Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	% Alternate Level of Care days: Total number of inpatient days designated as ALC divided by total number of inpatient days, times 100 (%; Mental health patients; Q4 15-16 through Q3 16-17; Hospital collected data)	948	18.70	18.70	16.70	Our current performance on this indicator shows improvement and we continue to work with our community partners and the LHIN. ALC remains a high-priority issue for CAMH given that many of our ALC clients remain in our care because there is a lack of good quality, appropriate and affordable supportive housing options. We will continue to advocate for a more coordinated and robust system-level strategy to address this housing crisis and we will continue to work with the community to build and sustain valuable housing partnerships. This indicator will continue to be monitored on our Balanced Scorecard. However, we will no longer be monitoring this indicator on our 2017/18 QIP given our focus on a smaller number of measures - aligned to corporate quality

improvement priorities - that are both actionable and will be acted on.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Develop proposal for transition housing option with a community partner utilizing space at CAMH to reduce the burden on acute care and Continue to work with partners on housing solutions, advocating at all government levels	Yes	A successful funding proposal for a transitional housing project was developed and submitted to the LHIN. The community partner is the Canadian Mental Heath Association and there is approved funding from the Ministry of Health and Long-term Care. We continue to work with our partners on housing solutions, including our participation with the Toronto Mental Health and Addiction Supportive Housing Network, TC LHIN, and the provincial LHIN Collaborative on Mental Health & Addictions Flexible Service Support Housing Options Work Group.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	% in mechanical/physical restraints (%; All inpatients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital collected data)	948	4.30	3.40	6.10	Improved data collection and quality has increased the total number of reported restraints for this QIP indicator. This rate represents a quarterly average over Q3 15-16 to Q3 16-17. We were not able to achieve the desired target and are taking steps to focus on areas of highest restraint use. Our commitment to restraint reduction is unwavering.

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Conduct focused intervention on 3 units with high restraint use	Yes	We implemented collaborative care planning and post-event client debriefing on 2 pilot units. At baseline, we found minimal adherence, which improved as the pilot progressed. We discovered, however, that client participation in care-planning and debriefing was most dependent on the client's level of wellness. Once we began to capture staffs' attempts to engage clients in care planning and debriefing the rates improved, however, client participation remained dependent on level of wellness.
	Yes	Two new initiatives are underway to decrease patient time in restraint and decrease restraint recurrence: • Patient Education: our Client Experience Assistant - a person with lived experience - is meeting with staff and patients across our inpatient units to share a new resource, “Feeling at Ease in Hospital,” which is a pamphlet designed to help patients feel more comfortable during their hospital stay and to facilitate the development of safety and comfort plans • Recovery Rounds: initiated on pilot units in January 2017 to elevate the importance of restraint minimization and recovery-oriented care through witnessing of

restraint and seclusion events by clinicians. Witnessing contributes to organizational change through oversight, accountability, timely communication, and commitment that surrounds every restraint and seclusion event. It also provides an opportunity to work with teams to collectively identify strengths as well as opportunities for improvement in restraint minimization techniques. Furthermore, the insights from other units can be shared, creating consistency and transparency across the organization. Recovery Rounds are mandatory and occur daily, Monday – Friday, if there was a restraint event in the last 24 hours. The clinical team includes the following members:

- Senior Leadership
- Senior Manager, Quality, Patient Safety & Risk
- Patient Experience Officer (QPSR)
- Nurse covering patient
- Unit Clinical Manager
- Unit Clinical Team Leader
- Unit Practice lead

In addition to these initiatives, we also:

- Created a Powerform in our clinical information system (I-CARE) to capture client debriefing information (e.g. has the client participated), which is "pulled into" the Team Treatment Plan, thereby improving access
- Streamlined the collaborative care-planning tool
- Piloted Phase One of our revised Prevention & Management of Aggressive Behaviour (PMAB-R) program from September 2015-June 2016. Module 6 of this program – Emergency Restraint Protocols – provides education and training on emotional/psychological issues as they relate to staff and clients as well as team response and application to ensure staff are properly equipped to follow CAMH's restraint procedures to avoid harm to self and others. Phase 2 of PMAB-R will be implemented beginning in 2017 across CAMH

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3	% of Patients with completed socio-demographic questions (%; ED patients; Q4 15-16 through Q3 16-17; Hospital collected data)	948	CB	80.00	93.00	We identified that socio-demographic data was captured in multiple forms within our clinical information system (I-CARE) so we implemented changes to our technology to address this issue and we completed brief refresher training with those capturing the information. The data is now pulled from I-CARE into our CAMH data warehouse so that we can implement monthly compliance audit reports to ensure compliance meets or exceeds our target.

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Technology changes to I-CARE assessments and existing reports to measure completeness of this data is underway. Once these changes are made, further communication and a refresher training strategy will be initiated across the organization including the Emergency Department	Yes	• All of the change ideas were implemented through changes in our technology, gaining access to data via our data warehouse and refresher training for staff collecting data • The changes have helped us to exceed our target • To further improve on this indicator, we are incorporating monthly data audits to maintain our current status or improve and to be able to address areas where compliance is a concern

• A key lesson learned is to ensure that data is captured in a consolidated way within the clinical information system (I-CARE) to make accessing the data easier
• Advice to give would be to ensure you can track data and identify locations where data is collected to address data quality or compliance issues

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4	7 day readmission - the number of stays with at least one subsequent hospital stay within 7 days divided by the total number of hospital stays in a qiven quarter (%; All inpatients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital collected data)	948	CB	CB	5.00	We initiated planning for a comprehensive project (to be implemented in 17/18 QIP year) to address discharge processes, including improving discharge summary completion time frames and developing patient-oriented discharge materials.

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Continued improvement of care through standardization and implementation of ICPs	Yes	ICPs involve standardizing care practices and assessments. Standardization is an important aspect of improving quality. In 2016/17, we began work to develop standardized processes of care for discharge as well as standardizing care for specific patient populations through ICPs.
Patient/family engagement in the discharge process	Yes	Partnering with OpenLab to be the first mental health hospital using a Patient-Oriented Discharge Summary (PODS). This will be a focus in 2017/18.

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5	Average Length of Stay (ALOS)for inpatients admitted to EAU through ED (Hours; All inpatients admitted through ED and subsequently transferred to another inpatient unit; Q4 15-16 through Q3 16-17 (rollng four quarters); Hospital collected data)	948	CB	CB	17.60	We continue to see an increase in the number of patients presenting to our Emergency Department (ED). We remain committed to improving the experience of patients requiring admission to our hospital. However, we recognize that wait times are limited by volume and capacity. By decreasing LOS and ALC, we are able to create movement and reduce wait times in the ED. However, this is not an indicator completely under CAMH's control.

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Improve patient flow across CAMH	Yes	We are seeing some improvement in this area; however, we continue to see increased volumes and complexity of patients. We are undertaking a LEAN review process across our Acute Care Program to further improve patient flow.

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6	Dementia Integrated Care Pathway falls rate (%; ICP Dementia Pathway Patients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital collected data)	948	CB	CB	16.70	This indicator was defined as a “monitoring only” indicator. Therefore no target was established. Moving forward, although we will continue monitoring this indicator on our Balanced Scorecard, we have chosen to retire the 3 ICP indicators from our 2017/18 QIP. We are committed to focusing on a smaller number of measures - aligned to corporate quality improvement priorities - that are both actionable and will be acted on.

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Monitor falls rate for patients on this pathway	Yes	This indicator measured the number of falls ICP patients had in comparison to non-ICP patients. The results for this indicator are presented quarterly and it shows that ICP patients have a lower fall rate than non-ICP patients. However, to properly assess this, we need a larger sample size and we will continue to monitor this indicator for the Dementia ICP patients. Measuring this indicator did provide the clinical team with a different perspective, beyond the clinical outcome indicators usually associated with ICPs.

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7	Dementia Integrated Care Pathway polypharmacy (% patients on 1 or fewer medications) (%; ICP Dementia Pathway Clients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital collected data)	948	CB	CB	91.00	This indicator was defined as a “monitoring only” indicator. Therefore no target was established. Moving forward, although we will continue monitoring this indicator on our Balanced Scorecard, we have chosen to retire the 3 ICP indicators from our 2017/18 QIP. We are committed to focusing on a smaller number of measures - aligned to corporate quality improvement priorities - that are both actionable and will be acted on.

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Monitor % of patients on one or fewer medication on the pathway	Yes	This was a "monitoring only" indicator to measure the polypharmacy rate for patients exiting the Dementia Pathway. Based on the principles of the pathway and the clinical outcomes, 91% of the patients left the ICP on 0 or 1 scheduled psychotropic medication. One of the key learnings has been that patients with Behavioural and Psychological Symptoms of Dementia can be treated with 0 or 1 scheduled psychotropic medication. Moving forward, we require a larger sample size to ensure the improvement is significant.

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8	ED Wait times: 90th percentile ED length of stay for admitted patients (Hours; ED patients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital NACRS)	948	10.40	10.40	11.40	We have experienced a dramatic increase in the volume of patients accessing our Emergency Department, affecting wait times.

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9	Involuntary - Unauthorized Leave of Absence (I-ULOA); # of patients reported as I-ULOA (Counts; All inpatients; Q4 15-16 through Q3 16-17 (rolling four quarters); Hospital collected data)	948	59.00	61.00	50.00	Through the implementation of our robust change strategies, we have seen a significant decrease in incidents of Involuntary - Unauthorized Leave of Absence, exceeding our target for 2016/17. Given this, we are removing this indicator from our 2017/18 QIP. Involuntary Unauthorized Leave of Absence continues to be a corporate priority and, as such, we will continue to monitor this indicator within the Safe & Well domain of our Balanced Scorecard. Staff education and post-incident debriefing for U-LOAs and F-ULOAs had a positive effect as did implementation of environmental controls.

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Review and renew risk assessment and focus on physician education/support for assessment prior to passes	Yes	Took a 3-pronged approach: Patients – using evidence-based tools and process to evaluate patients' risk for absconding; Staff/Physicians – invested in education and training, increased efforts to engage physicians to review risks (i.e. medication management). Environment – implemented changes in the environment, and ensured appropriate resources, both human and technological. A standardized absconding risk assessment tool (LARA) pilot was initiated on Unit 2-5 (an inpatient

		unit with the highest U-LOA numbers), however the unit closed prior to completion.
Embed I-ULOA assessment in I-CARE through CAMH-wide Risk Flagging	Yes	• A new risk flagging alert in I-CARE has been implemented as part of Safe & Well CAMH and I-ULOA (potential to abscond) is one of the risk flags • In addition to I-ULOA, teams involved in the pilot initiative can flag one or more of the following risks involving a client: o Aggression/violence o Sexual aggression o Weapons o Letter of trespass o Arson • This initiative is about communicating risk – when there is a significant risk, staff need to be alerted and have it documented so the information can be accessed quickly
Care teams adhering to Pass/Privilege Policy in determining off-ward privilege for inpatients	Yes	Offered ongoing education and ‘learning from experience’ opportunities for both staff and clients, through the debriefing process. Gained active feedback from staff through regular feedback mechanisms (i.e. staff meetings). Reviewed compliance on a quarterly basis.
Explore creation of "secure" outdoor spaces to mitigate I-ULOA risk, while continuing to respect the need for patient access to fresh air	Yes	Limited number of ‘secure’ outdoor spaces. Challenge with accessing spaces - requires negotiation to avoid disruption in pre-planned use of the space. Spaces are used, nonetheless, when available. Facilitating safe “transport/escort” to the secure space can also be quite challenging. Recommend Security, Professional Practice, and Operations (and possibly Education Services from a PMAB perspective) collaborate to establish protocols for how this can be resourced and facilitated safely. Collaboration with the Office of Redevelopment – for improved secure outdoor space – is planned for Phase 1C and 1D of the redevelopment.
1) Development of ULOA toolkit and resource repository	Yes	Toolkit containing policies, guidelines, educational materials and evidence-based, best practice and peer reviewed literature was developed.

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10	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital (Rate per total number of admitted patients; Hospital admitted patients; most recent quarter available; Hospital collected data)	948	88.00	95.00	95.00	The key change feature was creating additional pharmacist positions in the Emergency Department, allowing us to schedule additional shifts to cover Sundays and evenings each week. Pharmacist support includes developing Best Possible Medication Histories to facilitate prescriber medication reconciliation, follow-up to ensure medication reconciliation is completed, and education and training of prescribers. Medication reconciliation is resource intensive, especially to maintain a high performance. It takes time for staff to become proficient with the process. Also, this is a collaborative initiative, requiring participation and support from physicians and nurses.

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Pharmacy support embedded in our process to improve performance (standard practice amongst peer TAHSN hospitals)	Yes	Supporting medication reconciliation in the Emergency Department, the source of the majority of our admissions, was effective. Through the additional pharmacist support for the process we were able to achieve our target this year.
Physician education	Yes	Education and training of the many prescribers covering the Emergency Department is key to ensure the admission medication reconciliation rates are maintained. Pharmacist support for this on an ongoing basis has been successful.

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11	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients ; Most recent quarter available; Hospital collected data)	948	CB	CB	61.00	This year we did not have discharge medication reconciliation as an improvement target. We collected baseline data only to inform future work. The challenges of discharge medication reconciliation are identified as: 1. CAMH has a very busy Emergency Department, with patients coming in for only a short period of time before discharge (for example within 24 hours) and thus not enough time to provide discharge medication reconciliation, and 2. Discharge can happen in any unit across the organization, making it difficult to allocate resources

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Establish validated methodology to determine completion rates of medication reconciliation at discharge.	Yes	From our examination of discharge medication reconciliation functions and process we have developed an improvement plan and target for next year's 2017/18 QIP.

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12	Percent positive result to OPOC question: "I think the services provided here are of high quality." (%; All Outpatients who completed the survey; Q4 15-16 through Q3 16-17; Ontario Perceptions of Care (OPOC) validated survey tool)	948	89.00	89.00	94.20	Since 2010, CAMH has administered an annual survey to collect valuable patient feedback in order to improve the quality of care we provide. In 2015, we changed our survey to the Ontario Perception of Care for Mental Health and Addictions (OPOC – MHA) as the primary tool for measuring in- and out-patient experience across CAMH. This validated tool was developed by CAMH research scientists and is being adopted for use across the province. In 2015, we added this indicator to our QIP to better understand our outpatients' perceptions of their care. We now have data from two cycles of the OPOC administration and are establishing a more meaningful target for our 2017/18 QIP. Additionally, we launched a review of our outpatient services in 2016 to identify opportunities for increased access and engagement. The findings have not yet been released; however, we anticipate a change to our outpatient care structures and processes.

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Review of ambulatory clinics to identify opportunities for increased access and engagement	Yes	Ambulatory Review completed and opportunities identified.

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13	Percent positive result to OPOC Survey question: "I think the services provided here are of high quality." (%; All Inpatients who completed the survey; Q4 15-16 through Q3 16-17; Ontario Perceptions of Care (OPOC) validated survey tool)	948	69.70	70.40	79.40	Understanding the perspectives and experiences of our patients is crucial to the quality improvement process at CAMH; and the administration of our annual patient survey is one of the primary and arguably most ambitious means by which we gather these insights and information. In 2015, we adopted a new survey tool - the Ontario Perception of Care for Mental Health and Addictions (OPOC - MHA) - and, as such, we have a new question by which to measure patient satisfaction. Although it appears that we far exceeded our target, we are cautious in our interpretation of this result, given that the target was established based on the results from our previous Client Experience Survey. Nevertheless, we now have data from two cycles of the OPOC administration and we can now establish a more meaningful target for the 2017/18 QIP.

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Target improvement initiative focused on communication, engagement in care, and being treated with respect.	Yes	Discussions with patients about their medications, safety and comfort measures, and what to expect during their hospital stays have been integrated more fully into community meetings across our inpatient units. To facilitate patient engagement, the Prevention of Restraint Committee developed two patient resources - "Feeling at Ease in the Hospital" and "Restraint Use" - which have been shared with staff and patients through dedicated education sessions, led by our Patient Experience Assistant, on each of our inpatient units. Early feedback is encouraging from both staff and patients. For example, staff have identified that the "Feeling at Ease" pamphlet is beneficial for developing Safety & Comfort plans collaboratively with patients. Similarly, patients have indicated that the pamphlets are helpful for identifying ways to relieve their stress while in hospital.
Ensure key patient preferences and needs are included in handover processes from one shift to another and on transfer across units.	Yes	The SBAR (Situation, Background, Assessment, Recommendation) framework was implemented on inpatient units as an evidence-based tool that standardizes the transfer of relevant information at care transitions. This standardization is effectively minimizing communication breakdown and errors.
Further data analysis to identify factors that correlate highly with overall satisfaction	Yes	Our Performance Improvement team performed correlational statistical analysis to identify items that correlated highly with overall experience. For inpatients, a priority target for improvement efforts related to the question "Staff helped me identify where to get support after I finished the program/treatment." This priority area falls into the bottom positive responses, yet is highly correlated with the overall patient experience. The results of the analyses, along with qualitative feedback, were used to identify quality improvement priorities.
Strengthen "patient voice" in care by having peers, individuals with lived experience, and family	Yes	We created a newsletter for clients and staff reflecting the outcomes of the 2015 OPOC. The top results that correlated with client satisfaction were highlighted, along with the top areas identified for

representatives on key initiatives.

improvement. A Client Experience Assistant - a person with lived experience - engaged over 120 patients in discussions about the 2015 OPOC results. The intent was to see whether or not the results resonated with current clients (at the time), and to gather additional feedback for the Quality Council. This initiative allowed the program to learn directly from their patients about how to better serve their needs and for the patients to connect with other people facing similar challenges. Throughout the process, immediate steps were taken to meet newly voiced client needs - an example of quality improvement in action. The results of the 2015 OPOC were also shared more broadly with patients, families, and staff using various methods – newsletters, articles on our intranet, and during staff and other inpatient community meetings. Beyond the OPOC, we launched a formal review of our family engagement strategy in 2015. The review explored a range of strategies for supporting the effective representation, participation and empowerment of families at the organizational level. Building from evidenced-based practices, we launched the Office of Family Engagement to work with clinical programs to ensure improved family engagement at the point of care; review family engagement activities in program planning and evaluation; develop a family engagement strategy and evaluation plan; engage with families to provide health information and supports; and liaise with family engagement leads across Ontario to share best practices.

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14	Total cumulative # CAMH patients currently on or have completed an Integrated Care Pathway (ICP)(inpatient and ambulatory care) (Counts; CAMH Patients on an ICP; Since inception; ICP manual data collection tool, I-CARE)	948	1286.00	1900.00	1975.00	CAMH continues to further develop and sustain the current ICPs. As of now, CAMH has more than 1900 patients that have been enrolled in an ICP and two ICPs that have been implemented at external sites. DA VINCI (Depression and Alcoholism: Validation of an Integrated Care Initiative), through the ARTIC grant, was implemented in 8 other health settings, including primary care and has had over 350 patients enrolled across the province since 2015. The Dementia ICP is currently in process of being implemented at two other clinical settings. Moving forward, although we will continue monitoring this indicator on our Balanced Scorecard, we have chosen to retire the 3 ICP indicators from our 2017/18 QIP. We are committed to focusing on a smaller number of measures - aligned to corporate quality improvement priorities - that are both actionable and will be acted on.

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Develop strategy for monitoring outcomes associated with pathways	Yes	The ICP program has been working closely with Performance Improvement – Reporting and Analytics - to develop evaluation frameworks for the Integrated Care Pathways. An evaluation framework was tried and tested with the concurrent ICP - DA VINCI (Depression and Alcoholism: Validation of an Integrated Care Initiative). This was a good proof of concept on how to measure ICPs, not just focusing on clinical outcomes, but also spread and reach, patient satisfaction and engagement. Other ICP evaluation frameworks are in progress.