JHSOK 1.N.1-2 Performance Analysis / Performance Improvement Report

The purpose of this document is to ensure JHSOK's continuous pursuit of excellence through improvement monitoring and analysis in anticipation of CARF- accreditation. JHSOK will share with persons served and other interested stakeholders information about our performance as a business entity and our ability to achieve meaningful outcomes for the people we serve through our programs.

Introduction

JHSOK is dedicated to a process of continuous improvements of our organization's business functions and programs based on the collection of information and data that are reliable, valid, and specifically linked to the indicators contained in this report. JHSOK seeks to address identified needs to:

- Improve JHSOK's business functions in the areas of Leadership, Human Resources, Health & Safety, and Financial Responsibility & Integrity.
- Improve the effectiveness of our Community Living Services Program in OCI, Homeshare, and Supported Living
- Improve access to feedback reporting from our persons served and stakeholders;
- Improve Service Delivery Efficiency for Persons Served
- Improve Program Experiences for Persons Served

This report is intended to satisfy the CARF requirements for an analysis of business and program performance; and the priorities and means for improving performance in Efficiency, Effectiveness, Access, Experience, and Business Functions

The mission statement developed in 2019 was deemed appropriate for the current employee climate and current population of persons served by the organization. Leadership developed a Culture Deck, Identity Statement, Persons Served Statement, and Strategy Screen in 2021/22. Strategic planning pertaining to Goal 3 in Programs was undertaken in August 2022 with the Senior Leadership Team. Strategic planning pertaining to Goal 4 and 5 (Assets and Fiscal Responsibility) was undertaken in Feb 2023 with the Board and Senior Leadership Team.

Completion of this report included the review of several performance indicators, with several being set for performance improvement in 22-23 and others set for performance improvement in 23-24.

The majority of JHSOK functions, operates on a fiscal year which begins April 1st and ends March 31st. JHSOK compiled, tracked, and analyzed data between **2020 to 2022** to inform our Performance Measurement and Improvement Plan priorities.

Performance Analysis– In Brief

JHSOK collects and analyzes data/information from multiple sources and ways to monitor performance; set Performance Improvement priorities; and direct strategic planning.

A/ We conducted the following unique data analysis, collections, and reviews:

1. Program & OHS:
   - Medication Administration Errors (OH&S)
   - Peer Employment Work Hours (Strategic Plan Goal 4)
   - Violence Risk Assessments & Review (WorkSafe BC) (OH&S)
   - Critical Incident Documentation and Follow Up (OH&S, Identified for Performance Improvement)
2. Human Resources:
   - TEE Completion Review (Strategic Plan Goal 2, Identified for Performance Improvement)
   - Personnel File Completion: CRC's, Driver's Abstracts (Strategic Plan Goal 2, Human Resources Plan, Identified for Performance Improvement)
   - OD Drills/HR Training reviewed (OH&S)
   - Personnel Policy to meet CARF standards (Strategic Plan Goal 1)
   - Acting Director Compensation Policy (Strategic Plan Goal 2, Human Resources Plan)
   - Turnover reports (Strategic Plan Goal 2, Human Resources Plan)
3. Financial:
   - Rent Collections Audit (Strategic Plan Goal 4, Identified for Performance Improvement)
   - Amortization/Capitalization Policy & Schedule Review (Strategic Plan Goal 4)
   - CSC Halfway House Program Financial Viability Review (Strategic Plan Goal 4 & 5)
   - Springfield House Financial Viability Review (Strategic Plan Goal 4& 5)
   - Food Program Budget (Strategic Plan Goal 4)
   - Labor Costs and Allocations Trends for Housing Department (Strategic Plan Goal 4)
   - CLS Service Level Off-set Reports (Strategic Plan Goal 3 and 4, Identified for Performance Improvement)

B/ We conducted the following routine (i.e. occurs regularly) data collection and reviews:

1. Financial:
   - Preparation of monthly financial statements; reviewed by board and senior team (Identified for Performance Improvement)
2. Organization health:
   - Annual SWOT (Risk Management)
   - Risk Assessment and Plan updates (Risk Management)
   - Technology assessments and plan updates (ensures organization benefits from information technology and possess the "hardware" necessary to support the accomplishment of the organization's mission)
   - Stakeholder Engagement Survey (Strategic Goal 1, Identified for Performance Improvement)

3. OH&S:
- Monthly meetings
- OH&S report reviews from internal and external health and safety inspections (Risk Management)
- Tests of emergency plans and procedures
- Incident reports (Identified as Performance Improvement activity)

4. Human Resources:
- Employee Engagement Surveys (Strategic Goal 2, some markers identified for Performance Improvement)

5. Programs:
- Satisfaction questionnaires completed by persons served (Identified for Performance Improvement)
- Informal feedback from clients and staff

C/ We monitor and receive information from External Sources:
- Field trends from various sources: BCNPHA, BCH, CLBC, JHS BC, CSSEA, etc., accreditations surveyors and other providers;
- City of Kelowna reports and Central Okanagan Journey Home Society Reports
- Feedback/results from regulatory/licensing visits and inspections
- Participation in community collaborations/meetings, e.g. Coalition for Impactful Shelters
- BC Bid Requests for Proposal Submissions

D/ Accessibility Barriers and Safety Barriers Addressed or Removed in 2021/22:
Wheelchair ramp installed Hearthstone
- Stephen Village a/c system – in progress
- Cornerstone – safety cameras, fobs, and vestibule installed
- CA – clients with wheelchairs re-located to Housing First buildings
- Internal Communication – implementation of WorkVivo (Identified for Performance Improvement)

E/ Prioritized Strategic Objectives – 2023-2026

Goal: 1. Achieve Accreditation
Objectives: 1.1 Develop policies and procedures to ensure CARF Accreditation is realized.

Goal: 2. Maintain a competent, knowledgeable, and engaged workforce to carry out our mission
Objectives: 2.1 Provide an aligned, fair and consistent employee recruitment, performance management, and compensation experience across JHSOK
2.2 Develop the capabilities of the JHSOK work force
2.3 Develop the competencies of the JHSOK Leadership team
2.4 Meet and exceed CARF/ASPIRE accreditation standards for Human Resources strategy and planning

Goal: 3. JHSOK has relevant, accessible services founded on a well-work approach
Objectives: 3.1 Ensure well-work principles are used to develop and assess programs
3.2 Develop Key Performance Indicator's (KPI's) to measure success
3.3 Develop data collection and systems analysis tools

Goal:	4. JHSOK is fiscally predictable and sustainable
Objectives:	4.1 JHSOK has a diverse funding portfolio
	4.2 JHSOK's financial practices are accountable transparent and ethical
	4.3 Stabilize Justice program funding beyond grant cycles
Goal:	5. JHSOK's assets are being utilized to their fullest potential to meet the organization's Vision, Mission, and Goals
Objectives:	5.1 Ensure Senior Management has clear direction on how to proceed with underutilized assets (liquidation or re-purposing)
	5.2 Develop a clear and concise plan for underutilized assets

Performance Analysis – In Detail

Priorities for Performance Improvement 22/23

A/ Priorities in Business Functions:

1. **Increased leadership accessibility; Increased confidence in leadership; Increased Employee engagement (**Leadership & Human Resources)

We saw this as an important priority after our first Employee Engagement Survey conducted in 2021 indicated that employee perspective on leadership's open communication, confidence in senior leadership scores were below 70%. By 2022 survey, the scores did increase from high 60's to high 70's. We set target goals to increase accountable leadership/accessible leadership scores to 85% and 90% by 2023 survey.

Accountable leadership is a core value in the JHSOK Culture Deck. Accountability begins with accessibility. Leaders cannot be accountable and communicate openly if employees perceive them as invisible. Our 2022 Employee Engagement Survey indicated to us that it was more so Senior Leadership rather than Management team where the perception of accessibility, openness, and accountability was more pronounced.

Key Activities to increase leadership confidence & communications started in fall 2021 and continue:

- Data results shared with senior leadership team with understanding that improving these scores is a critical priority for JHSOK;
- Introduced WorkVivo as agency wide communications tool;
- WorkVivo Ambassador;
- Themes to engage employees;
- Increase communications from ED via WorkVivo;
- Monthly Culture Deck presentations from ED;
- Directors/Managers rolled out Culture Deck to their employees 22/23;
- Eco-System Posters in every work site;
- Culture-Values statements on Employee ID tags;
- Upcoming: add more Well Work practice info on Workvivo; Identify Well Work champions

2. **Ready to Work Workforce** (Human Resources)

We saw this as an important priority after a period of exceptional growth in the organization coupled with COVID impacting turnover rates and labor shortages. A file audit in 2021indicated that only 32% of all employees had CRC's up to date on their files. By fall of 2022, this was increased to 60%. The CRC accuracy is an indicator of the completeness of onboarding documentation for employees including other things like Driver's Abstracts, and First Aid. It also indicates that employees were falling behind on training. Investment in Employee Development through training is a Core JHSOK Value. Due to high turnover and COVID stalling training, many employees have not received critical training. Therefore, a Ready to Work Workforce was set as an important Business Function – Human Resources improvement goal. We endeavor to see by fall 2023, 85% of employees have up to date CRC's on file and similar rates exist for Driver's License abstracts and CPR. Additionally, by end of 23/24 fiscal year 200 employees will be trained

via Moodle platform; and 100% of new employees use Moodle platform within 90 days of hire.

Activities started in fall 2021 and continued to meet targets:

- Moved to exclusive CRC online only policy / platform in fall 2022;
- Developed one-page info sheet on how to access online portal;
- P&B department continuing to clear backlog;
- Complex employee CRC files are now better understood by JHSOK and we have a liaison in CRC office;
- Late CRC's are being pushed back to employee with a cc to Leadership;
- Applied for capacity building funding to get Training & Development Coordinator to engage the work needed to get everyone trained and files up to date. If approved work will start May 2023

3. **Ensure workforce handles critical incidents appropriately. Ensure workforce/clients has safe environment**. (Risk Management)

A file audit for 20/21 and 21/22 fiscal years of Critical Incidents and appropriate follow up revealed that accurate reporting and follow up rates were well below 50% in housing services and unreported in justice services. Rates in CLS were above 80%. An audit for 22/23 fiscal year will be conducted in spring 2023.

Due to the vulnerability of our clients and the risk environment in which we work, having accurate reporting and follow up of critical incidents is essential to our organization. We must continue to improve the safety of our workplaces for employees and clients. With accurate reporting and follow up, we will be able to better spot trends/risks and/or competency gaps that can be addressed through training, hazard reduction, or improved communications.

However, these activities cannot occur without first accurate reliable reporting and follow up – that leads to analysis. Therefore, we set performance improvement goal of: *Critical incident reports are complete, include: manager follow up, leader response, notification, approval from leader, outcome recommendations; Critical Incidents are labelled correctly.*

Goals for accurate reporting and follow up for 22/23 fiscal: CLS = 90%; HF = 50%; RP = 50%; Shelter = 25%; Justice = 100%

Activities identified:

- Training workshop for leadership & front-line employees:
    - Identification of and reporting of Incident Reports via CAMS in full.
    - Education regarding definition of primary and secondary incident.
    - Identifying who reviews & approves the Incident Report - Manager.
- Ensuring follow-up that Incident Reports have been completed correctly and are being followed-up on as needed. Program Directors to add to their perpetual calendar (monthly).
- CLBC & CARF require other incidents not listed in our current Incident Report as an option: choking, poisoning, unexpected illness & medication errors, communicable disease, infection control, biohazardous accidents & disease/parasite. The category 'Medical Critical Incident' is a recommendation to be added to the CAMS Incident Report (primary and secondary incident).

- It has been observed that there is no option available to report aggressive behaviour (physical or verbal) in general, rather only 'aggression between individuals. We will rename "aggression between individual" to simply "aggression" and all forms of aggression will be recorded there.

4. **Monthly financial statements prepared for review by Board of Directors within two months of close of month** (Financial)

A well-run organization committed to performance improvement includes ensuring financial transparency and fiscal responsibility. To achieve this, JHSOK must ensure that we are on a Fiscally Predictable and Sustainable Path. Part of the work includes ensuring good fiscal governance and oversight that occurs in a timely manner. One of the indicators of this is: *Monthly financial statements prepared for review by Board of Directors are within two months of close of month.*

In fiscal year 20/21 this indicator was met only 67% of the time and in 21/22 it fell to 30%. A number of factors contributed to these scores: illness of Finance Director; COVID outbreaks; short staffed with other finance employees; building deficiencies; lack of financial processes in place to monitor grants.

We set a goal for 22/23 at 80%, recognizing that it is imperative that the board of directors and Executive Director and Senior Leadership team can know the financial status of the organization no later than two after financial activities have occurred.

Key Activities started to meet or exceed 80% performance indicator:

- Hired CPA consultant to help us with systems improvements/efficiencies
- Streamlined finance categories e.g. General Administration
- Set reminders and hard deadlines with Finance dept
- Closing "off" months in Sage
- Running draft statements
- Developing grant finance management process
- Educating and sharing financial statements with senior leadership team

B/ Priorities in Community Living Services Programs

1. **Assist persons served in identifying and achieving Quality of Life goals** (Program Effectiveness in OCI, Homeshare, Supported Living)

A critical role CLS plays in the community is assisting our persons served with meaningful inclusion and improving quality of life. This is the most meaningful work we can do as an organization. However, an analysis of goal setting and achievement for persons served in 20/21 and 21/22 indicated that improvements were needed in our programs pertaining to goals for improving quality of life. In 20/21 we saw only 15% of our clients set and realize goals in community activities, relationships, recreation (arts and leisure), and life skill. In 21/22, we improved marginally to 19%.

Therefore, performance improvement: Total # of goals achieved pertaining to community activities and relationships (inclusion), therapeutic recreations (arts and leisure) / Life-skill development was set at 25% for 22/23 and 35% for 23/24.
Key activities to meet our performance targets include:

- Monthly circulation of community resources will be shared with CLS - by Manager of OCI, Template already developed.
- First monthly circulation w/ commence Feb 1st and on-going.
- Shared a Curiko with CLS employees. This is a platform for people with disabilities to connect online with shared interests and skills.
- Nov. 22. Manager of OCI will follow up with team Feb 2023 on uptake on interest.
- Created a sync drive with local community activities. Shared info with CLS Team.
- QSL are now directly meeting w/ clients to take the lead on service planning and follow up (because this was not happening well by OCI's). This starting Feb 2023. Should improve likelihood of goals being set and it being documented.
- QSL's attend monthly meetings with Possibilities to address social isolation - to address individual-challenges on this type of goal setting. On-going since 2021.

2. **Client Program Feedback & Satisfaction Surveys are Accessible** (Improving access)

As part of JHSOK's continuous performance improvement is to ensure that we include the needs and views of persons served in future program design and directions. To include these needs/views, we have an annual Persons Served survey that asks key questions concerning program satisfaction, safety, and needs being met.

While the survey results are quite positive overall, an audit of the number of persons served taking the survey revealed that for the past three years participation rates of persons served were 51% (22/23), 27% (21/22), and 47% (20/21). Problems contributing to the low accessibility rates include:

- Lack of follow up from OCI's
- July is challenging month due to employee absences for vacation;
- Anonymity isn't provided as the client is assisted to do the survey with their worker that includes feedback about the worker

Therefore, an accurate understanding of program satisfaction and participant needs is not being captured. We set out a goal to see an improvement in the total number of persons served taking the annual survey so that a more robust and nuanced picture of program satisfaction could be realized, and this data would be used to make future program performance improvements. Our goal *Client Program Feedback & Satisfaction Surveys are Accessible*, is indicated by seeing 90% of our persons served participating in the survey in July 2023.

The performance improvement plan we have put in place to meet this target:

- Perpetual Planning Calendar
- Develop incentives to complete surveys (Include Me does this). $10 gift card to every persons served who completes some or all of the survey;
- Anonymize/protect client confidentiality - we will give the survey with an envelope that is sealable and client initials on the seal.
- Start sharing results with clients and all CLS employees and funder;
- Communicate expectations of survey participation and its importance in May and June to CLS Employees;
- Monitoring during survey collection month numbers of surveys completed each week;
- Assign this task as dedicated to one QSL or one OCI to focus on assisting/ promoting/ executing the survey;
- Last two weeks of June, OCI's instructed to start talking about the survey to persons served and about the importance of their participation and the incentive.

3. Improve Program Delivery Efficiency

Program Delivery Efficiency is an important part of performance improvement for CLS programs at JHSOK. With three key programs and over 100 clients, it is integral that CLS programs monitor efficiencies in our program service delivery outcomes. Efficiencies can reduce costs, reduce stress/demand on labor, and increase utilization of allocated resources. Goals in efficiency were set for all three programs:

3.a. Clients in OCI Program are receiving and using their allotted hours

Increase Participation in programs; hours allocated for client are achieved; Hours are met within a 5% variance each quarter as indicated by service level offset reports.
Analysis of service level off set reporting for past three years indicated that all hours weren't being taken up resulting in JHSOK having to pay back to the funder unspent dollars (i.e. unspent time for the person served). Service level offsets were: $43,000 in 20/21 and $30,000 in 21/22.

Reasons connected to this problem were:

- Backfill: who, what, when, where and why is not well understood by all that need to and therefore is not happening right time right place;
- Staff in place to fulfill backfill - sufficient staff to meet the need.

Repaying funds to the funder is time consuming for the administrative office and is an indicator that persons served are not getting all their allowed service hours.

Performance improvement goal has been set at $15,000 (approx. less than 1% of the total budget).

Key activities for the performance improvement plan are:

- Develop a better efficiency system that flags when a backfill is needed for certain clients. (Feb/Mar 23);
- Re-negotiate contracts with CLBC to have contracts aligned to end at March 31st. This will help align contracts. - CLS Director Feb/March 23;
- Monthly reports are generated for hours delivered (on-going). This is used to provide backfill. This is already being done but will now align with the contracts all being started and terminating at the fiscal year end.
- CLS creating a "global" staff position who can grab and deliver backfill hours (Feb 2023)

3.b. Clients in the Supported Living Program are connected to JHSOK internal resources

Maximize use of allotted CLBC funding for interdepartmental resources. CLBC provides $250/month for JHSOK internal resources to be offered to clients at Harvey and Hollywood. This can include resources such as: peermanship (community garden, yard work), safe meal prep training from food services, diabetes education from healthcare coordinator, and harm reduction training from harm reduction coordinator.

In our review, we noticed that these funds are currently not being utilized and there is no system in place to implement these services.

Performance Improvement planning indicates that fully utilizing these resources will improve efficiencies/costs for the program and give persons served access to meaningful program participation that can improve their quality of life. The new funding was implemented in 2022, and we have set a goal to utilize 100% of these funds for 22/23 and 23/24. To achieve this, key activities:

- Supported Living manager to develop survey to gather input from clients on what resources/skill development/work duties they would be interested in (February 2023)
- Supported Living manager to meet with JHSOK departments to determine action plan (March 2023)
- Supported Living manager to develop excel sheet to track service (March 2023)
- Supported Living QSL to develop monthly activity calendar for clients (March 2023)
- Program Director to complete evaluation and propose funding for all Supported Living models (March 2024)

3.c. Clients in Homeshare remain housed at 1 year

An effective and efficient program is one in which clients are placed into the right Homeshare with the right provider where both the client and provider are committed to its success. Efficiency in this case is measured by seeing a reduction in the % of Homeshare providers giving notice on contracts and clients not remaining in arrangement for at least a year. Lower notices means that up front work to place the right client with the right provider was done and we're getting more efficient in matching clients to providers. In 20/21 we had 10% of homeshare providers giving notice on their contracts, and in 21/22 this was 11%.

Reasons provided for homeshare notification included: challenging behaviors, and lack of critical incident reporting from homeshare providers.

Our goal: 0% of Homeshare providers give notice on their contracts in the first year of the client's placement. To achieve this performance standard, we will:

- Competency based training on positive behavioral support has been added to the Moodle system
- Critical incident reporting will be added to the Moodle system as part of health and safety training
- Provide training on this to ensure accurate documentation and timely follow up.

4. **Services Provided to Clients are Valued** (Program Service Experience)
CLS programs are committed to providing services to persons served that are valuable and in touch with community needs. As such, asking stakeholders, employees and persons served about their perception of the services value is a critical activity in performance measuring and improvement.

Our indicators: *Stakeholders report satisfaction with services offered; Employees report their work makes a difference; Persons Served report Satisfaction with services*.

For employees working in the program, we ask:
JHSOK Offers opportunities for me to use my skills and training = 85%;
My work at JHSOK Makes a difference = 85%;
I see how my work contributes to positive outcomes for our clients = 85%

We see a need to improve scores to 85% from 80% range and recognize that not employees in CLS are receiving Well Work foundational training within 3 months of commencing employment.

Key activities related to performance improvement:
1. Management will share client satisfaction survey results annually (September)
2. Management will share results of goals achieved annually (March)
3. Well work will be implemented on Moodle system to allow for improved tracking of completion

For Stakeholders, we ask:
I am satisfied with the services offered by JHSOK = 85%;
JHSOK offers innovative solutions for person with complex needs or situations = 85%

Previous year data show 71% and 80% scores on these questions respectively. However, we do not have a stakeholder survey specific to CLS stakeholders and there was a lack of meaningful data obtained from the agency wide stakeholder survey.

Key activities for 22/23: Create stakeholder survey specific to CLS services to obtain data on program service experience and to create improvement plan.

For Persons Served, we ask:
Overall, I am satisfied with CLS Services = 95%

Current data shows good performance in this question area posed to Persons Served. However, low response rates to the survey suggests that the 95% satisfaction rate is unreliable. Better program planning can only occur if we have more participants in the survey.

We have set a goal to maintain a 95% satisfaction rate while bringing up participation rates to 90%.

See improvement plan for survey accessibility measure.

We conducted the following unique data analysis, collections, and reviews:

A/ Program & OHS

1. Medication Administration Errors

A review of Medication Administration in early 2022, indicated high error rates pertaining to documentation of med administration. There were not high med administration errors i.e. persons served being given the wrong, too much, or insufficient medication, however there were high rates of errors in documenting the provision of medications.

The documentation errors were attributed to:

- Poor capacity with front line employees in understanding the importance of accurate documentation;
- Too many competing demands/priorities on front line staff;
- High turnover rates with front line staff;
- Not enough supervision (or ability to do so) of Health Coordinator and Management

JHSOK was concerned about our ability invest the on-going needed resources (training & staffing) to improve medication administration documentation. As such, we decided to cease all medication administration in the agency by front line employees. Medication administration is only done within the health care worker team and is guided/overseen by the Health Care Manager.

2. Peer Employment Work Hours

A monitoring of peer employment work hours started in the fall of 2022, one year after the launch of the program. The review was taken because:

- Peers were being paid in cash, and this was presenting a risk to the agency and the employee charged with handling large amounts of cash;
- Cost overruns in the labour at the Cornerstone Shelter prompted concern that Peers were being employed too often and when there was no urgentstaffing shortage.
- Compensation rationale (Living Wage) wasn't well understood in the context of workers living at program sites.

Analysis showed that Peers were being worked too often and being regularly scheduled rather than pitching in when its busy. Pay rationale for the Peer program had not been well rationalized.

Resulting from our review, we made the following changes:

- Moved Peer worker hours to maximum 6 hours per week; implemented policy that more peers be given opportunity to work
- Reduced Peer custodial hours from 49 to 29 as per BCH funding and to prepare for new year where all COVID funding will end
- Suspended the program at CS completely for Feb and March to reduce wage line deficit

- Implemented a minimum wage policy because all peers have steeply discounted subsidized rent and are provided two meals free of charge per day.
- The Peer Program is under complete review for Feb/March 2023, with a slow re-introduction planned for April. While under review, the program will be developed more fully with clear outcome indicators, funding, and scalability attached to it.

3. Violence Risk Assessments & Review (WorkSafe BC) (OH&S)
WorkSafe BC conducted random Violence Risk Assessments & Reviews at all our housing properties. Our properties were deemed to be following applicable standards. See reports.

4. Critical Incident Documentation and Follow Up (OH&S, Identified for Performance Improvement). See Performance Improvement Plans discussed above.

B/ Human Resources

1. Personnel (and other) Policies to meet CARF standards (Strategic Plan Goal 1): we reviewed the Personnel Policy in 2021 to ensure that it was meeting CARF standards. In 2022, we used the CARF Evidence Standards questions to review the personnel policy again to ensure that we had all required CARF policy standards. Some items were identified in summer/fall of 2022 and the Personnel Policy, Finance Policy, OH&S Policy, and/or CLS Program Policy manuals were updated.

2. TEE Completion Review (Strategic Plan Goal 2, Identified for Performance Improvement): in spring 2022 we introduced a new tool Total Employee Engagement. The tool is designed for one-to-one conversations between leadership and their employees. The goal is to improve employee engagement and leadership accessibility to front line employees.

In January 2023, nine months after introducing the tool, we conducted an analysis of number of qualified employees who have had the TEE with their manager/leader. Completion rates were at 42% when they should have been at approx. 75%. TEE Completion Review has been identified for performance improvement in 23/24 fiscal year, with another review planned for January 2024.

3. Acting Director Compensation Policy (Strategic Plan Goal 2, Human Resources Plan): Our Human Resources Plan and Culture Deck identified opportunities for promotion and acting assignments would be made available to JHSOK employees, including Acting Director Assignment opportunities. We did not have a compensation policy for Acting Director compensation. We developed a policy.

4. Turnover reports (Strategic Plan Goal 2, Human Resources Plan): Turnover reports were produced in 2021 and 2022. We saw marked improvement in turnover rates between 2021 and 2022. We attribute this improvement to several new Human Resource policies and strategies we implemented starting in fall of 2020 (see Human Resources Plan). As such, we did not identify Turnover Rates in our Performance Improvement plan for 22/23.

5. Personnel File Completion: CRC's, Driver's Abstracts (Strategic Plan Goal 2, Human Resources Plan). Personnel File completion and training has been identified for Performance Improvement and is discussed above.

6. OD Drills/HR Training reviewed (OH&S): in 2021/22 we reviewed Overdose Training completion rates. Our review revealed that some departments were not conducting OD Drills and/or getting their employees to Harm Reduction Training. We brought the data to the senior team and flagged the issue for departments with low rates. We implemented a plan where the Harm Reduction Coordinator would train key personnel in the CLS department so that they could be Trainers for their own departmental employees.

C/ **Financial**

1. Rent Collections Audit (Strategic Plan Goal 4, Identified for Performance Improvement)
We conducted a two-year review (20/21 and 21/22) in rent collection arrears; the review indicated that we had a problem with reliable and consistent rental collections in our residential and housing first properties. We have identified the need to conduct a rental collection review for 22/23 and this is scheduled for April. As a result of the rental arrears problem, we have implemented the following key activities:

- Set this into our performance improvement plan for 23/24
- Working with the finance office to develop an oversight and accountability policy
- Tenants identified as in arrears between 20 -22, have been placed on aggressive repayment programs; some tenants vacated instead
- SDHS worked with the Ministry of Social Development to arrange for some rental arrears to be repaid.

2. Amortization/Capitalization Policy & Schedule Review (Strategic Plan Goal 4)
Amortization and capitalization were arbitrarily set by the independent auditing firm and there was no policy in place at JHSOK as to how amortization and capitalization should be calculated. The CPA consultant drafted a policy based on industry best practices and this was adopted by the board of directors in Feb 2023. Next steps will be a review of the amortization schedule to adjust it to the policy.

3. CSC Halfway House Program Financial Viability Review (Strategic Plan Goal 4 & 5)
The CSC Halfway House program funding agreement had not been assessed against the actual costs to operate the program in several years. The financial viability of the program was reviewed in summer of 2022. We discovered that the daily per diem rate was too low to cover fixed costs of running the program. Additionally, the funder was not being charged rent for the use of the space and therefore there was no accumulation of surplus funds to help off set repairs to the building. The men living in the building who were not attached to CSC beds were also underpaying rent at a $375/month, which is far below market value and the costs of housing them at this property. We undertook the following activities:

- Developed an actual cost to run program budget based on fixed costs, labor costs, and occupancy rates
- Petitioned to the CSC funder that a substantial increase was required for the 23/24 fiscal year for this program if they wanted to continue the partnership; this was met with a commitment to raise the per diem rate effective April 1, 2023.
- Raised the rent of the other men living in the building to $650 per month effective Jan 1, 2023
- A modification to the 22/23 agreement was made so that empty beds could be filled with temporary transitional clients

4. Springfield House Financial Viability Review (Strategic Plan Goal 4& 5)
Like 1033 above, the Springfield "Good Neighbor" House had not had a proper cost/value assessment done. An assessment was conducted in spring 2022 and we determined that the good neighbor house project was problematic in a number of ways: rent paid by the upstairs neighbors was so far below market rental that it wasn't covering costs of running the house; the upstairs neighbors were paying less monthly rent than the vulnerable client that JHSOK was mandated to support who is living in poverty; no surplus was being generated against the property to offset repairs (short and long term); the good neighbors were mostly frustrated with the vulnerable client and did not actually do much to support her. As a result, we will be undertaking the following:

- The upstairs neighbors will be moving out at the end of May
- The upstairs will be converted to a Supported Living with CLBC as funder
- Funding model will be like 1043 and will include wear and tear costs against the asset

5. Food Program Budget (Strategic Plan Goal 4)
In spring of 2022, we undertook a review of the allocated budget for food provided by BCH for shelter, and the three housing first buildings. The review indicated that there were inconsistent budgets across all four properties with shelter receiving the value of a approx. $2 per person per meal while Stephen Village received a value of a $4 per person per meal. Additionally, the rising food costs since COVID was making it difficult to be able to meet our contractual obligations to feed guests. Finally, packaging and delivery costs were rising, and this was cutting into the food budget for Shelter.

As a result, these are the key activities:

- We conducted a costing analysis and determined the amount of budget needed to reasonably meet our contractual obligations.
- We met with BCH and provided them with our cost analysis and where the pressures were, and advocated for a budget increase
- In October, BCH was able to raise the budget to approx. $8.50 per day per person across all sites, and this was applied retroactively to April 2022.
- BCH communicated an intention to further increase the budget to $10.00 per day per person by 23/24 fiscal year.

6. Labor Costs and Allocations Trends for Housing Department (Strategic Plan Goal 4)
We undertook a review of the labor wage rates and total number of labor hours allocated through BCH across our housing programs; a market scan of wages in BC; rising cost of living rates; and how much other service providers in our sector pay for similar work. We used this in our budget submission to BCH to demonstrate that: 1. wage rate increases to our management and senior team line were needed as they had not increased in 4 years; 2. we needed a higher overnight shift premium ; 3. wage equity across the sector was needed; and 4. JHSOK was doing our part by consolidating positions and reducing hours. We are awaiting our new BCH budget and anticipate that wage rates will be improved.

7. CLS Service Level Off-set Reports (Strategic Plan Goal 3 and 4). This has been identified for Performance Improvement and is discussed above.

We conducted the following routine (i.e. occurs regularly) data collection and reviews:

A/ Financial

Preparation of monthly financial statements; reviewed by board and senior team: we identified this for Performance Improvement in 22/23 and is discussed above.

B/ Organization Health

1. SWOT (Risk Management): we developed a SWOT in 2021 and refreshed it in early 2023.
2. Risk Assessment and Plan updates (Risk Management)
3. Technology assessments and plan updates (ensures organization benefits from information technology and possess the "hardware" necessary to support the accomplishment of the organization's mission)
4. Stakeholder Engagement Survey (Strategic Goal 1). We have identified for Performance Improvement in our CLS Program the need to get a greater number of stakeholders participating in our Stakeholder Survey so that we can get a better picture of how our stakeholders perceive our program value.

C/ OH&S

1. Monthly meetings
2. OH&S report reviews from internal and external health and safety inspections (Risk Management)
3. Tests of emergency plans and procedures
4. Incident reports (Identified as Performance Improvement activity)

D/ Human Resources:

Employee Engagement Surveys (Strategic Goal 2): we identified some markers identified for Performance Improvement discussed above.

E/ Programs:

Satisfaction questionnaires completed by persons served: identified for Performance Improvement discussed above

We monitored and received information from External Sources:

A/ Field trends from various sources: BCNPHA, BCH, CLBC, JHS BC, CSSEA, etc., accreditations surveyors and other providers; City of Kelowna reports and Central Okanagan Journey Home Society Reports

B/ Feedback/results from regulatory/licensing visits and inspections

C/ Participation in community collaborations/meetings, e.g. Coalition for Impactful Shelters

D/ BC Bid Requests for Proposal Submissions

Strategic Objectives Prioritized for Fiscal Year 22/23 Board/Senior Team

Goal: 4. JHSOK is fiscally predictable and sustainable
Objectives: 4.1 JHSOK has a diverse funding portfolio
4.2 JHSOK's financial practices are accountable transparent and ethical
4.3 Stabilize Justice program funding beyond grant cycles

Goal: 5. JHSOK's assets are being utilized to their fullest potential to meet the organization's Vision, Mission, and Goals
Objectives: 5.1 Ensure Senior Management has clear direction on how to proceed with underutilized assets (liquidation or re-purposing)
5.2 Develop a clear and concise plan for underutilized assets

The senior team and board of directors set aside our strategic planning day for 22/23 fiscal year to specifically focus on Goal 4 and 5. This was prioritized because:

- Our asset properties at Harvey and Gordon are getting older and we do not have replacement reserves set up
- The assets are getting more difficult to find appropriate programming as they are only suitable for sober communal living and they are not disability accessible
- The costs of maintaining the assets exceeds the revenues coming into the site
- JHSOK does not have a reliable funding source that is not tied to specific funder priorities

Resulting from our strategic planning meeting, we agreed on key plans for the Harvey properties as well as our Peermanship and Training programs for the next 3 to 5 years. See Strategic Plan summary report.

Specific to Community Living Services

We have made a commitment to improving program quality by:

- Defining managers roles-both by programs and geographic regions- Giving all staff clarity about who is their direct supervisor, and managers clarity about what they are responsible for.
- Providing group supervision for all CLS staff- Staff are placed in cohorts and meet monthly to work thru challenging issues that one or more may be facing.
- Providing liaison supports for Person Served involved with Community Court.
- Ensuring policies, procedures, plans, forms and other documents are consistent with CARF's standards for Community Housing, Community Integration, and Host Family/Shared Living
- Increasing our ability to bring more Homeshares into the program and ensuring that they are a good fit by hiring a dedicated Homeshare Coordinator who supports the homeshare reviews and coordinates the program
- Updating CAMS reporting tabs so that we are able to report/monitor key deliverables identified through CARF
- Providing more supports to our Quality Service Leads including greater access to PossAbilities Behavioral Specialists
- Sunsetting risky program practice for which we were under resourced - money trustee handling for clients
- Proving positive training support to frontline staff offered thru PossAbilites Support specialists

Risk Management

JHSOK is committed to long range planning to ensure service continuity and to a formal periodic risk management process as a part of the strategic planning process. See Risk Management Review / Matrix.

Areas assessed:

1. Identify any loss exposures,
2. Analyze and evaluate loss exposures,
3. Identify a strategy to rectify identified exposures,
4. Implementation of actions taken to reduce risks,
5. Monitoring of actions taken to reduce risks,
6. Report results of actions taken to reduce risk,
7. Implement any necessary changes as may be dictated by a changing service and/or business environmental to ensure the inclusion of risk reduction in all quality/performance improvement activities.

The Executive Director and Senior Team are responsible for an annual risk management assessment and compiling the findings for inclusion in the organization's strategic planning and daily operations. The formal Annual Risk Management Assessment for 2022 was conducted in accordance with the JHSOK policy on risk management and CARF's accreditation standard.

The senior leadership team recognizes that there is a changing demographic with our clients: more complex, more challenging behaviors, higher risk of OD death. In response, we have implemented:

- CRACK program
- OD Drills
- made permanent the Harm Reduction Coordinator role
- drug checking program
- Drug User Focus Group.

Leadership team has engaged in the following advocacy to serve our changing demographic, which includes the following:

- The ED sits on external committees and ad hoc externally organized meetings related to services and needs of complex populations. Advocacy with Interior Health Authority has led to the IH's commitment to working with Shelter Operators in being able to address the health and mental health challenges of clients in shelter and supported housing.
- Our housing leadership team has been working closely with IH to secure funding and/or better practice regarding home care for our ageing population in Supportive Housing. We have observed the need for increased health care supports in our housing programs due to substance use, however a lack of support from IH staff to attend due to the perceived nature of risk, i.e. sharps. We have created a hospital ward discharge form that is streamlined for all shelter use and a coordinated team that meets daily to discuss potential discharges and best fit & care.
- Our CLS leadership team has been working closely with IH to create an ACT team specific to CLBC clients as it is recognized that the complex nature of these individuals are in need of a specialized team.

JHSOK remains committed to working to meet our client needs. However, our philosophy of Well Work and self-determination, and the imperative for safe workplaces/program spaces means that some clients are not suitable for services and we will exit from the program clients who can or will not work with us to keep them, our staff and other clients safe.

Risk assessment in staffing ratios has been reviewed. With recent staffing shortages, we had several supported housing buildings operating on lone worker. There were no significant incidences related to the lone worker situation. This indicates to us that ensuring that we never have lone worker is not a high priority. JHSOK has cameras, visitor logs, and access to security personnel at short notice. These are all in place to mitigate risk. The Shelter underwent a significant security system upgrade in 2022 to ensure clients and staff are safer including a two-entry safe vestibule system.

Health and Safety CARF standards

JHSOK has ensured that we are implementing CARF requirements in written emergency procedures and drills. This is done monthly. This will address procedures for:

1. Fires
2. Bomb Threats
3. Natural Disasters
4. Utility Failures
5. Medical Emergencies
6. Violent or other Threatening Situations

The drills schedule were implemented October 2022. Prior to the implementation, we held a OH&S Olympics to train personnel on safety risks. We are bringing on a Moodle training platform to get employees trained in the OH&S procedures and quizzes.

Technology

The Technology and Information Systems Plan was developed in response to the CARF accreditation standard that requires accredited organizations to formally document their plans regarding technology and information systems. There have been no changes in the past year. JHSOK uses SFY to support our IT needs and to monitor tech related risks.

Outcome Management

JHSOK uses CAMS to monitor case management for clients. The CAMS system continues to be the right tool for supporting our outcomes management needs. We have identified that more individual case planning needs to occur and this is being incorporated into client planning in 22/23 and onwards. We also need to develop high level Program Outcomes and this is identified as a Strategic Priority for 23/24 fiscal year. Other outcome management points are discussed above in the Performance Improvement identified markers in Efficiency, Effectiveness, Experience, and Access.

Accompanying Document: Performance Management Plan (M1)
Copies of this report are distributed to members of the organization's leadership and made available to clients and employees.