

## 2018-19





## 2018-19 ANNUAL REPORT













## **Thank You**

to our dedicated staff, volunteers, Board of Directors, clients, and communities











## Accomplishments 2018-19

This was a year of transformative change in health care. The biggest impact started in June with the election of a new provincial government. This change started slowly with the appointment of a new Minister and in the fall the Premiers Council on Improving Healthcare and Ending Hallway Medicine was formed. The committee released their first report in January, followed in February by the legislation that introduced Ontario Health and Ontario Health Teams. By March the Board of our funder the South West Local Health Integration Network and others were replaced provincially.

In addition to the system changes, many of our health care partners also saw major leadership and organizational changes over the past year. Southwestern Public Health formally launched as a merger of the former Elgin and Oxford Public Health Units, while our partners at St. Thomas Elgin General Hospital, East Elgin Family Health Team and Canadian Mental Health Association saw changes in leadership.

In the fall municipal elections, many new faces joined both the West Elgin and Dutton/Dunwich Councils. In October we held a thank you breakfast for all the individuals who ran for both councils. We look forward to continuing to work well with both local councils as we build our communities together.

The year did see an increase in some resources that we were able to bring to the Centre. In September we received confirmation that funding from the Ministry of Health and Long-Term Care Community Infrastructure Renewal Fund was approved to replace our Heating/ Ventilation and Air Conditioning system. We also received Recruitment and Retention funds to give many of our staff pay increases.

Our Assisted Living and Community Support Services programs also received a modest 2% increase to their budgets. We received new funding to backfill our Chiropodist for a day a week for the offloading service started the previous year. Additionally, in January we received additional funding that allowed us to provide care to three more Assisted Living clients. As the year ended in March we received confirmation of funding for the launch of our Youth community engagement work. This capped off a great year for that group that saw our Child and Youth Worker and the Youth Advisory Committee deliver a 'May the Force be With Youth' presentation at our association's provincial conference in June.

Our team is always working hard to deliver great services and care every day. They also look to the community for input on new programs and services that are required. One major project started this year was as part of the provincial Alliance for Healthier Communities Social Prescribing project. Borrowing from work done in the United Kingdom, we have built a West Elgin Community Resource Booklet that highlights many of the activities available in the community to help combat social isolation and loneliness. This research project runs until December 2019 and should demonstrate the value of our comprehensive approach to care.

Some other changes included the launch of a Stroller Walk in June, a new Cardiac rehab program in October and the Let's Talk Pregnancy program in November. In January our Dietitian started providing services at the Dutton Medical Centre. In February, the advanced access process was changed to allow more clients to schedule their clinical appointments up to five days in advance.

Heading into the new 2019-20 fiscal year, it appears that the speed and volume of change will continue to increase, including how the Centre will fit in with a possible Elgin Health Team. Now more than ever we will need strong community voices on both our Board of Directors and our Client and Family Advisory Council to help us navigate through these uncharted waters. We welcome you to join us on this journey.

Sincerely,

Jennifer Ford Board Chair

ndy through

Andy Kroeker Excecutive Director

## M-SAA Indicator Tracking 2018-19

As part of the agreement with our main funder, the South West Local Health Integration Network (South West LHIN), the Health Centre signs a three- year Multi- Sectoral Accountability Agreement (M-SAA). For each year in the agreement the targets and corridors are set for the indicators. New indicators may be added and old ones dropped. The results are reported to the LHIN for Q2 (April 1- September 30), Q3 (December 31) and Q4 (March 31) each year. As shown below green results are meeting the target, yellow are within the acceptable corridor, while red are not meeting the expected results. The Health Centre uses this information to show us the areas that require a review of appropriateness of targets, are reflective of staff vacancies and areas that may need more attention.

Indicator	Q4 YTD (%)	Q4 Proposed Target YTD 18/19	Q4 Target Perf Stand LOW	Q4 Proposed Perf Stand HIGH
Schedule E1: Core Indicators				
	4 60/	40		
Balanced Budget- Fund Type 2	1.6%	\$0	\$0	\$0
Proportion of Budget Spent on Admin	19.7%	19.6%	15.7%	23.5%
Schedule E2a: Clinical Activity Detail				
General Clinic Individuals Served	2,382	2,150	1,935	2,365
General Clinic Service Provider Interactions	14,144	14,139	13,432	14,846
Foot Care Individuals Served	470	509	433	585
Foot Care Service Provider Interactions	1,997	2,000	1,800	2,200
Nutrition Individuals Served	212	200	160	240
Nutrition Group Sessions	42	35	28	42
Nutrition Group Participant Attendance	485	250	200	300
Nutrition Service Provider Interactions	376	350	280	420
Physiotherapy Individuals Served	294	425	340	510
Physiotherapy Group Sessions	59	5	4	6
Physiotherapy Group Participant Attendance	133	25	20	30
Physiotherapy Service Provider Interactions	1,619	1,800	1,620	1,980
Counselling Individuals Served	272	350	280	420
Counselling Group Sessions	64	36	29	43
Counselling Group Participant Attendance	587	430	344	516
Counselling Service Provider Interactions	1,475	1,950	1,755	2,145
Chronic Disease Individuals Served	162	200	160	240
Chronic Disease Group Sessions	67	50	40	60
Chronic Disease Group Participant Attendance	508	250	200	300
Chronic Disease Service Provider Interactions	1,320	1,000	900	1,100
Diabetes Individuals Served	912	950	808	1,093
Diabetes Group Sessions	46	20	16	24
Diabetes Group Participant Attendance	349	250	200	300
Diabetes Service Provider Interactions	3,013	3,250	2,925	3,575
Community Engagement Individuals Served	158	250	200	300

**Community Engagement Group Sessions** 

Indicator	Q4 YTD (%)	Q4 Proposed Target YTD 18/19	Q4 Proposed Target YTD 18/19	Q4 Proposed Perf Stand HIGH
Community Engagement Group Participant Att	1,064	500	425	575
Community Engagement Service Provider In	367	550	468	633
Pers Health Wellness Individuals Served	307	125	100	150
Pers Health Wellness Group Sessions	185	150	120	180
Pers Health Wellness Group Participant Attend	1,984	1,700	1,530	1,870
Pers Health Wellness Service Provider Interact	530	450	360	540
Meals Delivery Individuals Served	51	70	56	84
Meals Delivery Combined	4,058	3,500	3,150	3,850
Congregate Dining Individuals Served	466	470	376	564
Congregate Dining Attendance Days	8,292	4,800	4,320	5,280
Transportation Visits	5,914	4,200	3,780	4,620
Transportation Individuals Served	166	200	160	240
Assisted Living Resident Days	10,228	8,030	7,629	8,432
Assisted Living Individuals Served	37	25	20	30
Caregiver Support Visits	2,154	1,200	1,080	1,320
Caregiver Support Individuals Served	372	350	280	420
Visiting Social and Safety Visits	2,482	1,500	1,350	1,650
Visiting Social and Safety Individuals Served	119	100	80	120

#### Schedule E2b: CHC Sector Specific Indicators

Cervical Cancer Screening Rate (PAP Tests)	83%	75.0%	60.0%	90.0%
Colorectal Screening Rate	85%	74.0%	59.2%	88.8%
Inter-professional Diabetes Care Rate	96%	95.0%	76.0%	100.0%
Influenza Vaccination Rate	69%	70.0%	56.0%	84.0%
Breast Cancer Screening Rate	82%	65.0%	52.0%	78.0%
Retention Rate (NPs and Physicians)	98%	90.0%	72.0%	100.0%
Access to Primary Care	68%	60.0%	54.0%	66.0%

Green is meeting the target, yellow is meeting the corridor, while red is not meeting the corridor.

% Green 70%

% Yellow 17%

% Red 13%

Total 100%

#### **Our Mission**

The West Elgin Community Health Centre team works with our communities and our partners to provide accessible, high quality health care, health promotion and community support services.

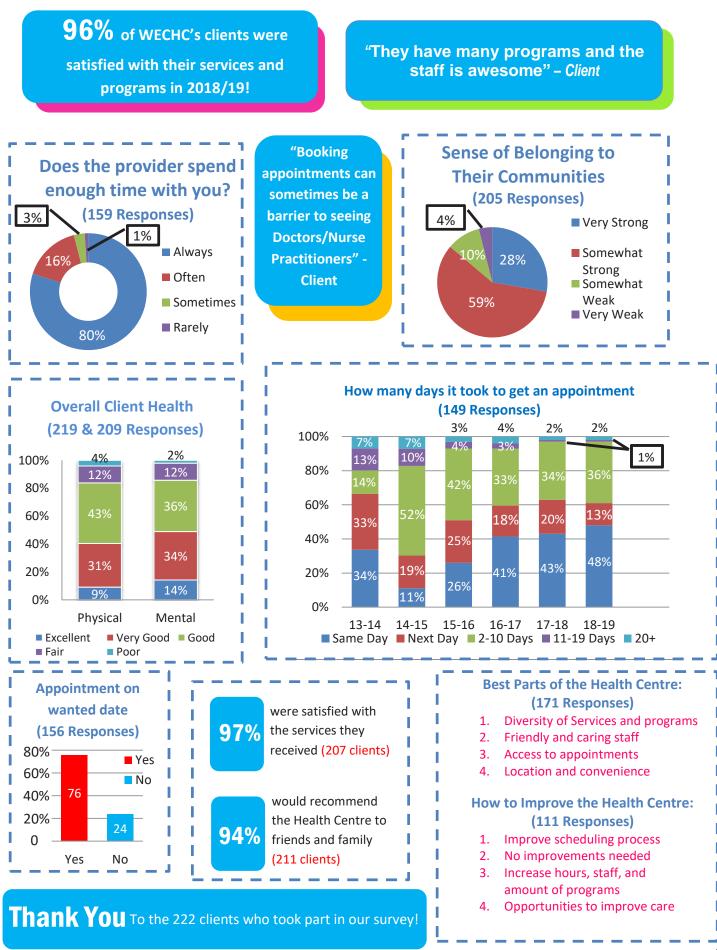
#### **Our Vision**

We envision caring and vibrant communities where people achieve and maintain the highest possible level of well-being.

#### **Our Values**

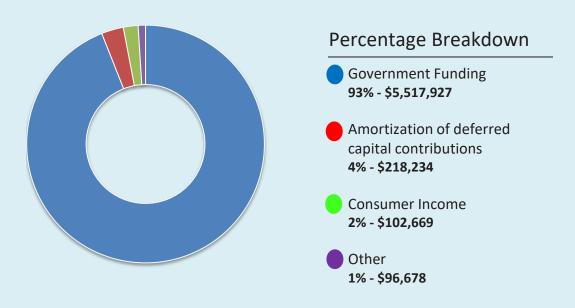
- Person- Centred and Community- Centred
- Service Excellence
- Teamwork
- Accountability
- Leadership
- Respect

### Overall Satisfaction with the Centre in 2018/19



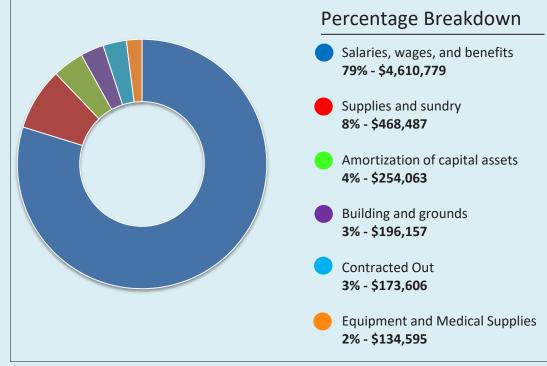
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#### Financial Operations For The Year Ended March 31, 2019



#### **Revenues (\$5.94 MILLION)**





For a complete set of financial records, please visit our website at wechc.on.ca

## Every One Matters.

# 2018-19



### Building Caring, Vibrant, Healthy Communities

West Elgin Community Health Centre 153 Main Street, West Lorne, Ontario NOL 2PO T 519-768-1715 F 519-768-2548

East Elgin Diabetes Education Program 424 Talbot Street West, Unit L5 Aylmer, Ontario N5H 1K9 T 519-765-4797 F 519-765-4977

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The West Elgin Community Health Centre wishes to thank its funders for their continued support: The South West Local Health Integration Network, and the United Way of Elgin Middlesex