Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

3/26/2014

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a quality improvement plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to HQO (if required) in the format described herein.

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Overview

CAMH is an academic health science center dedicated to transforming the lives of people living with mental illness. Our purpose statement is "At CAMH, we Care, Discover, Learn, and Build to Transform Lives". The values that guide the organization are Respect, Courage and Excellence. In 2012, CAMH developed a strategic plan with six directions:

- Enhance recovery by improving access to integrated care and social support;
- Earn a reputation for outstanding service, accountability and professional leadership;
- Build an environment that supports healing and recovery;
- Ignite discovery and innovation;
- Revolutionize education and knowledge exchange and
- Drive social change.

Our focus has been on supporting transformative change while building staff capacity and capability in best practices. In 2014-15 we will continue with several major initiatives, including:

- "Go live" of our new Clinical Information System – we have been engaged in design and development of an electronic health record and will go live in May 2014.The design and development phase required extensive process and workflow review.
- Final year of a three year Best Practice Spotlight Organization (BPSO) initiative that involves implementation of 8 best practices – the BPSO is a designation awarded to organizations for the work of their clinicians in raising awareness of Best Practice Guidelines (BPGs) and enhancing patient care and outcomes through BPG implementation.
- Evolution of our clinical program structure to enhance access and transitions across the organization and across the sector - this includes a re-examination of where and how services are delivered. It is leading to development of new care approaches such as our Partial Hospital Program (PHP) and realignment of outpatient services.
- Refinement of our risk management, patient safety, and quality of care structures and processes – in 2014 we will launch the CAMH Clinical Quality Framework, a tool for promoting a collective understanding of clinical quality. This framework describes dimensions of quality within a matrix that has been customized in alignment with our CAMH Strategic Plan and provides a structure to plan, organize, and integrate quality improvement activities.
- Building system competency through partnerships with community agencies, housing providers, Healthlinks, LHINs, and the Ministries of Health and Long Term Care, Community and Social Services, Child and Youth Services, and Community Safety and Correctional Services.

Our priority quality improvement activities have been in the safety domain over the past two years. In 2014-2015, the priority has shifted to Access and Integration. This reflects the focus of our organizational initiatives. The QIP is aligned with Hospital Service Accountability Agreement commitments and our own Balanced Scorecard. CAMH was accredited with Exemplary Standing by Accreditation Canada in January 2012 and we will be preparing for a site visit in June 2015.

Integration & Continuity of Care

Integration is a priority for CAMH both internally and externally. Effectiveness and efficiency of care is challenged by an insufficient supply of health and social services for our patients, both pre- and post-hospitalization. A lack of appropriate discharge destinations creates challenges with long stay patients, most of whom require supportive housing. For the past three years CAMH has focused on creating system capacity and competency through advocacy and partnerships with supportive housing agencies, including an innovative housing partnership linking CAMH, Lansdowne Property Management (LPM), Madison Community Services and the City of Toronto. Through this partnership, we were able to provide safe and supported transitions for 20 long-stay CAMH patients to independent bachelor apartments. In fact, partnerships such as this demonstrate how we continue to work to improve community integration by acknowledging the unique needs of our patients and providing the supports necessary for successful transitions from hospital. In an expansion of these efforts, we are focusing on developing a new partnership involving Pilot Place Society, Reconnect Mental Health Services and CAMH.

We are working to reduce the average Length of Stay for patients discharged between 4 and 90 days. We are documenting increasing acuity, complexity and co-morbidity in our patient population with associated challenges for discharge. Our integration objectives are focused on reducing unnecessary hospital days.

Another exciting initiative at CAMH is the development and implementation of Integrated Care Pathways (ICP). This began as a pilot in 2013 and is now spreading across the organization. ICPs are an evidence-based approach to inter-professional care that we hope will pave the way for development of quality-based procedures (QBPs) in the mental health sector. By standardizing care, we aim to increase coordination, reduce variation and achieve better outcomes. The inter-professional nature of ICPs supports teamwork and our experience to date has been highly positive.

Challenges, Risks & Mitigation Strategies

Our transformation agenda requires a focus on designing future care environments and processes. The organization is undergoing intense change. We are working to support and develop staff through the experience of this change. Multiple leadership and organizational development activities are in play. Initiatives include town halls and Quality Improvement Executive Leadership Walkarounds to all parts of the organization, investments in inspirational leadership programs, and implementation of manager development activities. We anticipate major organizational stress during the Clinical Information System (CIS) implementation beginning in Q1 and continuing through Q2.

A high-risk initiative in 2014 is our commitment to become a "tobacco-free" facility. This will have an impact on our patients, staff, and visitors. Challenges for the upcoming year are being mitigated through extensive planning and preparation, including broad stakeholder engagement and formal project management.

We will continue to focus on data integrity and management and ongoing partnerships with peer mental health hospitals to further work on shared measures and collective reporting on results; and where possible, we will aim to establish internal measures by reviewing several cycles of our own data. In June 2014, we will launch an enterprise-reporting initiative aimed at integrating people, processes and technology to facilitate integrated, analytic reporting across the organization. This is a multi-phased initiative that includes an enterprise reporting portal and data warehouse. Continued work with Enterprise Risk Management will help to identify and develop templates and plans for our clinical risks.

In addition, ongoing tracking, monitoring, and analysis will identify the impact of key changes on improvement outcomes; for example, the impact of tobacco-free implementation on involuntary missing clients, with a focus on adding strategies and/or modifying activities to achieve desired outcomes.

Our facilities continue to be a challenge. While we build new care spaces, the reality for many of our care areas is an aging facility that challenges best care. We are vigilant regarding these issues and are utilizing technological solutions to support our care teams where possible. Continuing challenges in our sector include: the lack of valid and reliable indicators; the lack of appropriate baseline or benchmark data; data management issues and increasing acuity and complexity of patients in our care. These are being addressed through increased emphasis on data management internally through the Enterprise Data Management initiative and through external partnerships such as the Ontario Mental Health and Addictions Quality Initiative which brings together sector partners to address these challenges collectively.

Information Management Systems

Information Management Systems is a key component of our transformational agenda. Working with Cerner Canada and others, we are implementing a new Clinical Information System (CIS) in the spring of 2014. The CIS will replicate the best elements of our existing flow of care and consolidate, streamline and standardize our clinical information systems and tools. The new CIS is, however, much more than a software investment – it is part of a widespread realignment and evolution of our clinical practices as envisioned in CAMH's Strategic Plan. Through its enhanced information management capabilities, CIS will help us improve the quality and safety of the care we provide by further supporting patient recovery through care mapping, safety alerting and incorporating best practice tools. The new system will improve the quality of our information and create new opportunities for collaboration among CAMH staff, programs, and the community.

Engagement of Clinical Staff & Broader Leadership

We have utilized various methods to engage clinical staff and leadership in establishing shared quality improvement goals for the organization. These include: Quality Improvement Leadership Walkarounds led by the Executive Leadership Team (ELT); a CEO Blog on our internal website; E-leader communications; initiative-related articles and updates on our website; quarterly meetings of the Senior Management and Directors group; and a Managers' Forum. We have also established Quality Councils within each major clinical program that report to the Clinical Leadership Teams. The program Quality Councils provide the structures to identify, address, bridge and align local (unit and program) and corporate quality needs and to inform and advance respective quality agendas. There was extensive clinician engagement in the development of the CAMH Clinical Quality Framework that communicates the quality structure and priorities.

Accountability Management

In addition to executive leaders' compensation being tied to achievement of targets, organizational leadership will be held accountable for achieving QIP targets by designating an executive leader for each target. The Executive Leadership as a team will review target performance and change activities quarterly - making refinements to activities as needed. The specific relationship between attainment of the QIP targets and compensation are shown below.

Quality Dimension	Priority	Objective	Weighting	CEO Compensation	ELT Compensation
Safety	Maintain	Improve medication safety	20%	1.25	0.75
	Maintain	Reduce use of physical restraints			
	Improve	Reduce involuntary missing clients			
Effectiveness	Maintain	Improve organizational financial health	20%	1.25	0.75
Access	Improve	Reduce unnecessary time in hospital (Avg. LOS 4-90 days)	20%	1.25	0.75
Patient Centered	Improve	Improve patient satisfaction	20%	1.25	0.75
Integration	Improve	# of non-forensic long stay clients	20%	1.25	0.75
	Improve	# of clients on ICP			
Total 'at risk' pay related to QIP				6.25	3.75
Total 'at risk' pay not related to QIP				18.75	11.25
Total 'at risk' pay				25.00	15.00

Health System Funding Reform

Health System Funding Reform (HSFR) involves evidenced-based allocations to targeted groups though the Health Based Allocation Model (HBAM) and the use of Quality Based Procedures (QBPs). No QBPs are being developed for the field of mental health. Exclusion from HSFR initiatives is disadvantageous to our organization. We have no mechanism to access funding through volume increases or delivery of high quality care. We are undertaking a number of steps in preparation for HSFR and have embraced the challenge to apply the best clinical evidence in the delivery and evaluation of quality care in our sector. Specifically, we have initiatives focusing on workload measurement, the Clinical Information System, and enterprise reporting. As part of our clinical transformation, we are developing, implementing and evaluating Integrated Care Pathways (IPC) that will also be integrated in our CIS. These IPCs are evidence-based procedures for inter-professional mental health care that could be transformed into QBPs and demonstrate our commitment to the principles and philosophy of standardization of evidenced-based care.

Accountability Sign-Off

I have reviewed and approved our organization's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act.*

Bud Purves
Board Chair

Pam Jolliffe
Clinical Quality Committee Chair

Dr. Catherine Zahn
Chief Executive Officer

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Quality Improvement Plan 2014-2015 Work plan

AIM	MEASURE							CHANGE				
Objective	Indicator	Unit/ Population	Source/ Period	Current Performance	Target Performance	Target Justification	Priority Level	Planned Improvement Initiatives	Methods	Process Measures	Goal for Change Ideas	Comments
SAFETY												
Improve Medication Safety	% clients with completed med reconciliation at admission:	% / Min sample of 100 patient records	Manual chart audits done via Pharmacy Department Q4 12/13 and Q1 and Q2 14/15. We hope to switch to CIS report for Q2 and Q3.	98%	**98%**	Sustain performance while undergoing changes in technological platform and processes. Switching from manual audits on a sample to system generated report on 100% of patients	**Maintain**	1.Improve tracking mechanism for medication reconciliation 2.Ensure all clinical staff (interprofessional team) understand their roles and responsibilities throughout the process including documentation of the best possible medication history (BPMH) in the Cerner system	Implement the new clinical information system (CIS)	Sign off on process map by interprofessional leadership Develop and implement education on new system by May 29th	Workflow processes to be finalized by April 15 Testing of desired workflow to be complete by May 15	We expect significant change with the implementation of new technology solution. The new tracking mechanism has the potential to change our denominator from a sample to 100% of admissions
Reduce Use of Physical Restraints	The number of patients who are physically restrained at least once in the 3 days prior to admission assessment divided by all cases with a full admission assessment.	%/All patients	OMHRS, CIHI, Q4 2012/13 to Q3 2014/15	2.9%	**2.9%**	Continue to be a leader in this area with restraint use below the provincial average. Further reductions in target are difficult to achieve in our current environment. We are also committed to enhancing system capacity by decreasing length of stay – thus expect to have	**Maintain**	Re-evaluate current restraint practices to identify opportunities for further education and process improvement	Review current practices re: restraint use under 6 core strategies used for initial initiative Revise weekly restraint debriefing form and process Reinforce	Stakeholder feedback completed Revised form and process piloted April /May 2014 Development and implementation of Interdisciplinary plan of care (IPOC)in new CIS	Review complete- April 30,2014 Recommendations endorsed by Executive team – May 2014	We made significant gains in reducing restraint use through a focused initiative and plan to evaluate the sustainability mechanisms in a context of increasing acuity and complexity. Learning from post incident and weekly debriefing are critical to enhancing care. Our plans to extend "smoke free" objective to "tobacco free" poses

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						patients with greater acuity and complexity s			education: promoting safety and comfort, de-escalation as prevention and alternative strategies.	–June 2014		significant risk that will be mitigated by increased education, communication, leadership oversight and monitoring
Improve patient safety	Reducing Involuntary Missing Clients	# of Events/na (Count of missing involuntary client events)	From electronic incident reporting system # of missing involuntary clients events. Q4-2013/14 - Q3 2014/15	80 Q3 YTD	**76**	While there are no benchmarks for this indicator, absconding has been identified as a key safety challenge for our sector. We are aiming for a 5% improvement	**Improve**	Incident reviews to identify additional contributory factors Change in process for contractors and visitors coming on the unit Enhanced leadership oversight that extends to off hours (evenings, nights, weekends, holidays)	Incident review by unit manager and risk management Process mapping Staff education Regular communicatio n with afterhours managers	Identification of contributory factors (positive and negative) Development /revision of guidelines and processes Quarterly check in at manager meetings	Plan for optimizing and mitigating contributory factors New processes adopted by contractors and visitors Consistency in oversight and follow up	Finding an appropriate balance between supporting rehabilitation via passes and restricting movement and freedom is challenging. We are committed to both understanding the impact of missing patient events on patient safety and reducing such events

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EFFECTIVENESS												
Improve organizational financial health	Total Margin: Percent, by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year.	%/n/a	OHMRS/Q3	1.00	0	Hospital Services Accountability Agreement requirement Leading practice	**Maintain**	Implement attendance support program Reduce overtime Quarterly review of performance by executive leadership	Continued communicatio n attendance management policy Manager education on staffing and scheduling Scheduled agenda item for Executive and senior leaders	Monthly reporting of sick time and overtime to program leadership Quarterly reporting to Executive and board	100% reporting Action plans for individuals with high sick time Adjustments to staff complements to increase flexibility Early implementation of mitigation strategies as needed	

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ACCESS												
Reduce unnecessary time in hospital	Average Length of Stay (LOS) for clients discharged within 4-90 days	% /discharged clients	ADT / Q42013-14 –Q3 2014 - 15	Q3 YTD - 25.9	**25.4**	There are no established benchmarks. We decreased average LOS for this population by 1 day /year for past 2 years. This year we will aim for a further decrease of 0.5 days.	**Improve**	Early and consistent focus on discharge planning	Continued implementation of discharge policy and LOCUS tool Collaboration with community partners	Develop process for monitoring discharge plans on all clients	Timely discharges and enhanced patient flow	We continue to experience increased complexity and comorbidity in the population and continued challenges with respect to discharge destinations. Even modest change in average LOS have significant impact on access to care
PATIENT CENTERED												
Improve patient satisfaction	% of positive responses to client experience survey question "overall how would you rate care and services you receive at the hospital"	% /all inpatients completing the survey	Annual In house survey	65.2 %	**66%**	This is an area we wish to improve. WE have selected this improvement target as we need to better understand the factors that influence overall satisfaction. Our change strategies are focusing on further analysis and modelling with potential for piloting quality improvement	**Improve**	Further data analysis to identify areas for targeted improvement Increase data reliability Improvement in response time to client complaints submitted via client relations office. Work with stakeholders, including, the CAMH Client Empowerment council.	Undertake qualitative analysis and modeling Explore opportunities for formal validation of tool Review current data and processes to better understand the complaint categories and	Program specific reports and areas of improvement Establish work group Develop project plan	Program based action plans developed and implemented by program quality councils Project plan developed and implementation started by October 2014	It is difficult to identify and address factors that contribute to overall performance Robust client relations process is consistent with ECFAA intent and expectations.

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						activities to asses impact.			contributory factors			
INTEGRATION												
Reduce unnecessary time spent in hospital	# of non-forensic long stay clients (patients who have been here for one year or more)	Number of patients /na	ADT	47	46	Based on an average of last three quarters - minus 5%	**Improve**	Leadership and advocacy for system solutions Ongoing emphasis on discharge planning	Discharge planning formally embedded as an expectation of regular interprofes-sional team review	Continued dialogue and collaboration with the LHINs and CCACs to understand the needs of hard-to place clients, and partnerships with housing providers. Team review guidelines developed and implemented by May 2014 Monitoring mechanism to be developed		The majority of the long stay clients are ALC and discharge is hindered by appropriate housing destination. While ALC remains a high priority for CAMH, it is not an indicator that is easily influenced by our efforts. Increased capacity and coordination are needed at a system level to achieve this aim
Improve efficiency and quality of care	# of patients currently on or have completed an integrated care pathway (ICP) either in	# of patients	Integrated Care Pathways spreadsheets: all data related to ICP is currently captured manually	25	**150**	This is a new process and indicator for CAMH and our sector. It is a priority and thus a target that is 6X current performance	**Improve**	Focus on the sustainability and growth of the 3 pilot ICPs in 2013/2014 Identify lessons learned and develop strategies for development and implementation of new	Change Management Knowledge Translation Project Management	Monthly review and report on # of patients on a pathway. Report to be given at the ICP Steering Committee (Leadership)	Ensure clinical care excellence and integrating evidence based practice through the growth of pilot ICPs and new ICPs for 2014/2015. Numerical goal of	This is a new indicator for us and going from 25 to 100 is a stretch target that is consistent with our strategic goal. Development of ICP is an exciting evidence based approach to inter-professional care that is

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	an inpatient setting or ambuiatory care							ICPs planned for 2014/2015	Process Improvement Integration of ICP processes within Clinical Information System (CIS)	ICP SharePoint Site: # of patients on pathway regularly updated for Clinical Leadership Team	ensuring 100 patients are either on or have completed an Integrated Care Pathway by March 31st 2015	akin to quality based procedure for mental health and addictions