated breastfeeding, % breastfeeding at 4 months

Results:
Interpretation:

Rating: Warning

		Total # of births	% Initiating breastfeeding	% breastfeeding at 4 months	Of those initiating, % breastfeeding at 4 months
Flin Flon	**2002**	36	30 (83%)	12 (37%)	40%
	2003	32	26 (81%)	17 (53%)	47%
	2004	33	13 (40%)	11 (33%)	84%
	2005	33	27 (82%)	16 (48.5%)	59%
	2006	25	17 (68%)	15 (60%)	88%
	2007	37	25 (67.5%)	13 (35%)	52%
The Pas	**2002**	58	31 (53%)	17 (29%)	55%
	2003	50	27 (54%)	20 (42%)	74%
	2004	69	54 (78%)	30 (43%)	55%
	2005	52	44 (85%)	27 (64%)	61%
	2006	36	27 (75%)	20 (55.5%)	74%
	2007	75	36 (84%)	28 (37.3%)	44%
Snow Lake	**2002**	11	8 (73%)	5 (20%)	62%
	2003	11	10 (91%)	5 (27%)	30%
	2004	10	8 (89%)	2 (22%)	29%
	2005	4	3 (75%)	1 (25%)	33%
	2006	3	3 (100%)	1 (33%)	33%
	2007	5	3 (50%)	1 (20%)	33%
Sherridon	**2002**	1	0 (0%)	0 (0%)	0%
	2003	1	1 (100%)	1 (100%)	100%
	2004	1	1 (100%)	0 (0%)	0%
	2005	2	Unknown	0 (0%)	0%
	2006	0	0 (0%)	0 (0%)	0%
	2007	0	0 (0%)	0 (0%)	0%
Cranberry Portage	**2002**	2	2 (100%)	0 (0%)	0%
	2003	10	8 (80%)	7 (70%)	88%
	2004	6	6 (100%)	5 (83%)	83%
	2005	3	1 (33%)	1 (33%)	100%
	2006	3	2 (66%)	1 (33%)	50%
	2007	7	7 (100%)	4 (57%)	57%
Cormorant	**2002**	9	5 (58%)	2 (22%)	40%
	2003	4	3 (74%)	2 (50%)	67%
	2004	6	2 (66%)	0 (0%)	0%
	2005	8	8 (100%)	1 (12.5%)	12.5%
	2006	1	0 (0%)	0 (0%)	0%
	2007	2	1 (50%)	0 (0%)	0%
Totals	**2004**	**102**	**67 (65.7%)**	**41 (40.1%)**	**61.2%**
	2005	**85**	**71 (83.5%)**	**43 (50.5%)**	**60.6%**
	2006	**68**	**49 (72%)**	**37 (54.4%)**	**75.5%**
	2007	**112**	**88 (78.6%)**	**41 (36.6%)**	**46.6%**

In 2007, 78.6% initiated breastfeeding and 46.6% were still breastfeeding at 4 months. Despite the notable increase in initiation rates, the duration beyond 4 months is lower than it has been for years.

Action Plan:	The hard work of the Breastfeeding Committees in the larger centres appears to be paying off from the initiation perspective. We have identified the need to provide additional education on the NRHA Baby Friendly Initiative. Breastfeeding support groups locally and the provincial help lines have also been noted as supports to the mothers seeking information. Future plans are for the statistics to be gathered through the new database rather than manually. Continue to monitor indicator.