Kingston, Frontenac, Lennox & Addington
COMMUNITY CARE ACCESS CENTRE
2004/05 Annual Report

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Stan Collins
Board Chair

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(A) Executive Director

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1) Message from the Board Chair and Executive Director

The year began with an immense challenge: how to cope with the effects of the rise in rates of the Access Centre's new service contracts for personal support and nursing services. The rates for purchased services had been low for several years. We knew the rates would go up, but no one expected an increase of 20 per cent for personal support and 36 per cent for nursing, the two services that consume a major proportion of the Access Centre's budget. We were determined to find a client compassionate and safe solution that would reduce our spending rate by 20 per cent and save $4.7 million over the fiscal year. And we succeeded. In the process, the Access Centre created innovative new strategies for managing community health care that are being studied by others and may well be published as scientifically important.

We agreed, from the beginning, that our plan had to be based on our code of ethics which was introduced by the board the previous year and our rigorous policies governing quality of service. In other words, our new approach had to be consistent – and demonstrably consistent – so that all clients were treated fairly and the quality of the services that clients received remained high. The trick was in determining client priority.

One of the two most important achievements of last year's major challenge is that the KFL&A Access Centre managed to break new ground in the area of determining client service priorities. We developed important new assessment tools that enabled the Access Centre to maintain quality of care for its clients while safely shortening service provision and serving as many people as before. These tools include:

- priority guidelines for making decisions about allocating home health-care services to clients. This tool was developed in consultation with area hospitals and the Access Centre's Medical Practice Committee and with the assistance of Queen's University's Centre for Health Services and Policy Research. It has been evaluated by Queen's researchers and represents a break-through in home health-care priority tools, along with the following:
- a tracking system for following clients who have to wait for care to ensure that they are not at increased risk and to maintain regular contact to ensure that their condition has not changed.
- nursing "intensity and duration-of-care" guidelines for the 12 most common diagnostic groupings. Developed with service providers, the guidelines promote teaching self-care and learning independence and lead to faster discharge of clients without affecting outcomes.

- a similar respite guideline strategy was also developed to determine the level of support a caregiver may require to continue to manage caring for their loved one at home

Of course, none of these technical strategies on its own would have achieved success without the stronger connections that we made with our community health care partners – the hospitals, service providers, long-term care homes and retirement homes – whose understanding and co-operation were essential in achieving the Access Centre's goals. While these partnerships were already developed, they have been considerably strengthened over the last year. This was our second significant achievement. Without these strong connections we could not have accomplished the following:

- Established new co-operative and practical arrangements with hospitals, which received systemic crisis designations twice in 2004/05, to ensure that people in acute care hospital beds who no longer needed hospital care and those in crisis in the community were considered first for admission to long-term care homes. These arrangements helped to reduce the substantial pressure on hospital beds
- Established a consistent standard of care with retirement homes for augmenting and dividing the level of care they and the Access Centre provide to residents
- Supported the establishment of a new ambulatory patient clinic by two partner hospitals enabling the CCAC and the two partner hospitals to provide clients/patients with an alternative source of care. The convenient and cost-saving clinic, which was a trial project last year open on week days, has worked so well that it is now permanently hosted by one hospital and open seven days a week

As a cost-saving measure, we renegotiated most of our administrative contracts, including phone and liability insurance and the lease of our main office. We now use one-third less office space at our present location, in a revised office designed with the advice of our front-line staff in cooperation with the expertise of a local architect.

The challenges last year were difficult, but by the end of the year, we had instigated many positive and innovative changes for managing and improving home health care in Kingston, Frontenac and Lennox & Addington.

Signature, Board Chair

Signature, (A) Executive Director

Introduction

The KFL&A CCAC provides a wide range of professional and support services in homes, schools and other places outside of hospital, based on an assessment of each individual's needs. The services included are: case management, the management of admissions to long-term care homes, assess and determine eligibility for Adult Day Services, nursing services, personal support, homemaking, essential house cleaning, respite care, physiotherapy, occupational therapy, speech therapy, social work, nutritional counselling, transportation for medical purposes, the provision of medical supplies and medical equipment and information about and referral to other community services. CCACs co-operate with other community organizations that have similar objects.

KFL&A CCAC Mission and Values

Mission: *Our mission is our purpose*

Our objective is to connect citizens to health care and to other resources needed to achieve their maximum potential for health, dignity and independence wherever they live in the community.

Values: *Our values guide our decision-making and actions*

Clients First	We strive to be advocates on behalf of clients and families while managing within available resources.
Accountability	We strive to deliver results that benefit our clients, our community, our health care partners and our staff, using open communication and transparent governance.
Responsiveness	We strive to be fair and timely in assessing our clients and in providing them with access to services.
Excellence	We strive to provide quality service to our clients and our community by setting high standards, working towards clear goals and conducting research to develop best practices for community-based health care.

In October, 2003 the Board was briefed, by the Executive Director, on the proposed development process for the business plan. The assumptions, operational and strategic objectives were reviewed and discussed with the Board in January 2004, February 2004, and March 2004 meetings and in February, 2004 the Board approved the 2004/05 Business Plan and Budget for submission to the Ministry of Health and Long-Term Care. (MOHLTC)

Key Initiatives and Achievements/Progress

In 2004/05 some of the key initiatives for the KFL&A CCAC were:

1) Common Assessment Instrument

The continued implementation of the common assessment instrument for all long stay clients included progress in the following areas: education of the case managers about the development of goals and service plans; training regarding use of the laptop in the home; further development and implementation of the methodology for monitoring key performance indicators.

2) Clinical Priority Setting Guidelines

The development of the following priority setting tools was completed in co-operation with Queen's University's Centre for Health Services and Policy Research. The case managers use these guidelines/tools to assist with clinical decision-making in determining a priority of acuity.

- Therapy guidelines
- Nursing guidelines
- Personal Care and In-home Support guidelines

3) Ambulatory Patient Clinic

In January 2005, an ambulatory patient clinic was opened at KGH. The provision of nursing care in the hospital setting, for those clients/patients that can mobilize without undue hardship, allows for CCAC nursing resources to be better utilized for home bound clients and for acute care nursing resources to be utilized for in-patient clients. The type of clients/patients that are seen in the clinic include for example: clients needing wound care, clients needing injections.

4) Nursing Guidelines

Nursing guidelines were developed and initiated in co-operation with the nursing provider agencies under contract with the CCAC. These nursing guidelines set out expectations for self care and independence and anticipated intensity and duration for the provision of specific nursing interventions; for example, medication administration, care of new insulin dependent diabetics, care of clients with hypertension. These guidelines were audited and revised, as needed, during the initial months of implementation.

5) Retirement Homes

In order to provide an equitable level of service to clients residing in retirement homes, the CCAC implemented a consistent standard of care for all clients requiring CCAC services living in a retirement home. The CCAC met with all retirement homes in the catchment area to review and implement this approach.

6) Respite Care

The CCAC developed and implemented respite guidelines in the provision of respite to caregivers that have dependent loved ones in the home. The assessment process also included the application of a standardized evidence-based caregiver strain index to assist case mangers with the professional assessment of the level of respite required.

7) Quality Project

The CCAC initiated a number of activities with respect to quality:

Balance Score Card:

The balance score card is a reporting methodology, which provides an overall report card on the current results for a core set of measures. This report is provided to the Board of Directors monthly, and compares current performance results to organizational and business plan targets for the CCAC. The four areas for reporting performance measures include: customer service, learning and growth, finance and processes.

Quality Framework:

The CCAC implemented a quality framework for the organization that included a well documented process; Plan; Do; Study; Act. The quality framework was adopted by the organization and education to staff regarding the framework was provided. Activities include:

- Regular audits of the charts of clients who are assessed as high priority to ensure consistency of clinical decision making/use of the tool across case managers
- The creation of intensity and duration guidelines for nursing
- The development and implementation of an automated incident tracking system
- Revising the Quality management process to ensure regular and timely reporting up to and including the Board of Directors.

Occurrence Reporting System:

The occurrence reporting system was re-designed and implemented to document and inform management of identifiable risk to the organization, its staff and clients; to allow risk identification and analysis; to avoid, reduce or prevent similar events from occurring in the future; and to monitor the quality of services provided by contracted service providers and CCAC staff.

8) Wound Care Project

The CCAC initiated planning for a multidisciplinary, community-based wound care project establishing a steering committee to utilize the expertise of committee participants in developing standards for wound care across all health care sectors.

9) Leg Ulcer Protocols

The CCAC completed implementation of the evidence-based leg ulcer protocol reviewing all established procedures with the nursing agencies providing nursing care to CCAC clients with leg ulcers. This involves ongoing monitoring of patient outcomes.

10) Stoke Rehab Final Report

The CCAC in co-operation with the Stroke Strategy completed a pilot project to evaluate enhanced therapy service provision to clients post stroke. The project results were compiled by the Stoke Strategy and released to the public. The results indicated a significant improvement for those clients receiving enhanced therapy provision post stroke. The provision of enhanced therapy services to post stroke clients in line with the research evidence has been implemented.

11) Palliative Care Integration Project

The CCAC continued to participate in the Palliative Care Integration Project which included implementation of standardized assessment tools; e.g., pain assessment and collaborative care plans for all adult palliative clients across the health care sectors. Currently research concerning various electronic means of reporting up to the minute pain and symptom information is underway.

12) Long Term Care Bed Planning

Given the limited capacity and high utilization of long-term care beds in the KFLA region, the CCAC in co-operation with its health care partners developed a position paper on pressures and options with respect to the provision of care to clients who no longer require acute care but are not able to return home. Options proposed or underway include the development of convalescent care, interim long-term care bed and transitional care bed proposals, and a proposal for an additional 78 long-term care beds in the Kingston, Frontenac region.

Executive Director and Board of Directors OIC Appointments

Community Care Access Centres have a board of directors composed of as many members as the Lieutenant Governor in Council appoints, up to the maximum number of members prescribed by regulation. The Lieutenant Governor in Council designates a chair and may designate a vice-chair of the board of directors from among the members.

There is no limitation, although appointments are usually for one to three years, and board members are eligible for reappointment.

The board generally meets monthly with additional meetings as required.

In 2004/05 the board of the Kingston, Frontenac, Lennox & Addington Community Care Access Centre consisted of the following appointed members.

The KFL&A Community Care Access Centre Board Members		
Position	Incumbent	Tenure
Chair	Carole A. Weir	02/16/02 – 02/15/05
Member	Rod Hughes	02/16/02 – 02/15/05
Member	Diane Duttle	02/16/02 – 02/15/05
Member	Peter J. Radley	12/18/02 – 03/31/06
Member	Stan Collins	01/20/03 – 04/19/06
Member	Beverly McLellan	02/16/02 – 02/15/06
Member	Hélène Ouellette-Kuntz	02/16/02 – 02/15/06

Executive Director	Allen G. Prowse	02/16/03 – 02/15/06

2) Community Partnerships

Community Partnerships with Other Service Providers

The KFL&A CCAC is a partner in the Southeastern Ontario Health Sciences Centre and as part of this co-operative health-care delivery system it works closely with;

- ⇨ Kingston General Hospital (KGH)
- ⇨ Hotel Dieu Hospital (HDH)
- ⇨ Providence Continuing Care Centre (PCCC)
- ⇨ Queen's University, Faculty of Health Sciences
- ⇨ Kingston, Frontenac, Lennox & Addington Public Health
- ⇨ Kingston Regional Cancer Centre (KRCC)
- ⇨ Lennox & Addington County General Hospital

The KFL&A CCAC is also a member of the Health Care Network of Southeastern Ontario. The Network has representation from all hospitals, CCACs, and Public Health, in the counties of Hastings, Prince Edward, Frontenac, Lennox & Addington, Lanark, Leeds & Grenville and the City of Kingston.

Significant Community Committee Representation

The staff of the KFL&A CCAC provided representation on the following community committees:

- ⇨ **Advance Directives**
- ⇨ **Alternate Level of Care (ALC) Focus Group** (KGH, KFL&A CCAC)
- ⇨ **Avoiding the Duplication of Services Working Group** (KRCC, KFL&A CCAC)
- ⇨ **Cardiac and Thoracic Surgery Joint Care Practice Team** (KGH, KFL&A CCAC)
- ⇨ **Central Frontenac Community Services**
- ⇨ **Central Frontenac Long –Term Care Committee**
- ⇨ **Congestive Heart Failure Collaborative Care Plan** (KGH, KFL&A CCAC)
- ⇨ **Congestive Heart Failure Collaborative Care Plan Working Group** (KGH, HDH, KFL&A CCAC)
- ⇨ **Dementia Care Regional Network**
- ⇨ **District Health Council** – Residential Needs of Specialized Populations
- ⇨ **Early Expressions Steering Committee** (KFL&A Health Unit - Preschool Speech and Language – KFL&A Health CCAC)
- ⇨ **Elder Abuse Network**
- ⇨ **Elder Abuse Prevention Services**
- ⇨ **Frontenac Accessibility Advisory Committee**

- ⇨ **Frontenac, Lennox & Addington Mental Health & Addictions Coalition**
- ⇨ **Geriatric Triad Group**
- ⇨ **Geriatric Psychiatry Urban Kingston**
- ⇨ **Health Care Network of Southeastern Ontario Contingency Planning Committee** (KFL&A, HPE, LLG)
- ⇨ **KFL&A Dementia Network**
- ⇨ **KFL&A Falls Coalition – Stay On Your Feet Project** (KFL&A)
- ⇨ **KFL&A Public Health – Long Term Care Infection Control Committee** (KFL&A)
- ⇨ **KGH Accreditation Orthopedics Committee** (KGH)
- ⇨ **KGH Cardiac Care Program Accreditation Committee** (KGH)
- ⇨ **KGH Cardiology Joint Practice Care Team** (KGH)
- ⇨ **KGH: Emergency Joint Practice Care Team** (KGH)
- ⇨ **KGH: Internal Medicine Joint Practice Care Team** (KGH)
- ⇨ **KGH: Transitional Care Joint Practice Care Team** (KGH)
- ⇨ **Kingston Health and Housing Coalition** (KGH, KFL&A Public Health -Street Health, North Kingston Community Health Center, Family Medicine Centre, Area Shelters)
- ⇨ **L&A Medical Clinical Team**
- ⇨ **Land O'Lakes Community Services**
- ⇨ **Lennox & Addington Community Mental Health Program and Services Committee**
- ⇨ **Lennox & Addington County Hospital Accreditation Committee**
- ⇨ **Lennox & Addington Hospital Medical Clinical Team**
- ⇨ **Board of Directors, Lennox & Addington Seniors Outreach**
- ⇨ **Medical Practice Committee** (KGH, HDH, KFL&A Community Physicians)
- ⇨ **Nursing Research Council of Southeastern Ontario Health Sciences Centre**
- ⇨ **Orthopedics Joint Practice Committee** (KGH)
- ⇨ **Palliative Care Integration Project (Regional & Local)** (KGH, KRCC, PCCC, LTC, Hospice Kingston, & KFL&A CCAC)
- ⇨ **Palliative Care Pain and Symptom Management Resource Team** (KFL&A)
- ⇨ **Palliative Medicine and Supportive Care Program Committee**
- ⇨ **Planning Committee for the Heath-Care Providers of South Eastern Region of Ontario Infection Control Program** (HEROIC)
- ⇨ **Post Partum Adjustment Coalition**
- ⇨ **Professional Services Consultation Form Working Group** (KGH, KFL&A CCAC)
- ⇨ **Psychogeriatric Resource Network** (KFL&A)
- ⇨ **Regional Acquired Brain Injury (ABI) Network**
- ⇨ **Regional Alternate Level of Care (ALC) Committee**
- ⇨ **Regional Infection Control Program Working Group**
- ⇨ **Regional Palliative Care & End of Life Care Steering Committee**
- ⇨ **Regional Oncology Nursing Council of Southeastern Ontario**

(Regional Cancer Centre)

- **Regional Stroke Steering Committee**
- **SEOHSC Contingency Planning Committee** (HDH,KGH, KFL&A Public Health, PCCC, City of Kingston, Health Sciences Centre, Quinte Health Corporation, KFL&A CCAC)
- **SEOHSC Pandemic Influenza Planning Sub-Committee** (HDH,KGH,KFL&A Public Health, PCCC, KFL&A CCAC)
- **Urology Joint Practice Committee** (KGH)
- **Working Group – Development of Benchmarks – Process of Eligibility Determination for Admission to Long Term Care Facilities** (KGH, KFL&A CCAC)
- **Wound Care Working Group** (PCCC, KGH Kingston Chronic Wound Care, Kaymar, all KFL&A CCAC contracted nursing providers, KFL&A CCAC)

Initiatives/Achievement with Community Partners

- Development of the Palliative Care Tools and training
- Respiratory Rehabilitation Project – Evaluation of an Integrated Respiratory Rehabilitation Program: Achieving optimal outcomes through long term follow-up to respiratory rehabilitation (PCCC, Community Therapy Providers, Medical Equipment Vendors, Queen's University)
- Change Foundation Project – Closing the gap in home care: development of service allocation priority instruments (Queen's University Health Policy and Research)
- Completed a comprehensive client satisfaction survey in co-operation with 19 other CCACs reflecting improved results over those achieved on the previous survey in 2001.

3) Financial/Statistical Information

Financial Summary

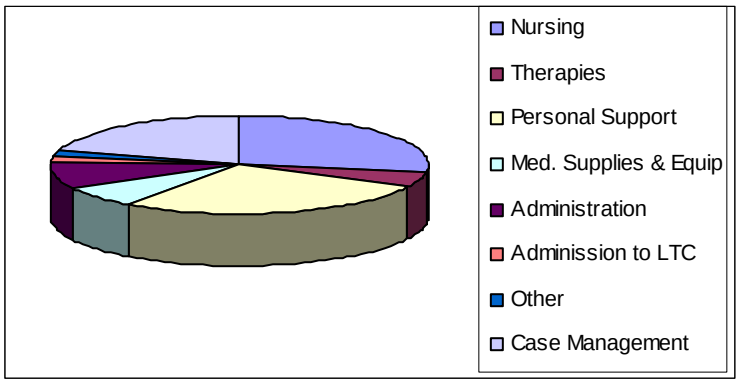
FINANCIAL POSITION for the 12-month period ending March 31, 2005	
current assets	$3,198,869
capital assets	$ 351,343
total assets	**$3,550,212**
LIABILITIES and deferred capital contributions	
current liabilities	$3,198,869
and deferred revenue	
deferred capital contributions.	$ 351,343
total liabilities and deferred capital contributions	**$3,550,212**

Funding

provincial funding.	$26,624,966
other revenues and revenue amortization.	$ 363,673
total revenue	**$26,988,639**

Expenditures

In 2004/05, expenditures totaled $26,988,639. Purchased client health services and direct client care accounted for 89.5% of the budget with 10.5% for administration.



Audited Financial Statements Attached

4) Performance Information Highlighting Key Successes

Service Highlights

Services

Service	Visits	Individuals Served
Nursing	**149,134 Visits**	**3,461**
Physiotherapy	**7,691 Visits**	**1,526**
Occupational Therapy	**6,538 Visits**	**1,522**
Speech Therapy	**2,145 Visits**	**298**
Nutritional Counselling	**927 Visits**	**242**
Medical Social Work	**607 Visits**	**127**
Personal Support	**271,686 Hours**	**1,744**
Total Case Management	**12,910 Visits**	**13,300**
Palliative Education Group Sessions	**40 Sessions**	**64**

Clients

The KFL&A CCAC served 8,962 people and their families. That is about one in every 20 people in the area. On any given day, approximately 2,940 people are receiving health care through the KFL&A CCAC. Included in the above numbers 1,389 people were assisted in finding a new home in a Long-Term Care Home.

Client Satisfaction Results

Percentages refer to an "Excellent" response from clients as opposed to a rating of "good", "fair", "poor".

March 10, 2004 – KFLA CCAC Client Satisfaction			
Case Management	**2002**	**2004**	**CCAC Average***
Responsiveness	62.6%	68.0%	65.5%
Attitudes/Behaviours	73.7%	77.8%	75.1%
Communication	63.7%	69.8%	67.8%
Relationship	72.0%	75.2%	78.6%
Education	88.2%	82.9%	85.5%
Case Manager responds in a reasonable time	97.5%	98.1%	98.6%
Can call Case Manager with Questions	98.8%	97.6%	97.6%
Know who is Case Manager	49.0%	59.8%	68.4%
Regular Contact with Case Manager	70.9%	58.8%	58.2%
Problem not having contact with Case Manager	88.6%	94.2%	92.6%
Case Manager treating you in a caring manner	69.9%	78.7%	73.5%
Case Manager treating you with respect	77.5%	77.0%	76.6%
Case Manager ensuring care provided	65.3%	73.4%	69.7%
Case Manager involving you in care	62.0%	66.1%	65.9%
Understanding needs by Case Manager	62.6%	68.0%	65.5%

*total of 20 CCACs comprise the average

March 10,2004 – KFL&A CCAC Client Satisfaction				
Nursing	**Service Provider 1**	**Service Provider 2**	**Service Provider 3**	**CCAC Average**
Responsiveness	61.2%	92.2%	68.6%	77.3%
Attitudes/Behaviours	65.7%	91.2%	71.6%	80.5%
Communication	65.9%	85.1%	70.1%	74.4%
Completing work	57.1%	83.6%	67.3%	71.7%
Education	64.0%	83.5%	67.3%	71.7%
Nurse respects home/belongings	69.4%	86.3%	72.5%	80.6%
Nurse treating you in caring manner	62.0%	96.1%	70.6%	80.4%
Nurse communications with providers	74.3%	78.6%	61.9%	71.3%
Nurse taking time for questions	70.2%	86.3%	72.0%	77.8%
Understanding nursing need	57.1%	92.2%	74.5%	75.9%
Nurse telling you arrival time	64.6%	82.0%	70.6%	71.9%
Nurses do not miss visits	93.9%	98.0%	90.2%	89.2%
Same quality of care at all nurse visits	90.0%	92.2%	98.0%	92.6%
Different nurses made this difficult	67.7%	71.4%	91.4%	77.5%
Same nurse has provided care	34.7%	58.8%	31.4%	49.6%
Nurse making sure needs met	61.2%	92.2%	68.6%	77.3%
Nurse providing information re: care	62.5%	86.3%	60.4%	73.5%
Nurse helping you understand medications	66.7%	84.2%	74.3%	74.2%
Nurse teaching how to take care of self	63.4%	79.5%	64.1%	70.8%
Nurse doing what is expected	67.3%	84.3%	68.6%	73.7%
Nursing skills/knowledge	60.4%	84.0%	64.7%	74.2%
Nurse arriving on-time	44.0%	82.4%	68.6%	67.0%

March 10,2004 – KFL&A CCAC Client Satisfaction					
Personal Support	**Service Provider 1**	**Service Provider 2**	**Service Provider 3**	**Service Provider 4**	**CCAC Average**
Responsiveness	74.4%	67.3%	66.3%	78.0%	68.6%
Attitudes/Behaviours	79.0%	73.5%	76.1%	83.3%	72.3%
Communication	71.5%	68.8%	64.9%	78.7%	67.2%
Completing work	68.9%	62.2%	64.3%	75.4%	64.1%
Consistent Care	75.6%	80.7%	77.1%	80.1%	74.5%
PSW respects home/belongings	79.1%	66.0%	74.4%	82.4%	71.8%
PSW treating you in caring manner	78.9%	81.3%	77.8%	84.3%	72.8%
PSW understands needs	67.8%	64.0%	69.2%	84.3%	67.4%
PSW taking time for questions	68.6%	79.5%	64.4%	71.4%	65.6%
PSW telling you arrival time	78.2%	64.0%	60.9%	80.0%	68.4%
Same PSW provides care	58.2%	68.0%	68.1%	70.6%	59.6%
Different PSW made this difficult	58.3%	56.3%	48.3%	57.1%	58.4%
Same quality of care at all PSW visits	91.2%	92.2%	94.5%	92.0%	90.9%
PSW never did not miss visits	84.4%	89.8%	77.8%	84.3%	83.5%
PSW making sure needs met	74.4%	67.3%	66.3%	78.0%	68.6%
PSW worked independently	71.3%	61.7%	63.3%	76.5%	66.8%
PSW skills	71.4%	56.1%	61.9%	64.4%	60.6%
PSW did expected work	67.8%	60.4%	67.0%	76.0%	63.3%
PSW made use of time	65.6%	64.7%	66.3%	78.4%	63.6%
PSW arrived on time	68.9%	66.7%	62.9%	81.4%	66.0%
PSW were polite/courtesy	69.2%	62.5%	64.3%	57.9%	55.5%
Able to get PSW questions answered	95.8%	87.5%	81.3%	94.7%	91.2%
No difficulty reaching someone at PSW office	100%	87.5%	81.3%	94.7%	85.6%

Continuous Quality Improvement Plan and Achievements

Achieving improvements in quality involves a number of parallel activities; a) developing processes for auditing and review, b) risk and event monitoring, c) research and the application of evidenced-based practice and d) monitoring ongoing operations against available standards and business objectives.

The primary focus of ongoing quality improvement efforts during this year has been on developing a quality framework, creating a balanced scorecard, revamping the internal occurrence tracking system, analyzing the trends, conducting relevant and appropriate audits and initiating training in quality concepts and quality tools.

The balanced scorecard consists of four quadrants: Learning and Growth, Customer Service, Finances and Processes. There are a total of thirteen indicators being tracked and reported to the Board on a regular basis. Thresholds are in the process of being set based on historical data if available. The scorecard has also been presented to staff and emphasis continues to be placed on this to ensure that the staff understands all of the balanced scorecard parameters and their relationship to the core business.

Accreditation Award

The KFL&A CCAC was granted accreditation by the Canadian Council on Health Services Accreditation in November of 2003. The next accreditation survey will be in 2006.

Balanced Scorecard Quality Dimensions

Balanced Scorecard

Learning & Growth (Work life)	**Customer Service** (Client/Community Focus)
Objective: To develop and maintain highly motivated and skilled staff and to encourage life-long learning. **Indicators:** 1. % staff satisfaction 2. % staff attending internal and external educational sessions, funded and non-funded 3. # and types of staff complaints/injuries **Initiatives:** staff satisfaction survey, redevelopment of performance management systems and processes, standardized workplace assessment	**Objective:** To ensure continuity of care and effective service delivery across sectors and enhance client outcomes. **Indicators:** 1. # of audited charts that demonstrate care plans that are consistent with client needs 2. % client satisfaction 3. % of clients waiting for service and average waiting time **Initiatives:** client satisfaction survey (including LTC), respite tools, wound care protocol, ambulatory clinic
Finance (System Competency)	**Processes** (Responsiveness)
Objective: To maintain expenditures within 2% of approved budget **Indicators:** 1. # and % variance year-end total expenditures to total budget 2. average cost/client **Initiatives:** deficit reduction working group, implementation of MIS, improved utilization reports	**Objective:** To demonstrate the systems and processes in place that are needed in the organization; to manage affairs and meet obligations to the community. **Indicators:** 1. # and % of high-risk occurrences per year 2. % compliance of service providers r/t contract standards 3. # and % of annual business plan objectives achieved, partially achieved and not achieved 4. # and % of clients assessed within 2 wks 5. # of recommendations from management audits **Initiatives:** occurrence reporting P&P and forms, quality framework, documentation working group, CHIN

5) Information on Service Providers and Staff

List of Contracted Service Providers by Service

Nursing
All.Care Health Services
Paramed
St. Elizabeth Health Care

Personal Support and Homemaking
Paramed
Red Cross
St. Elizabeth Health Care

Therapies
Bayridge – PT Only
Hotel Dieu Hospital – Child Development Centre – OT Only
Kaymar

Medical Supplies/Equipment
Kingston Oxygen (KO2)
Medigas

Staff Development/Achievement Summary

Activities related to staff development over the fiscal year 2004/2005 included organization wide programs and workshops, individual learning opportunities, as well as presenting at the Ontario Association of Community Care Access Centres (OACCAC) Annual Conference and the Canadian Home Care Association conference. The Staff Development Committee focused on offering educational opportunities which would increase staff knowledge of community resources and changes occurring within the health care industry. A number of the offerings this year were open to the staff of the service providers, as well as the Access Centre staff. In addition, train-the-trainer programs are being developed in several areas so that in-house training can continue to occur.

The Programs/ Workshops topics for 2004/05 included:

- Heart and Stroke
- Long Term Care Homes
- PIECES (Physical, Emotional, Intellectual, Capabilities, Environment, Social Environment)
- Privacy Legislation
- Public Guardian and Trusteeship
- Consent and Capacity
- Ethics
- Infection Control
- Alzheimer
- Nursing and Personal Support Contracts
- Resident Assessment Instrument (RAI)
- Patient Master Index (PMI)
- Human Resources Development Canada Workshop
- Capacity Assessment

Individual workshop topics for 2004/05 included:

36 individuals were able to take advantage of learning opportunities external to the organization. Some examples of the learning opportunities include:

- Principles and Applications of Health Law
- Collective Bargaining Conference
- Taking Charge of Change
- Privacy Workday
- IT-E Health Forum
- Quest for Quality
- Integrating Financial Data
- Taxation
- Finance
- Dealing with Difficult People
- I&R Training
- Oncology Update
- ONS Radiation Therapy
- Geriatric Mental Health Law
- Orthopedic Care Conference
- Ontario Case Managers Conference
- Falls Prevention and the Elderly
- In Search of Good Death
- Cardiac Sciences Conference
- Alzheimer Disease, Diagnosis and Support
- Nursing Care at End of Life
- Incident Management Systems