

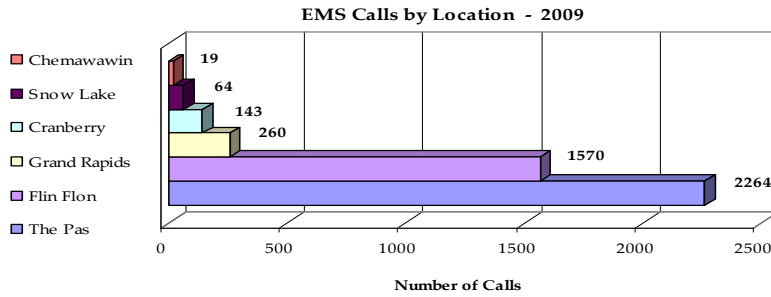


QUALITY SCORECARD

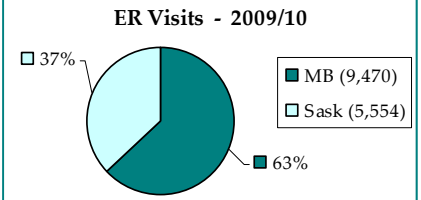
VITAL STATISTICS ON RESPONSIVENESS

November 2010

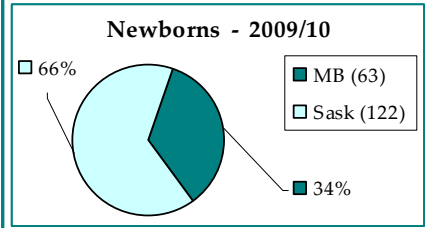
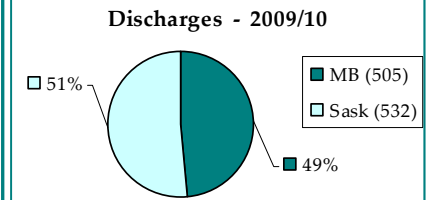
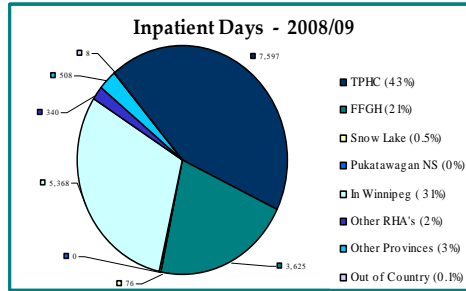
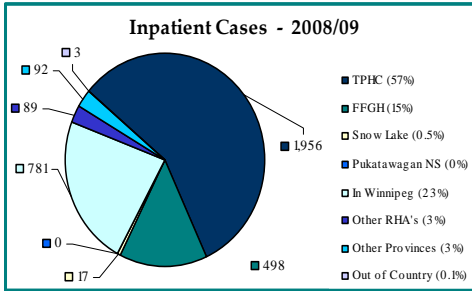
How many calls EMS responded to in 2009?



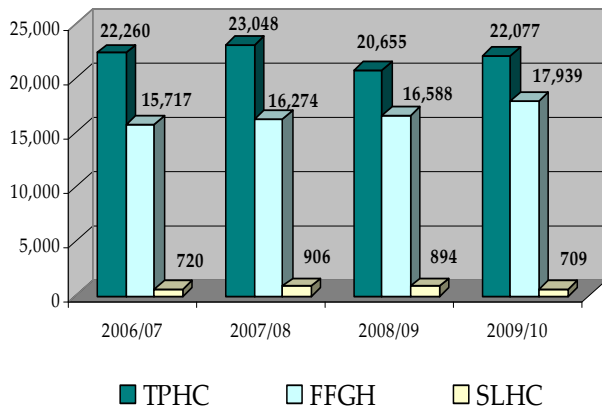
Saskatchewan Residents Use of FFGH - 2009-10



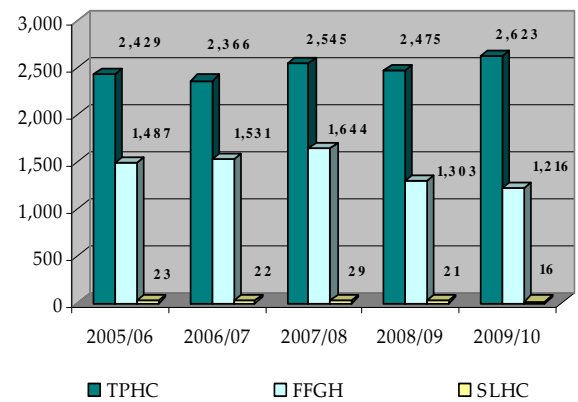
Where NOR-MAN Residents Access Hospital Services?



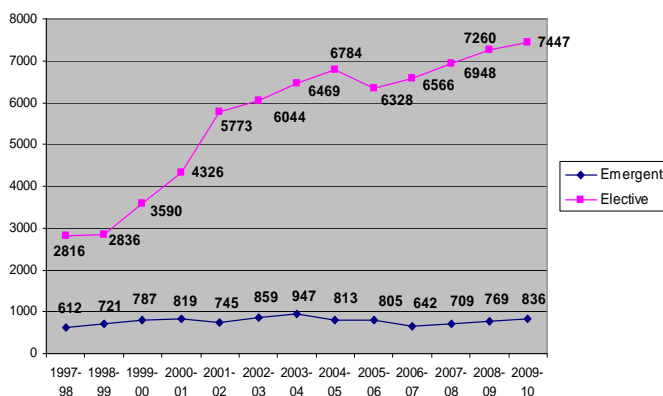
ER Presentations



Hospital Discharges



NPTP Warrants



Newborn Bed Occupancy Rates

Years	FFGH	TPHC
2009/10	15%	25%
2008/09	15%	23%
2007/08	15%	27%
2006/07	18%	25%

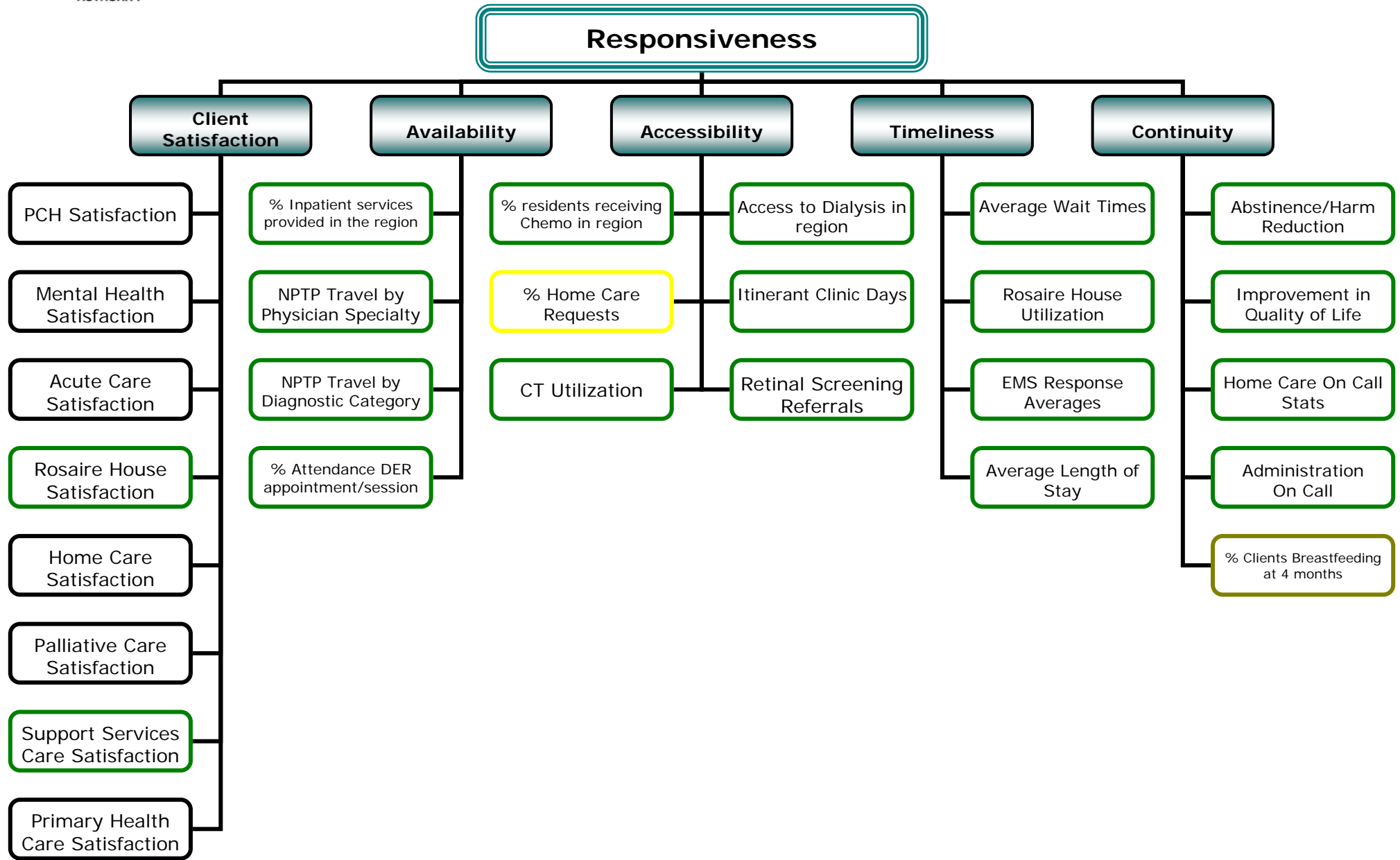
Hospital Bed Occupancy Rates

Years	FFGH	TPHC
2009/10	39%	63%
2008/09	36%	57%
2007/08	44%	60%
2006/07	39%	57%



Quality Scorecard: Responsiveness

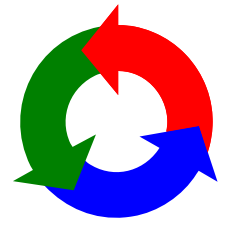
November 2010



NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness

Colour Codes: Blue = Optimal; Green = Good/ Ongoing CQI; Yellow = Warning/Room for Improvement; Dark yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = Data not available/In Development

NOR-MAN REGIONAL HEALTH AUTHORITY QUALITY SCORECARD "RESPONSIVENESS"



Date:	November 2010	Scorecard Area:	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	Reporter/ Source:	Long Term Care CQI Team
Board End:	Healthy People		
Reporting Period:	Status Update as of September 2010		
Indicator Name:	Resident Satisfaction with Experience in Personal Care Home		
Definition:	Resident Satisfaction Survey Selected Results		
Results:	Satisfaction Surveys are completed every 2 years with the last one being done in August 2009. The overall response rate was 27% however the site specific rates were as follows:		
Interpretation:			
Rating: <u>Black</u>	<ul style="list-style-type: none"> ▪ St. Paul's Residence: 15% ▪ Northern Lights Manor: 33% ▪ Flin Flon Personal Care Home: 41% 		
<u>New Data Not Available</u>	<p>A number of actions to improve the delivery of care and/or satisfaction with the living environment have been reviewed and implemented or are currently being reviewed and revised based on the results of the surveys as follows:</p> <ul style="list-style-type: none"> • Each Resident Advisory Council has had opportunity to review the survey results and discuss ways in which each facility can potentially improve upon the areas in which the respondents felt their needs were not being met as well as discuss any ongoing concerns within the facility. • A request has been submitted in our Health Plan for the past 3 years to provide funding to increase recreational staff for evenings and weekends. • Support services continue to conduct resident satisfaction survey regarding housekeeping and dietary. • Multidisciplinary Resident Care Audits are being done in all facilities, with the results being shared at staff meetings. An improvement in the care has been noted since these have been implemented. • Staff is being encouraged to promote resident autonomy and independence; which was one of the most common resident/family complaints-lack of autonomy. • The Resident Bill of Rights has been revised with input from the Resident/Family Council. The Bill of Rights is reviewed with staff on an annual basis and upon hire. An audit has been developed to measure staff compliance. • Monthly staff meetings and daily reports with the Health Care Team occur to discuss any ongoing concerns and/or improvements that can be implemented in the delivery of care. 		

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQI; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 1 -

Action Plan:

- Circulate Satisfaction Survey August 2011 in all facilities
- Continue with monthly Resident Care Audits; monitoring improvements.
- Prepare and share an annual audit summary of all audits related to resident care delivery with the Resident Council.
- Monitor family/resident complaints; share with staff.
- Continue with monthly staff meetings and daily team meetings.

Date: November 2010 **Scorecard** RESPONSIVENESS
Area:
AIM Dimension: Satisfaction with Services **Reporter/** Mental Health CQI Team
Board End: Healthy People **Source:**

Reporting Period: Status Update as of June 2010

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: **Black**

**New Data
Not
Available**

**Warning
Rate has
decrease
over time**

Areas of Excellence			
	2008	2006	2004
Staff encouraged me to take responsibility for how I live my life	100.0%	98.0%	84.4%
I like the services I received here	100.0%	96.2%	100%
I would recommend this agency to a friend or family member	100.0%	92.5%	87.5%
Staff here believe that I can grow, change and recover	97.4%	88.8%	84.4%
Staff were willing to see me as often as I felt it was necessary	97.4%	81.4%	84.4%
I was able to get all the services I thought I needed	94.7%	92.4%	81.3%
I am better able to control my life	94.6%	75.3%	71.9%
Staff asked about both my mental health and drug, alcohol or gambling concerns	93.3%		
I felt welcomed by the agency providing service	92.9%		
Staff told me what side effects to watch for	92.3%	66.6%	72.4%
If I had other choices, I would still get services from this agency	92.1%	85.1%	87.5%
Services were available at times that were good for me	92.1%	84.7%	96.9%
I deal more effectively with daily problems	91.9%		78.2%
I felt free to complain	89.5%		81.2%
I am better able to deal with crisis	89.5%	69.6%	71.9%
Staff returned my call in 24 hours	86.8%	88.8%	81.3%
I felt comfortable asking questions about my treatment and medication	86.8%	77.7%	87.5%
I, not staff, decided my treatment goals	86.1%	66.6%	65.6%

Things Done Well			
	2008	2006	2004
Staff helped me obtain the information I needed so that I could take charge of managing my illness	84.2%	77.7%	81.3%
The location of services was convenient (parking, public transportation, distance, etc)	83.8%	77.7%	68.7%
I was able to see a psychiatrist when I wanted to	83.3%	51.8%	62.5%
Staff were sensitive to my cultural background (race, religion, language, etc)	78.9%	80.9%	78.1%
Staff respected my wishes about who is and who is not to be given information about my treatment	76.3%	77.7%	81.3%
I was given information about my rights	76.3%	85.4%	71.9%
I was encouraged to use consumer-run programs	75.7%	69.3%	71.9%

Areas for Improvement			
	2008	2006	2004
I do better in school and / or work	74.1%	47.9%	31.3%
I am getting along better with my family	71.1%	67.3%	75.0%
My symptoms are not bothering me as much	65.8%	60.9%	62.5%
I do better in social situations	64.9%	69.6%	65.6%
My family and natural supports were as involved in my care as I would want them to be	64.3%		
My family and natural supports were offered an opportunity to participate in my care	59.3%		
My housing situation has improved	56.5%	34.8%	28.1%
I got some help for my drug, alcohol or gambling concerns in addition to my mental health concerns	50.0%		
If seeing an addictions worker: I got some help with my mental health concerns in addition to my addiction concerns	46.2%		

Adult Survey Response rate = 24.2% (38/157) **Bolded CODI Questions Response Rate = 36.8% (14/38)**
Average Respondent age is 43 years, Age Range is 18 – 66 years Female Response Rate = 86.6%

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQI; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 3 -

Action Plan:

No new data since last Scorecard. Next survey will take place in the Spring of 2011. In the NOR-MAN Region we continue to build actions plans from 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 four (4) times per year.
- To study and implement Provincial Suicide prevention paper initiatives.
- To study Aboriginal Suicide prevention data.

We have two (2) active Suicide Awareness and Prevention Community Committees in the Region. The Suicide Awareness and Prevention Community Committees are mentoring a group trying to establish a Suicide Awareness and Prevention Committee in Grand Rapids. We are planning to support training of another Trainer in the Applied Suicide Intervention Strategies Training (ASIST) to extend our capacity to deliver that particular best practice to the outlying communities. The Flin Flon Suicide Awareness and Prevention Committee is planning a Youth Conference in the Spring of 2011.

2. Housing

- To assist clients living with severe and persistent mental illness to choose-get-keep appropriate housing in the community of their choice

The most recent survey indicates that we have ongoing work to do in this area but our clients did endorse a healthy improvement in Mental Health Housing supports. The Provincial Portable Housing Benefit program has provided access to additional funding for 15 clients with severe and persistent mental illness to enhance housing options for this population.

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.

We provided Psychological First Aid Training to acute care staff and community leaders during the H1N1 preparation period, which raised awareness of mental health and wellness needs in the general population.

Date:	November 2010	Scorecard Area:	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	Reporter/Source:	Decision Support
Board End:	Healthy People		Acute Care CQI
Reporting Period:	Data not available		
Indicator Name:	Acute Care Client Satisfaction Levels <ul style="list-style-type: none"> • Ambulatory Care • Emergency Department • Inpatients 		
Definition:	% satisfied with experience in NRHA Acute Care facilities (Flin Flon General Hospital, St. Anthony's General Hospital, Snow Lake Health Centre)		
Results:	During the past three years, there has been limited use of the three (3) NRHA Client Surveys in place: In-patients, Emergency, and Ambulatory Care. A new combined survey tool has been designed and pilot tested and will be introduced in the spring of 2011. The new distribution plans are as follows:		
Interpretation:			
Rating:	<u>Black</u>		
<u>In Development</u>	<ul style="list-style-type: none"> • 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. Chemo and Dialysis <p>A marketing plan is being developed and will start in the spring of 2011 to ensure that all NOR-MAN residents know about our 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.</p>		
Action Plan:	<p>An Access database has been developed in conjunction with data capture software. We continue to work on the development of read-only access for 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 the Executive Director of Clinical Services at St. Anthony's and the Flin Flon General Hospital / Snow Lake Health Center for required action.</p> <p>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.</p>		

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQI; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 5 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Satisfaction with Services **Reporter/Source:** Addictions CQI Team
Board End: Healthy People

Reporting Period: April 1, 2009 to March 31, 2010

Indicator Name: Client Satisfaction Experience with Rosaire House

Definition: % Satisfied with experience at Rosaire House

Results:
Interpretation:

Rating: **Good**

CRITERIA	08/09	09/10	Difference
Individual Counseling	99%	95%	-4%
Large Group Sessions	90%	92%	+2%
Small Group Work	90%	92%	+2%
Meals	71%	82%	+11%
Visiting Hours	84%	84%	0
Chores	92%	91%	-1%
Leisure Time	92%	94%	+2%
Room/ Private Space	88%	94%	+6%
Talking with staff	99%	99%	0
Treated with Dignity	98%	100%	+2%
Talking with Clients	97%	97%	0
Length of Stay	69%	70%	+1%
Feel Better about Self	99%	99%	0
Learned about Addiction	96%	99%	+3%
Overall Satisfaction	91%	92%	+1%

Overall Satisfaction Rate by year:

- 2005/06: 91% reporting satisfaction
- 2006/07: 90% reporting satisfaction
- 2007/08: 91% reporting satisfaction
- 2008/09: 91% reporting satisfaction
- 2009/10: 92% reporting satisfaction

We remain consistent in our service delivery. Meal plans were changed this year and the clients were pleased with those changes. We continue to have the request for a longer program and again no change is recommended. Our niche continues to be an introduction to life problems that must be followed up on with community services such as NADAP, community mental health and community addictions (AFM).

Action Plan:

The Addictions CQI Team uses the information collected from surveys completed by each client at time of discharge, to guide Continuous Quality Improvement (CQI) efforts within Rosaire House. Priorities are:

1. Reduction of the wait list and we are pleased with the improvement

WAIT LIST	08/09	09/10	Difference
Average per month	91	82	-9
Average # weeks on wait list	8	6	-2

2. Focus on clients from the NOR-MAN region. (Actually our improvement to service the clients from this area has increased 7% as the Saskatchewan clients are within the catchment of the Flin Flon region).

AREA OF ORIGIN	08/09	09/10	Difference
NOR-MAN RHA	65%	67%	+2%
Rest of northern Manitoba	21%	16%	-5%
South of 53 rd parallel (MB)	13%	11%	-2%
Saskatchewan (NRHA catchment)	1%	6%	+5%

3. Focus on specific program needs including:

- Women – the facility was originally designed for 40% women admissions and we run close to 50% over the year. This has a significant impact on the facility with the number of children in care being brought to mothers and support programs needing access to the pregnant women.
- Gambling – this program focus has decreased with the development of community AFM resources which also operate out of the casino.
- Co Occurring Disorders Initiative (CODI) – these clients have very complex needs that require the services of both addictions and mental health clinicians. This continues to be a challenge with the staffing issues at community mental health.

SPECIFIC POPULATIONS	08/09	09/10	Difference
Female admissions (of total)	49%	48%	-1%
Pregnant women	17%	20%	+3%
Gambling disorders (of total)	29%	19%	-10%
Dual disorders (of total)	51%	59%	+8%

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

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Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Satisfaction with Services **Reporter/Source:** Decision Support
Board End: Healthy People

Reporting Period: Status Update as of September 2010

Indicator Name: Client Satisfaction Experience with Home Care

Definition: % clients answering excellent, very good, good, fair, poor or no comment to selected questions on home care survey

Results: NRHA Home Care clients were asked to participate in an in-person interview to rate the quality of services being provide by the NRHA with the following results:
Interpretation:

Rating: **Black**

**New Data
Not
Available**

Questions	# of Respondents	% Positive	% Negative
Length of time it took to get services started	69	95.7%	4.4%
Coordination of discharge from hospital to Home Care services	48	91.7%	8.3%
Services from Case Coordinator	61	62.3%	37.7%
Services from Resource Coordinator	27	59.3%	40.7%
Services by Home Care Staff - Meal preparation	36	94.4%	5.6%
Services by Home Care Staff - Household Maintenance	49	98.0%	2.0%
Services by Home Care Staff - Essential Laundry	21	81.0%	19.0%
Services by Home Care Staff - Personal care	38	92.1%	7.9%
Services by Home Care Staff - Respite	Suppressed	75.0%	25.0%
Services by Home Care Staff - Nursing services	39	97.4%	2.56%
Services by Home Care Staff - Overnight care	Suppressed	100%	
Promptness of Home Care staff	75	96.0%	4.0%
Reliability of Home Care staff	74	96.0%	4.0%
Presentation of Home Care staff	76	96.1%	3.9%
Knowledge of Home Care staff	76	90.8%	9.2%
Home Care Office hours	74	95.9%	4.1%
My services encourage me to be independent	74	85.1%	14.9%
Awareness of NRHA Complaint/Compliment form	64	29.7%	70.3%

Adult Survey Response rate = 24.4% (77/315) Female Response Rate = 69% / Male Response Rate = 31%
 Response Rates by community: Flin Flon/Channing 57%, Schist Lake 10%, Snow Lake 17% and The Pas 16%

There is no new data as the Home Care Client Satisfaction Experience survey is completed every 4 years with the next survey scheduled for 2012.

An exit appraisal survey is given to all Home Care clients who leave the program. In 2009-10, 249 surveys were sent out with a 16% response rate. The following provides some highlights from this survey:

- 93% were satisfied with the contact/ availability of Case Coordinator
- 82% were satisfied with the contact/ availability of Resource Coordinator
- 78% felt the program was flexible to change care plan
- 95% felt the service helped with independence
- 100% recommended the Home Care program

Action Plan: The Seniors Team/Home Care Program is using the survey results in their ongoing continuous quality improvement initiatives.

The team continues to evaluate programs and services using discharge interview data during the off survey years.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

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Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Satisfaction with Services **Reporter/Source:** Palliative Care Program
Board End: Healthy People

Reporting Period: Status Update as of September 2010

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: **Response Rate:** 43%
Interpretation:

Rating: New Data Not Available

Areas of Excellence:

- Family conference held to discuss the patient's illness
- Information provided by the care team about the patients' condition and likely prognosis
- Information given by the care team about the side effects of treatment
- The patient's pain relief
- Speed with which symptoms were treated
- How thoroughly the care team monitored the patient's symptoms
- Care team's attention to patients description of symptoms
- Availability of the care team to family
- Emotional support provided by the care team
- Opportunity to discuss spiritual matters
- The way in which admission to hospital was managed
- The ability of the care team to provide care when needed
- The way the family was included in treatment and care decisions
- The way the patient's condition and likely progression was explained to you
- The way the patient's physical needs for comfort were met
- The ability of the care team to respond to changes in the patient's care needs
- The practical assistance provided by the care team
- Overall satisfaction with Palliative Care services

Action Plan: The Provincial Hospice and Palliative Care Family Satisfaction Survey will continue to be completed every two years; next due in 2011. The key areas for improvement identified in the 2009 survey are:

- to provide improved bereavement support
- to explore possibility of increasing palliative care beds in acute care settings.

Pain and symptom management education continues to be a high priority within the NOR-MAN region.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQ; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 9 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Satisfaction with Services **Reporter/Source:** Support Services
Board End: Healthy People

Reporting Period: April 2009-March 2010

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**

Areas of Satisfaction	The Pas Actual Score	Flin Flon Actual Score	Aarmark Standard
Hot Food Temperature	97.05	92.68	85
Cold Food Temperature	95.85	93.70	85
Quality of Food	94.28	87.10	80
Server Courtesy	100.00	99.48	80
Overall Food Service Satisfaction	97.78	94.83	80
Room Cleanliness	100.00	98.93	85
Bathroom Cleanliness	97.4	96.65	85
Frequency of Room Cleaning	96.33	97.25	80
Timing of Room Cleaning	96.43	96.15	80
Cleaning Person Courtesy	99.60	99.45	80
Overall Housekeeping Satisfaction	98.83	98.43	80
Overall Average	97.60	95.85	81.8

Food and Housekeeping service satisfaction is above the ARAMARK standard for acute care facilities, and this is the first reporting period where we exceeded the standard in every single line.

We are receiving more surveys back from customers, and are visiting customers who are having specific issues in an effort to maintain and improve our scores.

Rosaire House client satisfaction has improved since we implemented the regional menu. Score in May 2007 was 63.0%. May 2008, the score was 78.6%. May 2009 score was 77.7% and May 2010 is 78.5%.

Action Plan: Continue to audit and respond to client needs.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Satisfaction with Services **Reporter/Source:** Support Services
Board End: Healthy People

Reporting Period: April 2009 to March 2010

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**

Areas of Satisfaction	The Pas Actual Score	Flin Flon Actual Score	NLM Actual Score	Aarmark Standard
Hot Food Temperature	94.1	97.1	100.0	85
Cold Food Temperature	94.1	97.1	100.0	85
Quality of Food	82.2	94.1	91.7	80
Server Courtesy	94.1	100.0	100.0	80
Overall Food Service Satisfaction	79.3	97.1	100.0	80
Room Cleanliness	100.0	100.0	100.0	85
Bathroom Cleanliness	89.2	94.1	100.0	85
Frequency of Room Cleaning	93.9	91.2	100.0	80
Timing of Room Cleaning	96.9	100.0	100.0	80
Cleaning Person Courtesy	93.8	100.0	100.0	80
Overall Housekeeping Satisfaction	93.8	100.0	100.0	80
Overall Average	92.0	93.4	98.5	81.8

Overall housekeeping service satisfaction levels are above the Aarmark standard for all LTC sites. St. Paul's reported one line not meeting satisfaction levels, and that was for overall food service satisfaction which was reported at 79.3. ARAMARK standard for this line is 80.0%.

Monitoring of meals is ongoing. A new Spring/Summer menu was developed and implemented with input from the residents throughout the region. A Fall/Winter menu is currently being developed for implementation this fall. With the new ARAMARK standards of having a Spring/Summer, Fall/Winter menu, the residents will experience change and variety more frequently.

Action Plan: Continue to audit satisfaction levels and respond to issues.

Date:	November 2010	Scorecard Area:	RESPONSIVENESS
AIM Dimension:	Satisfaction with Services	Reporter/Source:	Decision Support
Board End:	Healthy People		Community CQI

Reporting Period: Status Update as of September 2010

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

Definition: % clients answering excellent, very good, good, fair, poor or no contact to selected questions on Primary Health Care survey

Results: Following the pilot survey in the winter of 2008/09 a review of both the tools and the distribution process was started. Currently the pilot study tool, distribution method, delivery schedule and analysis criteria are being revised - redevelopment of the tool and process should be completed in the spring of 2011.

Rating: Black

In Development

A marketing plan is also being developed and will start in the spring of 2011 to ensure that all NOR-MAN residents know about our Primary Health Care 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: A presentation and discussion with the Primary Health Care Advocates to review both the distribution methods used and the low survey response rates is being planned. A presentation and discussion with Primary Health Care staff will follow to investigate the reasons for low response rates compared to the number of individuals accessing Primary Health Care Centre services during the survey distribution process. Also a discussion will be held with staff on how to improve both the survey tool and the distribution method.

Distribution of a revised Primary Health Care Client Satisfaction Survey will be scheduled for the spring of 2011 incorporating any required changes. Access database to be revised depending on survey tool changes.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQI; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 12 -

Date: November 2010 **Scorecard Area:** Responsiveness
AIM Dimension: Availability **Reporter/Source:** Decision Support Services
Board End: Optimal Recovery **Source:** Manitoba Health Table 19A

Reporting Period: Trend Analysis 1998-99 to 2008-09

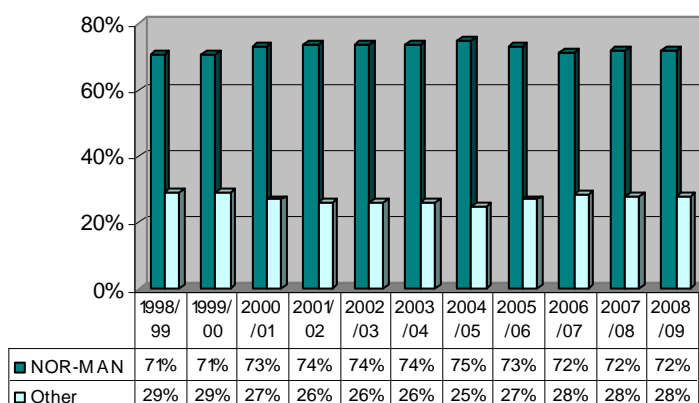
Indicator Name: % In-patient acute care services being provided in region for NOR-MAN residents

Definition: Total # acute care cases provided in region for residents of NOR-MAN
 Total # acute care cases provided overall for residents of NOR-MAN

Results:
Interpretation:

Rating: **Good**

NOR-MAN Inpatient Cases by Location



In 2008-09, 2,632 in-patient cases (72%) were provided within the region while 1,024 (28%) were provided out of the region. Of the 2,632 cases, 1,917 (73%) occurred at The Pas, 557 (21%) at Flin Flon, 25 (1%) at Snow Lake Health Centre and 133 (5%) at Pukatawagan Nursing Station. Of note, at Flin Flon General Hospital, there were an additional 815 non-resident cases from Saskatchewan 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: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Availability **Reporter/Source:** NPTP Program
Board End: Optimal Access

Reporting Period: Fiscal Year 2008/09 vs. 2009-10

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

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

Results:
Interpretation:

Rating: **Good**

The Pas & Surrounding Area			
2008-09		2009-10	
Total Referrals: 4633		Total Referrals: 5285	
1. Orthopedic	647 (14%)	Orthopedic	628 (12%)
2. Ophthalmology	462 (10%)	Ophthalmology	556 (11%)
3. Cardiology	422 (9%)	Cardiology	467 (9%)
4. Internal Medicine	380 (8%)	Surgery	396 (7%)
5. Oncology	379 (8%)	Oncology	386 (7%)
6. Surgery	326 (7%)	Internal Medicine	285 (5%)
7. Endocrinology	253 (5%)	Neurology	252 (5%)
8. Gynecology	213 (5%)	Endocrinology	248 (5%)
9. Neurology	209 (5%)	Gynecology	215 (4%)
10. Obstetrics	195 (4%)	Respiratory	203 (4%)
Flin Flon & Surrounding Area			
2008-09		2009-10	
Total Referrals: 3048		Total Referrals: 4061	
1. Internal Medicine	740 (24%)	Internal Medicine	734 (18%)
2. Orthopedic	568 (18%)	Orthopedic	554 (14%)
3. Oncology	354 (12%)	Oncology	416 (10%)
4. Ophthalmology	271 (9%)	Ophthalmology	305 (8%)
5. Surgery	259 (8%)	Surgery	236 (6%)
6. Renal	236 (8%)	Renal	231 (6%)
7. Cardiology	194 (6%)	Cardiology	223 (5%)
8. Gynecology	180 (6%)	Gynecology	206 (5%)
9. Dialysis	156 (5%)	Dialysis	158 (4%)
10. Neurology	146 (5%)	Neurology	140 (3%)

In 2009-10, there were 9,346 NPTP warrants by Physician Specialty. This is an increase of 1,675 warrants from 2008-09. Overall, the top regional NPTP warrants remained the same as 2008-09. They were:

1. Orthopedics 1,182 (13%)
2. Internal Medicine 1,019 (11%)
3. Ophthalmology 857 (9%)
4. Oncology 802 (9%)
5. Cardiology 690 (7%)
6. Surgery 632 (7%)

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

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQI; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 14 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Availability **Reporter/Source:** NPTP Program
Board End: Optimal Access
Reporting Period: Fiscal Years 2008/09 vs. 2009/10
Indicator Name: Northern Patient Transport Program travel by Diagnostic Category
Definition: Top 10 NPTP travel warrants by Diagnostic Category by site

Results:
Interpretation:

Rating: **Good**

The Pas & Surrounding Area			
2008-09		2009-10	
Total Referrals: 706		Total Referrals: 1171	
1. Eye Pressures	144 (17%)	Eye Pressures	347 (30%)
2. Mammography	94 (11%)	Mammography	118 (10%)
3. Ultrasound	63 (8%)	Ultrasound	88 (8%)
4. MRI	61 (8%)	MRI	86 (7%)
5. Chemotherapy	48 (6%)	Colonoscopy	78 (7%)
6. Colonoscopy	44 (5%)	CT	61 (5%)
7. CT	37(4%)	Angiogram	46 (4%)
8. Echocardio	35 (4%)	Gastroscopy	34 (3%)
9. PET Scan	29 (3%)	Echocardio	33 (3%)
10. Bone Scan	29 (3%)	Allergy Tests	33 (3%)
Flin Flon & Surrounding Area			
2008-09		2009-10	
Total Referrals: 668		Total Referrals: 835	
1. CT: The Pas	168 (25%)	CT: The Pas	153 (21%)
2. Mammography	68 (10%)	Chemotherapy	68 (9%)
3. MRI	67 (10%)	Mammography	65 (9%)
4. Ultrasound	43 (6%)	MRI	60 (8%)
5. Chemotherapy	35 (5%)	Ultrasound	57 (8%)
6. Colonoscopy	31 (5%)	EEG	51 (8%)
7. Bone Scan	22 (3%)	Colonoscopy	28 (4%)
8. EKG	22 (3%)	Angiogram	23 (3%)
9. Radiation	21 (3%)	CT: Other	18 (2%)
10. Pacemaker ,CT	19 (3%)	Abortions/ Bone Scan	17 (2%)

Overall, in 2008-09, there were 1,902 warrants for diagnostic procedures. This is an increase of 528 warrants from 2008-09. Overall, the top regional NPTP warrants in 2009-10 were:

1. Eye Pressures: 349 (18%)
2. Mammography: 183 (10%)
3. CT: The Pas: 153 (8%)
4. MRI: 148 (8%)
5. Ultrasound: 145 (8%)

Action Plan: Continue to monitor and investigate potential opportunities to provide diagnostic services in the region where feasible.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQI; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 15 -

Date: November 2010 **Scorecard** RESPONSIVENESS
Area:
AIM Dimension: Availability **Reporter/** Diabetes Education
Board End: Optimal Access **Source:** Resource (DER)

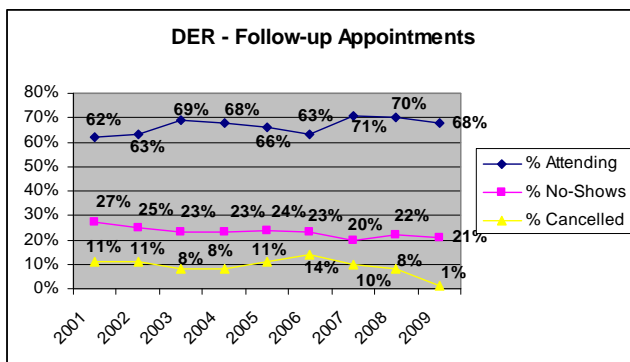
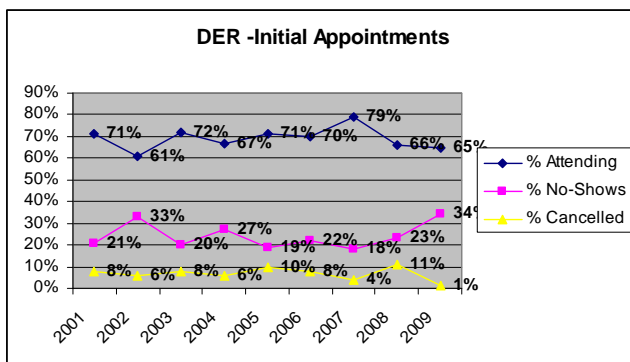
Reporting Period: Trend Analysis 2001 to 2009

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

Definition: % attending = $\frac{\# \text{ attendance}}{\text{total \# booked}}$ % no shows = $\frac{\# \text{ of no-shows}}{\text{total \# booked}}$ % cancelled = $\frac{\# \text{ canceling}}{\text{total \# booked}}$

Results:
Interpretation:

Rating: **Good**



In 2009, a total of 919 appointments were made with our DER nurses. Of those 351 were new. Of those scheduled for initial appointments, 65% attended and 34% were “no shows” and 1% cancelled their appointments. For follow-up appointments, a 68% attendance, 21% were “no shows” and 1% cancelled. The percentage rate for those attending an initial appointment has decreased slightly from last year but remains consistent with average regional attendance rates. For follow-up appointments, the percentage has also decreased slightly. Even though group sessions are used for some new clients many are still seen on a one-to-one basis.

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

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/Source:** MB Cancer Care Registry
Board End: Optimal Access

Reporting Period: Trend Analysis 1997/1998 to 2009/2010

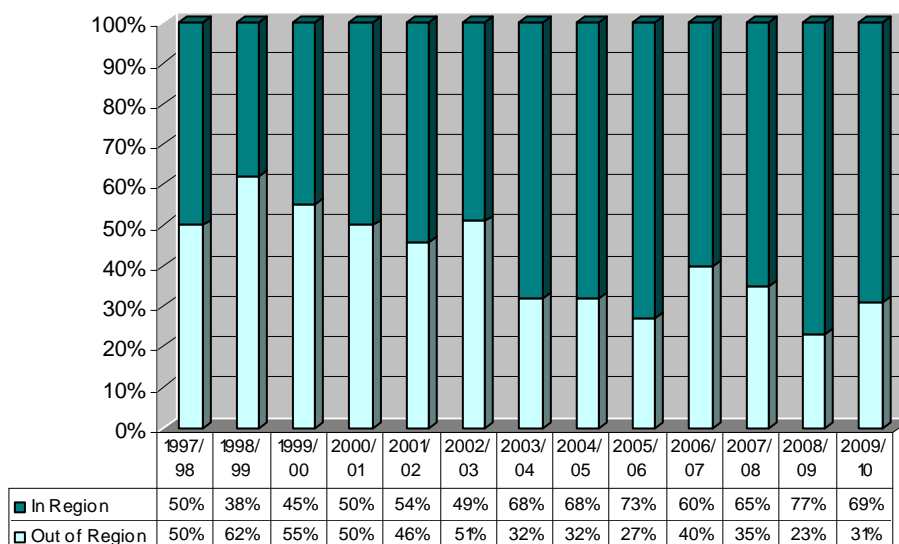
Indicator Name: % of NOR-MAN residents receiving Cancer treatment in region

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**

Where NRHA Residents receive Cancer Treatment



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 2009/10 fiscal year, 69% of NOR-MAN cancer patients were able to receive their treatment within the region (153 Chemo sessions were provided in Flin Flon and 118 in The Pas). A total of 14 NOR-MAN patients received treatments both in the region and at other treatment locations in the province.

Action Plan: Continue to monitor.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/Source:** Provincial Dialysis Program
Board End: Optimal Access

Reporting Period: As of October 2010

Indicator Name: Access to Dialysis in region

Definition: -# of individuals presently being treated in region/ total # able to be treated given current staffing levels.
 -# of individuals not able to receive treatment in requested NRHA location

Results:
Interpretation:

	# of Patients/ Total Potential	# NRHA Residents receiving treatment not in preferred location
The Pas	27/40	2
Flin Flon	5/8	2

Rating: **Green**

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.

Our dialysis unit in The Pas is presently staffed for 32 patients. We are currently at 27 patients. There are two patients being dialyzed in Winnipeg and once stabilized, they will be moved to The Pas. In Flin Flon, we have 5 patients presently receiving treatment. There are two patients being dialyzed in Winnipeg and once stabilized, they will be moved to Flin Flon.

Action Plan: Continue to monitor caseload and wait lists. If wait list warrants it, staffing in The Pas will be increased to accommodate our 40 patient capacity.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/Source:** Home Care CQI Team
Board End: Optimal Access

Reporting Period April 1, 2009 to March 31, 2010

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

Definition: # of new Home Care referrals fielded in 48 hours
 Total # of new Home Care referrals

of service implementations **not** completed within 48 hours
 # of new Home Care referrals fielded in 48 hours

Results Interpretation: New Home Care requests fielded in 48 hours = $\frac{153}{235} = 65\%$

Service implementations not completed within 48 hours = $\frac{31}{153} = 23\%$

Rating: **Warning**

As of March 31, 2010 Home Care caseload was 417. In 2009-10, there were 235 new referrals to Home Care. Of the new referrals, 65% were fielded in 48 hours which was the same as 2008-09. Of the new Home Care referrals that were fielded with 48 hours, the percentage of Service Implementations not completed within 48 hours was 23%, the same percentage as in 2008-09. The difficulty that is being experienced by Home Care continues to be the inability to recruit and retain Direct Service Workers despite ongoing recruitment attempts.

NOR-MAN RHA signed a Memorandum Of Understanding (MOU) with the MGEU collective agreement establishing a variety of FTE's for Health Care Aides, Mental Health Proctors and Home Support.

Action Plan: Continue to monitor. 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. Three (3) 0.5 EFT On-Call Workers were created in The Pas and three (3) in Flin Flon in response to after hours replacement calls.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/ Source:** NRHA
Board End: Optimal Access

Reporting Period: 2008 vs. 2009

Indicator Name: **Itinerant Clinic Service Days**

Definition: # of itinerant clinic service days provided in region by clinic area, separated by allied health professional days (AHD) & physician service days (PD).

Results:
Interpretation:

Rating: **Good**

Clinic	2008		2009	
	PD	AHD	PD	AHD
Orthotics (The Pas)	12	24	8	16
Psychology	21			
Psychiatry	54			
Breast Screening		46		42
Neurology (Flin Flon)	0			
Child Development (The Pas)	3		4	
Endoscopy (The Pas)				
Internal Medicine (Flin Flon Clinic)	15		9	
Surgery Program (Flin Flon Clinic)	30		89	
Obstetrics/ Gynecology (Flin Flon Clinic)			48	
Pediatric Dental (Flin Flon OR)	10		16	
Gastro (Flin Flon OR)			11	
Obstetrics/ Gynecology (Flin Flon OR)			5	

PD = Physician Days AHD = Allied Health Days

In 2008-09, we offered a total of 190 physician days and 70 allied health days for specialty clinics. NRHA attempts to offer a number of itinerant clinic 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.

We have seen a slight decrease in the number of visits to our region by two of the Psychiatrists over the past few years. Although we have been able to connect with Telehealth and receive consultative services from Winnipeg based Psychiatrists through that avenue. While it becomes increasingly difficult to recruit specialty services, we have been somewhat successful in providing itinerant surgical services by entertaining physicians who can see patients locally thus saving NPTP funds.

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 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.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQ; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 20 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/Source:** Diagnostic Imaging
Board End: Optimal Access

Reporting Period: Time Trends from 2005-06 to 2009-10

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
2008-09	213 (7%)	164 (6%)	2506 (87%)	2883
2009-10	227 (7%)	260 (8%)	2618 (84%)	3105

Rating: **Good**

There were 3,105 CT examinations in 2009-10 (259 monthly average) which was a 7.7% increase from 2008-09. The majority of CT scans were by referrals at 84%.

As of June 2010, wait list for a CT is 4 weeks, which is below the Manitoba average of 5 weeks.

Action Plan: Continue to monitor.

Date:	November 2010	Scorecard Area:	RESPONSIVENESS
AIM Dimension:	Accessibility	Reporter/Source:	Manitoba Retinal Screening Vision Program (MRSVP)
Board End:	Optimal Access		

Reporting Period: January 1 to December 31, 2009

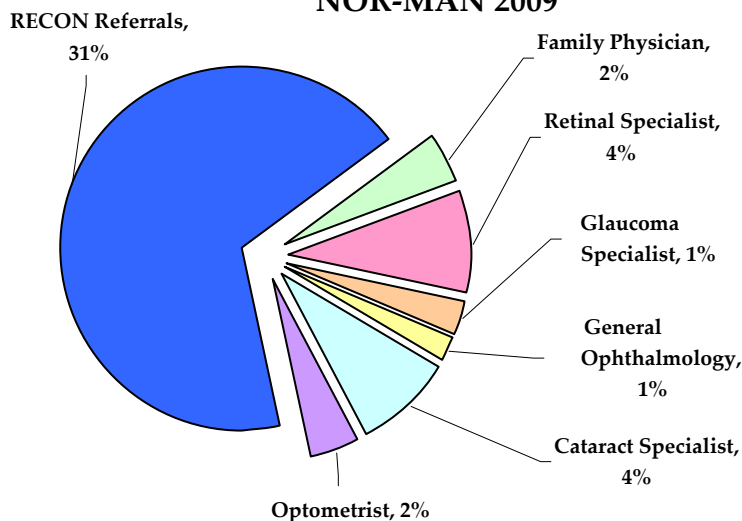
Indicator Name: % of Retinal Screening Referrals by Referral Specialty Type

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

Results Interpretation:

Rating: **Good**

**Distribution of Retinal Specialist Referral for MRSVP
NOR-MAN 2009**



Over the past four years the program initially expanded from just Flin Flon and The Pas to Channing, Cormorant, Wanless, Cranberry Portage, Sherridon, Grand Rapids, Easterville, Moose Lake and Snow Lake. Through funding provided by FNIHB, the MRSVP has been able to extend services to the First Nation communities of Mosakahikan Cree Nation, Opaskwayak Cree Nation, Chemawawin Cree Nation, and Misipawistik Cree Nation. We continue to reach out to new clients as well as to ensure that those requiring re-screening were provided this service.

From January to December 2009, a total of 295 clients were screened. Of those screened 30 (10%) were referred to Retinal Specialists, 6 (2%) to Glaucoma Specialists, 26 (8%) to General Ophthalmologists, 20 (6%) referred directly to an Optometrist, and 12 (4%) referred to their Family Physician. All clients screened will be screened again based on the recommendations of the reviewing specialists and the 2008 Clinical practice guidelines which recommend that re-screening occur minimally every 12 months from the time of initial screening.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQ; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 22 -

Action Plan: To fill the vacant Retinal Screening Nurse position with the program changing from pilot status to that of an ongoing program.

The Retinal Screening Nurse to continue to work closely with both the NRHA Regional Diabetes Program and the Diabetes Integration Program to ensure comprehensive diabetes/chronic disease care for all clients.

Date: November 2010
Scorecard Area: RESPONSIVENESS
Reporter/Source: Manitoba Wait Time Information
 Departments listed below

Reporting Period: As of August 2010

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**

Warnings are due to vacant positions

Program Area		Wait Time
Physiotherapy (The Pas)	Priority	62 clients (average wait of 49 days)
	Non-Urgent	103 clients (average wait of 123 days)
Physiotherapy (Flin Flon)	Priority	9 days
	Non-Urgent	28 days
Audiology		126-130 clients
Speech Language Pathology		20 clients
DER	The Pas	2 week or less
	Flin Flon	2 weeks or less
	Snow Lake	6 weeks or less
	Outlying Communities	6 - 8 weeks or less
Mental Health	Children/Youth	2 to 6 weeks
	Adult	1 week
Rosaire House		82 on wait list (annual average) 6 week wait time
Home Care		16 clients
CT Scan – The Pas		2 weeks (MB = 6 weeks)
Ultrasound –The Pas		6 weeks (MB = 7 weeks)
	Ultrasound – Flin Flon	2 weeks
X-Ray – The Pas		Same Day
	X-Ray – Flin Flon	Same Day
Long Term Care		12 clients - Flin Flon 7 clients - The Pas

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQ; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 23 -

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 demands for out-patient Physiotherapy services in The Pas continue to increase yearly. In 2009-10, the department received 633 referrals. This is an increase of 96 referrals (16%) from 2008/09 and an increase of 283 referrals (45%) from 2007/08. The wait times have also increased due to staff shortages. The department has been short a Physiotherapist since December 2009 and an Occupational Therapist since February 2009. The lack of OT services means that existing Physiotherapy services have incorporated several OT duties as part of their caseload and therefore decreasing the time available for the treatment of out-patients. As of October 4, 2010, these positions will have been filled and should positively affect the out-patient waiting list. In Flin Flon, wait times are not a concern. There were 377 referrals in 2009/10.

Mental Health - We continue to experience wait times for Mental Health Services at both locations but for a variety of reasons. In Flin Flon, most Adult clients referred for service are seen for initial assessment within one week. This may be extended to two weeks in the communities of Snow Lake and Cranberry Portage due to travel times. In The Pas and outlying communities served from that office, wait times range from 2-6 weeks, depending on urgency of the referral. This is due to staff shortages in both the Child and Adult programs. We have had good success with the introduction of the Mental Health Clinician – Intake position for Child and Adolescent services and have significantly cleared the wait list that developed during the previous reporting period. We have also made the decision to implement a similar position for the Adult service in The Pas and that position is currently posted.

Audiology – Ongoing attempts to recruit an Audiologist have been unsuccessful. The individual that was to start in January 2010, wanted to be assured of two (2) years employment. As he was not a Canadian citizen, this could not be guaranteed so he chose to seek employment elsewhere. It has been the intent of the region to contract an itinerant Audiologist until the position can be filled although we have been unsuccessful in contracting services. There has been no service since June 2009 and the current waiting list is 126-130.

Speech Language – We continue to have an active pre-school Speech Language Pathologist (SLP) therapy program in place. Wait times stayed constant for the first part of the year due to the assistance provided by a senior practicum SLP student. This student has been hired through the Children's Therapy Initiative for the past three (3) summers. She immediately filled the maternity leave left vacant in April. Additional funding through the CTI grant allowed her to provide full time services until mid August when she left the position. Although the position has been posted for over three (3) months we have been unable to fill the vacancy. The wait list of approximately 20 in August has been growing at approximately 2-3 referrals per week which is a common pattern once preschool and nursery programs start again in the fall each year. An additional SLP position is required to manage the continually growing requirements of the regional program, and if we are to ever meet the recommended caseload for a preschool speech therapist. An adult/geriatric SLP position continues to be identified as an area of need.

Diabetes Education Resource – Wait times to see the Regional Diabetes Program is less than in most areas of the province. Wait time in the larger communities is two weeks, with urgent referrals scheduled within a week. In out-lying communities, clinics are scheduled every six (6) weeks. Urgent referrals from out-lying areas can be scheduled in the larger communities within two weeks.

Rosaire House – The length of the wait list continues to decline along with the number of weeks the clients have to wait. Our aggressive follow-up protocol has been effective in making the community resources responsible for the referrals they make.

Home Care - The wait list in Home Care is related to staff shortages and the inability to recruit and retain Direct Service Workers despite ongoing recruitment attempts. Home Care's Caseload increased slightly from the previous year from 407 to 417 and there was also a slight increase in the number of new referrals (232 vs. 235).

Long Term Care – A number of clients could be managed longer in the community (versus PCH placement) if alternative housing options with 24 hour supports were available in Creighton, Flin Flon and The Pas. However, Home Care does not have the resources to provide 24 hour home care in individual homes and alternative housing units are not available in any of the communities. All LTC beds are fully occupied in the region at the present time.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQI; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 24 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Accessibility **Reporter/Source:** Rosaire House
Board End: Optimal Access

Reporting Period: 2008-09 vs. 2009-10

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:

Rosaire House Utilization Indicators	08-09	09-10
Occupancy Rate	80%	87%
# of new admissions	208	202
# non-admissions	345	268
% not completing rehab	24%	30%
% of admissions female	49%	48%
% of female clients who are pregnant	17%	20%
% stating gambling dependency	29%	19%
% of CODI referrals	51%	59%
% of clients from NOR-MAN	65%	67%
% of clients from rest of northern MB	21%	16%
% of clients from south of 53 rd	13%	11%
% of clients from Saskatchewan (Norman area)	1%	6%
Average age – male clients	37	37
Average age – female clients	33	34

Rating: **Good**

Warning

NOR-MAN RHA continues to be the only RHA in Manitoba to operate an Addictions Treatment Centre. More clients left the program early and completion rates were lower than in previous years as the complexity of issues plus types of mood-altering drugs being used makes an increased challenge to group therapy – shorter attention spans, withdrawal discomfort, etc.

The number of women coming for treatment remained fairly constant. We are seeing more referrals from pregnancy support services but these clients also have many needs that we cannot meet here – supports for other children, etc. Gambling is less of a priority than drugs such as crack, ecstasy and meth.

The increase in the number of clients with Co-Occurring disorders indicates the challenges being faced by this program. With only four (4) clinicians, there is only so much program flexibility. The need for a CODI Nurse and an Addictions Clinic Assistant has been identified as a critical volume pressure.

Action Plan: Continue to monitor.

Date:	November 2010	Scorecard Area:	RESPONSIVENESS
AIM Dimension:	Timeliness	Reporter/Source:	Medical Transportation Co-ordination Centre
Board End:	Quality of Care		

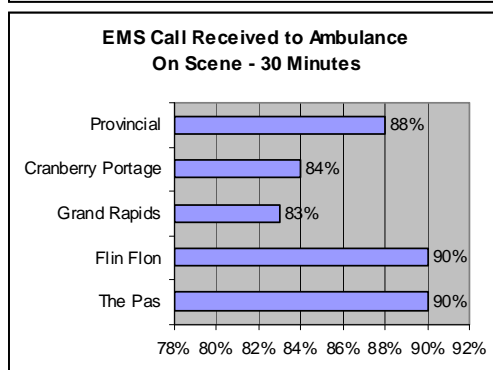
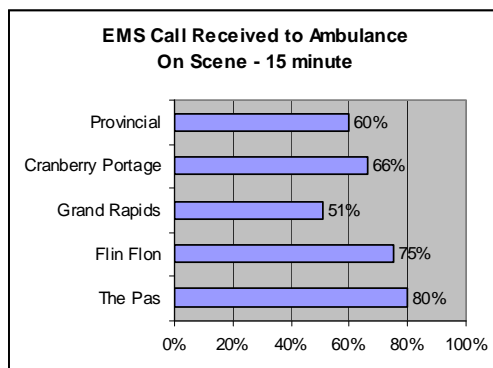
Reporting Period: January 1 to December 31, 2009

Indicator Name: EMS Response Averages

Definition: Percentage of EMS calls received that are on the scene within 15 minutes
Percentage of EMS calls that are on scene within 30 minutes.

Results:
Interpretation:

Rating: **Green**



In 2009, NRHA operated 4 sites in the region including The Pas, Flin Flon, Cranberry Portage and Grand Rapids. The remaining ambulance services in NOR-MAN were operated by volunteer services. In 2009, there were 2264 EMS calls in The Pas, 1570 calls in Flin Flon, 260 calls in Grand Rapids and 143 calls in Cranberry Portage catchments areas. The Medical Transportation Coordination Centre has established two indicators to measure response time for the Province. The first is the percentage of EMS calls received that are on the scene within 15 minutes. The Pas (80%), Flin Flon (75%) and Cranberry Portage (66%) were above the provincial of 60%. The second indicator is the percentage of EMS calls that are on scene within 30 minutes. The provincial average was 88%. Both The Pas and Flin Flon were above the provincial average at 90%

Action Plan: These are new indicators developed by the Medical Transportation Co-ordination Centre. Continue to monitor.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Timeliness **Reporter/Source:** CIHI eCHAP
Board End: **Source:** CHAP 1 Report
Reporting Period: Trend Analysis 2000/01 to 2008/09

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:

Typical Cases	Snow Lake Health Centre		Flin Flon General Hospital		The Pas Health Complex	
	Avg	Expected	Avg	Expected	Avg	Expected
2001/02	3.2	4.0	3.2	3.0	2.8	3.0
2002/03	2.8	3.8	3.3	3.0	2.7	2.9
2003/04	4.6	4.1	3.2	3.0	3.0	3.3
2004/05	3.6	5.0	3.2	3.0	3.0	3.1
2005/06	3.4	4.6	3.3	3.1	3.1	3.3
2006/07	3.5	4.3	3.3	3.1	3.3	3.6
2007/08	3.6	4.3	3.5	3.3	3.1	3.5
2008/09	1.7	3.6	3.3	3.1	2.9	3.3

Rating: **Good**

During the 2008/09 reporting year we have seen the length of stay in NRHA facilities for typical acute admissions drop and in both Snow Lake and The Pas the average length of stay are lower then the expected Average Length of Stay.

Action Plan: The Regional Utilization committee will be re-established and indicators will continue to be monitored.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Continuity **Reporter/Source:** Addictions CQI
Board End: Healthy People **Source:** Rosaire House

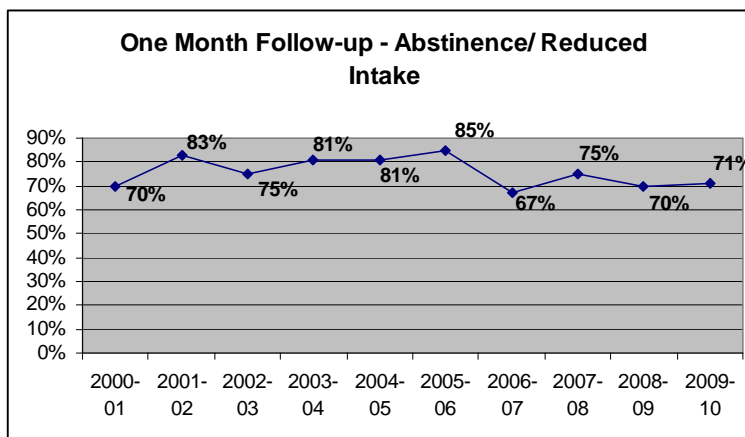
Reporting Period: Trend Analysis 2000-01 to 2009-10

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 the ten year time period, an average of 76% of Rosaire House clients after one month follow-up have indicated they have reduced their use of addictive substances or practices (eg. Gambling).

Abstinence/reduced intake rate in our follow-ups continues to be approximately 70%, but clients are finding it more difficult to cope when they leave the program as living situations are much more complex, with few supports for addiction. Most of the clients who come here have lived in environments where addictive behaviours are the norm.

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.

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

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Continuity **Reporter/Source:** Addictions CQI
Board End: Healthy People

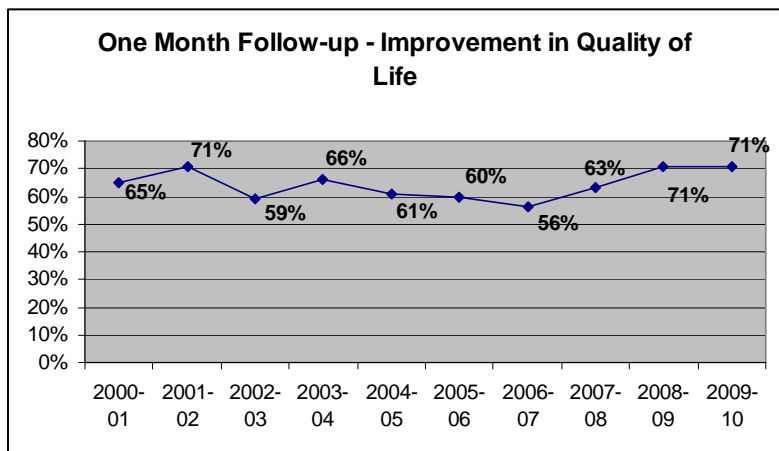
Reporting Period: Trend Analysis 2000-01 to 2009-10

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: **Good**



The benchmark for this indicator since 2000 is 65%, meaning that 65% of clients completing the program are reporting a more positive impact on quality of life at time of follow-up. In 2009-10, the rate was again above the benchmark level at 71%.

Clients continue to be satisfied with Rosaire House services and their learning opportunities. Main area of concern continues to be the length of the program – 40% would like to see us extend the program by a further two (2) weeks at least. Clients also indicate they have learned more responsible ways in which to behave and more positive approaches to handling their problems.

Action Plan: See previous indicator.

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Continuity **Reporter/Source:** Home Care CQI Team
Board End:

Reporting Period: March 31, 2009 to March 31, 2010

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	57%	72%	64%
Call From Hospital Emergency Staff	0%	1%	0%
Family Sick/ Death/ Emergency	10%	19%	14%
Scheduling Error	0%	1%	0%
Clients Family Canceling	4%	0%	2%
RN/LPN Canceling/Reinstating Service	1%	0%	1%
Other i.e. Wrong #/ Hang-ups	1%	0%	0%
DSW not available	7%	0%	4%
DSW forgot to go to assignment	4%	2%	3%
Call for Direction	15%	1%	8%
Weather Conditions	3%	3%	3%

Regionally, the on-call chart shows a decrease in 'Direct Service Workers (DSW) not available' from 15% in 2008/09 to 4% in 2009/10. Whereas 'Sick Replacement' conveys an increase of from 55% in 2008/09 to 64% in 2009/10. Following the creation of FTE's, we still continue to identify the follow:

- Inability to recruit and retain consistent staff: wage parity and lack of direct supervision.
- Staff burn out and increased sick time due to staff working extra shifts
- Increase in personal problems: family emergencies, aging parents, etc. have placed extreme pressures on staffing.
- All of the above has placed undue duress and stress on the on-call replacement workers.

In the area of scheduling accuracy, the process has identified the need to implement Staffing Officers/ Scheduling Clerks to reduce the number of errors for staff/ clients/ families. Also, workload demands on Resource Coordinators have increased resulting in a potential for error due to high need client service requests.

Action Plan:

- To recruit another on call replacement worker.
- To recruit and maintain available resources thus reducing stress on staff that provides Direct Service.
- Implementation of Staffing Officers in October 2010, thus allowing Resource Coordinators to provide direct supervision and support to all levels of Direct Service Staff.
- Continue to monitor.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQI; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 30 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Continuity **Reporter/Source:** Administration On Call Database
Board End:

Reporting Period: Fiscal Years 2007-08 to 2009-10

Indicator Name: Administration On-Call, % by reason, % by facility

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

Results:
Interpretation:

Rating: **Good**

Calls By Subject	2007-08		2008-09		2009-10	
	#	%	#	%	#	%
Staffing	74	52%	121	58%	151	71%
Bed Availability	18	13%	18	9%	5	2%
Physician Concerns	10	7%	12	6%	6	3%
Physical Plant	6	4%	6	3%	6	3%
Transportation	4	3%	6	3%	8	4%
Complaints	1	1%	1	0%	3	1%
IMS	1	1%	4	2%	0	0%
CI/CO	0	0%	1	0%	1	0%
Shortage of Meds	0	0%	0	0%	0	0%
Security	0	0%	1	0%	3	1%
Other	27	19%	38	18%	31	14%
Totals by Fiscal Year	141		208		214	

Calls By Facility	2007-08		2008-09		2009-10	
	#	%	#	%	#	%
St. Anthony's Hospital	84	60%	118	57%	110	51%
Flin Flon General Hospital	19	13%	25	12%	26	12%
St. Paul's Residence	26	18%	38	18%	34	16%
Personal Care Home	7	5%	6	3%	17	8%
Northern Lights Manor	0	0%	7	3%	14	7%
Snow Lake	2	1%	5	2%	2	1%
Other	3	2%	9	4%	11	5%
Total by Fiscal Year	141		208		214	

In March 2006, Senior Management instituted an Administration 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 May 2010, the Administration On-Call Rota was expanded to include clinical managers from Long Term Care, Acute Care and Primary Health Care. In 2009-10, there were 214 calls made, which was a slight increase in calls from the previous reporting period. The majority of calls by subject continue to be for staffing related issues at 71%, followed by other at 14% and transportation at 4%. The majority of calls by facility continue to be from St. Anthony's at 51%, followed by St. Paul's Residence at 16% and Flin Flon General Hospital at 12%.

Action Plan: Continue to monitor

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: Blue = Optimal; Green = Good Ongoing CQ; Yellow = Warning/ Room for Improvement; Dark Yellow = Data Limitations; Red = Trouble/ Extensive Work Required; Black = New Data Not Available/In development - 31 -

Date: November 2010 **Scorecard Area:** RESPONSIVENESS
AIM Dimension: Continuity **Reporter/Source:** Infant/ Youth Health Team
Board End: Healthy People

Reporting Period: Audit for 6 months (January to June) each year 2006-2009

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: **Dark Yellow**

Data Limitations

Community	Year	Total # of Births	% Initiating Breastfeeding	Of those Initiating, % Breastfeeding at 4 months
Flin Flon	2006	25	17 (68%)	15/17 (88%)
	2007	37	25 (68%)	13/25 (52%)
	2008	33	20 (61%)	13/20 (65%)
	2009	29	16 (55%)	9/16 (56%)
The Pas	2006	36	27 (75%)	20/27 (74%)
	2007	75	36 (48%)	28/36 (78%)
	2008	57	44 (77%)	21/44 (47%)
	2009	68	52 (76%)	38/52 (73%)
Snow Lake Sherridon Cr. Portage Cormorant	2006	7	<i>suppressed</i>	<i>suppressed</i>
	2007	14	11 (79%)	5/11 (45%)
	2008	16	11 (69%)	8/11 (73%)
	2009	14	12 (86%)	10/12 (83%)
Totals for	2006	68	49 (72%)	37/49 (76%)
	2007	126	72 (57%)	46/72 (64%)
	2008	106	75 (71%)	42/75 (56%)
	2009	109	80 (71%)	57/80 (71%)

Data Source: NRHA

** This data reflects only communities that transferred to the RHA. Data is based on manual counts for only the births in the first six months of each year. Counts under five (5) are suppressed but included in the total aggregate counts.**

In 2009, 71% of new mothers initiated breastfeeding according to the January to June 2009 Audit. This is the same percentage as last year's audit. Of those who initiated breastfeeding, 71% continued to breastfeed at four (4) months. This percentage is higher than the previous year.

NOR-MAN Regional Health Authority Quality Scorecard: Responsiveness (November 2010)

Ratings: **Blue** = Optimal; **Green** = Good Ongoing CQ; **Yellow** = Warning/ Room for Improvement; **Dark Yellow** = Data Limitations; **Red** = Trouble/ Extensive Work Required; **Black** = New Data Not Available/In development - 32 -

Action Plan:

- Breastfeeding committees in the region continue to meet. Projects / activities planned year round including breastfeeding week media campaign, poster campaigns, radio announcements, promotional materials and gifts given to breastfeeding mothers during breastfeeding week
- Breastfeeding support groups locally and the provincial help lines have also been noted as supports to the mothers seeking breastfeeding information
- The Provincial Baby Friendly Initiative has introduced a facility auditing process in attempt to promote and support breastfeeding and baby friendly hospitals. We are working diligently and will soon be going through the accreditation process. Continuing education opportunities for all staff will assist with the move to a community based Baby Friendly accreditation process
- Review of our breastfeeding indicator will be completed based on the new Baby Friendly Initiative that is currently being implemented
- Continue to monitor indicator