2022/23 Quality Improvement Plan

"Improvement Targets and Initiatives"

AIM		Measure						Change			
Issue	**Quality dimension**	**Measure/ Indicator**	**Unit / Population**	**Source / Period**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**
Theme I: Timely and Efficient Transitions	**Timely**	90th percentile ED/EOU LOS (Emergency Department wait time for inpatient bed)	Hours / ED & EOU patients	Hospital NACRS / Q4 21-22 through Q3 22-23	46.1	46.1	Maintain current performance	1) Plan, design and implement a quick-response team to support low-acuity patients to receive necessary assessments quickly, and to transition them to appropriate programs/services. These patients, who are Canadian Triage and Acuity Scale (CTAS) 4 and 5 patients represent approximately 25% of visitors to the Emergency Department (ED). The aim is to reduce traffic in ED and lessen documentation, which will lead to better and more responsive care	Implement quality improvement PDSA cycles, during a standard time period (e.g., 11am-8pm) when there is a high-volume of visitors to the ED assessed as CTAS 4 or 5. The team will use existing Registered Nurse (RN) and Social Worker (SW) staff resources, and a physician to support the quick assessment requirements of these patients	Median time from start of triage to discharge for patients designated as CTAS 4 or 5	Median time from start of triage to discharge for patients designated as CTAS 4 or 5 (CB)
								2) Alternate level of care (ALC) remains a high-priority issue for CAMH as we are challenged to manage the length of stay for patients who require admission from our Emergency Department (ED). As well, many of our ALC patients remain in our care due to a lack of good quality, appropriate and affordable supportive housing options. CAMH's ALC rate has remained high during the COVID-19 pandemic. CAMH will continue advocacy efforts for a more coordinated and robust system-level strategy to address the housing crisis and we will continue to work with community agencies to build and sustain valuable housing partnerships	1) Continued collaboration with high support housing agencies to develop and submit proposals to funders to create a variety of new housing options for ALC patients. If the funding is approved, the implementation of new housing partnerships is expected to improve bed flow throughout the hospital	1) Proposals developed and submitted 2) Proposal(s) accepted by funders 3) Initiate implementation planning with the high support housing agency (or agencies) for the approved proposal(s)	1) Proposals developed and submitted (Y/N) 2) Proposal(s) accepted by funders (Y/N) 3) Meeting scheduled with the high support housing agency to initiate planning and implementation (Y/N)
									2) Given pressures related to the COVID-19 pandemic, CAMH continues to work closely with LOFT at 250 College Street on transitioning patients in and out of the program	Number of ALC patients that move to 250 College Street	CAMH and LOFT aim to transition no less then 10 residents from 250 College Street
									3) CAMH continues to work with Regeneration Community Services in filling vacancies at the new supportive housing programs: Dowling and the Parkdale Step-Up Housing Program	1) Number of ALC patients that move to Dowling 2) Number of ALC patients and tenant-directed moves that transition to Parkdale Step-Up Housing Program	By the Spring of 2022, Dowling and the Parkdale Step-Up Housing Programs will be at full capacity

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Theme II: Service Excellence	**Patient-centred**	Percent positive result to the OPOC question: "I think the services provided here are of high quality"	% / All inpatients who completed the survey	Validated Ontario Perception of Care Tool for Mental Health and Addictions (OPOC) survey tool / Q4 21-22 through Q3 22-23	2021-22: 83.0% (Percent Positive)	83.0%	Indicator methodology changed to Percent Positive. Maintain current performance	1) Continue to advance implementation of the corporate Patient and Family Engagement Roadmap, in partnership with patients/families. At CAMH, we know that involving patients and families in quality improvement and decision making and listening to their feedback helps us to provide care that is more collaborative and responsive, better informed, and more likely to achieve better outcomes and experience	Launch and evaluate the Patient and Family Partners Program (PFPP), which is designed to recruit and match patient and family partners (PFP) to advisory groups, committees, working groups and special projects across CAMH. PFP's will be involved in partnerships, co-design initiatives, and improvements that impact quality and patient safety	1) Formal launch of the PFPP online completed 2) Operational management database developed 3) Number of staff engagement requests matched with a PFP 4) % of completed PFP Program evaluations (patient, family and staff experience) where PFP have been recruited/matched to a staff engagement request	1) Formal launch of PFPP completed by April 2022 2) Development of operational management database completed by July 2022 3) Number of staff engagement requests matched with a PFP (CB) 4) 10% completed PFP Program evaluations (patient, family and staff experience) where PFP have been recruited/matched to a staff engagement request
								2) Advance implementation of the Forensic Model of Care (FMOC) project. The FMOC project seeks to identify and optimize patient journeys through the forensic system by focusing on four key themes: • Create a valued experience for patients, families and staff • Revolutionize the way we deliver care • Design a safe work and care environment • Standardize how we work together to deliver the best care	1) Create patient and family education tailored to the forensic population. Education needs to be tailored in an effort to ensure patients and their families are informed about the expectations of illness, treatment and progress through the forensic system. This education should be provided to patients and families early in their stay	1) Welcome Package and educational materials developed in collaboration with patients and families 2) Welcome Package and educational materials disseminated to patients and families	1) Welcome Package and educational materials developed, in collaboration with patients and families, by September 1, 2022 2) Welcome Package and educational materials disseminated to patients and families by the end of September 2022

								The project defines how forensic patients will be cared for; both in the range of service that are needed and how that care should be delivered. The FMOC shifts care to a more patient-centric delivery of best practice-based care and streamlines services. Education, programming and staff training are key components of this larger project, which align with opportunities for improvement identified by patients and families (e.g., need for more activities, and programming, more information about programs and services and better orientation to units)	2) Create a plan to develop and deliver education to forensic clinical staff in motivational interviewing (MI) techniques to facilitate early engagement with patients. MI is seen as a valuable way for clinicians to engage patients in their care and to identify their priorities and goals	Plan developed (Y/N)	Plan to develop MI training by December 2022
								3) Advance the development of structured therapeutic programs and activities, which are centrally facilitated in the Therapeutic Neighbourhood (TN). The TN provides a dynamic environment where patients can work towards their goals by learning and acquiring new skills while actively engaging in their treatment. The long-term outcomes are to improve patient well- being and quality of life. The need for more activities and programming are identified as opportunities for improvement, through our annual survey (OPOC) and other feedback mechanisms	1) Implement strategies to improve access to TN programming (e.g., reduce the no-show rate, develop a SharePoint site for TN inpatients)	1) Percentage of appointments for which patients did not show 2) SharePoint site developed	1) 25% reduction in no-shows 2) SharePoint site developed by September 2022
									2) Staff training on structured treatment modalities	% of TN clinical staff who received Motivational Interviewing (MI) training	100% TN clinical staff trained in MI by December 2022
									3) Develop Measurement-based-Care (MBC) strategy (e.g., identify admission and discharge tools)	1) Tools identified 2) Design process to implement tools	1) Tools identified by September 2022 2) Process to implement tools designed by December 2022
									4) Continue implementation of an evaluation plan (e.g., administration of an inpatient satisfaction survey)	1) Number of completed surveys 2) Identify action items based on the survey results	1) 100 surveys completed by June 2022 2) One action item identified and implemented by December 2022

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Theme III: Safe and Effective Care	**Safe**	Workplace Violence Lost Time Injury Frequency (# of WPV incidents/100 FTEs)	Count / Worker	Local data collection / January - December 2022	0.48	0.48	Indicator methodology change to rate. Maintain current performance	Expand and enhance implementation of Safe & Well CAMH program, and Workplace Violence Prevention Committee recommendations and annual work plan	1) Implement revised Supervisor Competency Training	Number of Managers who have received the revised training	50-75 Managers trained
									2) Continue implementation and adoption of the recommendations from the risk assessments completed on high-acuity units	% of recommendations in progress or completed	100% of recommendations completed
									3) Continue roll-out of staff education/training for Trauma-Informed De-Escalation Education for Safety and Self-Protection (TIDES) in direct service inpatient and outpatient programs	% of newly hired inpatient and outpatient staff trained on TIDES	100% of new inpatient and outpatient staff will receive TIDES training prior to commencing work
Theme III: Safe and Effective Care	**Safe**	% of patients physically restrained during inpatient stay	% / All inpatients	Hospital collected data / Q4 21-22 through Q3 22-23	4.8%	4.8%	Maintain current performance	1) Continue the advancement of our Trauma-Informed De- Escalation Education for Safety and Self- Protection (TIDES) training implementation and sustainability, and the utilization of practice enhancements. The TIDES program strengthens the relationship underlying crisis prevention, de-escalation and physical intervention. To be flexible and responsive, the program considers the diverse needs of staff and patients across an array of interventions and treatment approaches, including acute care, inpatient, outpatient and aftercare services. This is achieved through three key goals: 1) Enhancing skills and building confidence through team-based learning 2) Driving fundamental day to day processes proven to keep everyone safe 3) Bringing learning to the point of care	1) TIDES implementation through various training modalities (e.g., simulation, inpatient/outpatient, hospital orientation, and program-specific training)	TIDES training completion rate	1) 100% of on-boarded direct service staff 2) 80% of existing staff will complete the TIDES training modules that were determined to be a priority for their unit through consultations or TIDES Cycle 2 needs assessments
									2) Work with clinical units to implement practice enhancements and utilize PDSA cycles for improvement (e.g., targeted work with Recreational Therapists, review of documentation standards, TIDES Specialists and TIDES Point-of-Care Facilitators attending huddles). Practice enhancements are aligned with interventions shown to reduce conflict and containment in inpatient mental health settings	1) % of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) Completion rate of Safety & Comfort Plans	1) 30% of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) 76% completion rate of Safety & Comfort Plans

									3) Continue to offer Train-the-trainer sessions to inpatient clinical staff to become Point-of-care facilitators (POCF) for their services. POCFs are direct care staff that receive additional training, mentorship and support to bring the knowledge and skills of TIDES to direct care teams across the organization. The role requires them to be content experts for their clinical teams around TIDES strategies and skills	% of inpatient clinical staff trained as POCFs	20% increase of inpatient POCFs by December 2022
								2) Scale and spread the Healthcare Excellence Canada (formerly Canadian Patient Safety Institute) Teamwork and Communication Safety Improvement Project on one Forensic inpatient unit. The goal of the project is to empower direct-care teams to actively solve local-level teamwork and communication issues that are impacting patient safety outcomes (e.g. restraints)	Optimize an evidence-based tool (e.g. SBAR) to continuously improve care team communication to reduce the number of physical restraint events on one inpatient unit	1) % of staff educated/trained using Team STEPPS communication tool (e.g. SBAR) 2) % of Safety & Comfort Plans completed within 72 hours of admission or following a restraint event 3) % of Client/Patient Event Debrief forms completed within 72 hours after a restraint event	1) 80% of staff educated/trained using Team STEPPS communication tool 2) 66% of Safety & Comfort Plans completed 3) 50% of Client/Patient Event Debrief forms completed within 72 hours after a restraint event

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Theme IV: Equity	**Equitable**	Percent positive response to the OPOC Survey question, "Staff were sensitive to my cultural needs (e.g. religion, language, ethnic background, race)"	% / All inpatients and outpatients who completed the survey	Validated Ontario Perception of Care Tool for Mental Health and Addictions (OPOC) survey tool / Q4 21-22 through Q3 22-23	2021-22: 84.7% (Percent Positive)	84.7%	Indicator methodology change to Percent Positive. Maintain current performance	1) As a part of Fair & Just CAMH – a CAMH-wide initiative to advance equity, diversity and inclusion – the Health Equity Office and Education Services are working collaboratively to develop and implement an education strategy. The Health Equity Certificate program (as part of the Health Equity and Education strategy) provides CAMH staff, managers and physicians with fundamental knowledge and skills needed to plan and implement equitable and culturally sensitive mental health and addiction programs and services	1) Develop, update and implement new competency-based curriculum courses	Number of new blended learning foundational courses updated and implemented (virtual and in-person)	Update and implement 2 blended learning (virtual and in-person) foundational courses
									2) Develop and pilot the delivery of the Health Equity Coaching Model (HECM), which is a collaborative initiative that engages with all staff across the hospital to improve clinical health outcomes through planning, policy and programming	1) Resourcing secured to develop and implement the HECM 2) First draft of HECM developed 3) Number of units/teams who have received the HECM pilot training 4) Number of training sessions delivered during the pilot	1) 2 dedicated health equity coaches 2) Model developed by September 2022 3) Training delivered to 5 units/teams 4) 5 training session delivered
								2) Continue implementation of the Dismantling Anti- Black Racism strategy (DABR), which is a focal point of Fair & Just CAMH. Through the DABR strategy, CAMH aims to deliver safe, culturally appropriate, accessible and equitable care for Black patients and families	Continue implementation of the 22 action items identified in the DABR strategy which aim to decrease anti-Black racism at CAMH by 2022. Action items are grouped into three focus areas; for patients and families, for staff and for CAMH	Number of action items completed or in-progress	22 action items completed or in-progress by December 2022
								3) Expand the San'yas Anti-racism Indigenous Cultural Safety Training (Core Mental Health course), as part of the continued implementation of the Truth and Reconciliation Action Plan which is a three-year strategy to create an environment where First Nations, Inuit and Metis staff feel safe at work, and CAMH staff and physicians understand how colonialism and resiliency impacts mental health and	Expand San'yas Anti-Racism Indigenous Cultural Safety training to the Executive Leadership team (ELT) and additional staff in Education, Research, PSSP, and clinical staff for inpatient and outpatient services	Completion of San'yas Anti-Racism Indigenous Cultural Safety training	1) 100% of the ELT will receive the training 2) 200 staff will complete the training by December 2022

								substance use enabling patients to feel safe to receive CAMH services. The curriculum and learning outcomes are designed to help participants: • Strengthen their knowledge, awareness, and skills for working with and providing service to Indigenous people and communities • Work more safely and effectively with Indigenous people • Begin considering their role in correcting, rebuilding and transforming systems to uproot Indigenous-specific racism • Improve the quality of client/patient care with enhanced knowledge of the roots of Indigenous trauma and the resilience factors for healing • The improvement of core clinical competency skills required to provide quality services to First Nations, Inuit and Metis patients			

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Theme V: Effective	**Effective**	Percentage of recurrent encounters (with at least three visits) where at least one minimum dataset (MDS) assessment was administered within a month of the first visit	Outpatients who had a recurring encounter and 3 checked in/out or confirmed appointments within 6 months after the registration of the encounter	Hospital collected data / Q4 21-22 through Q3 22-23	NA	CB	New Indicator for 22-23	Advancing the implementation and uptake of measurement-based care (MBC) is an organizational priority at CAMH. MBC is the systematic administration of validated clinical measures, specific to the mental health and addictions' population, to track symptoms, as well as wellness and functioning. These assessment tools are integrated into treatment approaches to guide the intensity of interventions and therapeutic responsiveness and agility. MBC has the potential to reduce variability in care quality, simplify and streamline decision-making and make care more responsive to patient needs	1) Psychosis Recovery and Treatment (PRT) 1. Modification of the Audit C Tool: In an effort to improve utilization rates of the Audit C tool; the PRT service is in the process of moving to the shortened version of the form, which will lead to higher completion rates while giving clinicians the data they require to support their patients. It is also accompanied by an algorithm to support treatment decisions 2. Changes to Metabolic Monitoring: Enhance the capacity for assessment completion by leveraging existing outpatient documentation to increase the rates of clinicians and physicians in completing waist circumference, vitals and measures, and blood work within 14-60 days from Outpatient admission 3. Changes to the RAI and the Antipsychotic Treatment Determination Form: In order to ensure that the PRT service adheres to the upcoming HQO-mandated changes to the RAI form, the PRT service is working with the Clinical Applications team, and physician stakeholders to implement these changes to the RAI form From both an outpatient and inpatient perspective, we will be including the mandated RAI changes noted above to the Antipsychotic Treatment Determination Form. As an important feature, Physicians completing this form will also have language included which will support better information sharing and context to support treatment decisions. This form is completed near admission, and will give physicians more information	1. Completion rates of Audit C form in outpatient clinics pre- and post-change 2. Metabolic monitoring data captured 3. Mandated changes to RAI and Antipsychotic Treatment Determination forms in place by April 1, 2022	1. Completion rates of Audit C form will increase by 20% by Dec 2022 2. Completion rates for PRT outpatients will increase by 20% by end of year 3. Response to the 4 new mandated RAI questions – 100%. Utilization of the Antipsychotic Treatment Determination Form increased by 30% by end of December 2022

									about not only whether the patient has received the treatment or not, but also, in the case where the patient has not received the treatment, the reasons/context behind not being given the treatment. Further, the inclusion of the HQO mandated questions into the Antipsychotic Treatment Determination Form will be important as the form: 1. Will auto-populate the HQO responses into the RAI, thereby reducing the need to document those responses directly into the RAI upon patient discharge; and 2. Allow for outpatients and inpatients to utilize the same form to support patient planning. Standardizing opportunities for MBC across inpatient and outpatient programs is an important feature of CAMH's plan for measurement based care		
									2) Slaight Centre for Early Intervention 1. Use of Clinical Redcap in Slaight Centre for Early Intervention to enhance patient completion of standardized measurement tools. RedCap is a secure, web-based application that captures data and puts it into a patient's EHR from which the treatment team along with the patient can collaborate regarding the treatment plan that is indicated 2. Refresh the administration of standardized assessment tools through training and the use of reporting for accountability	1. Complete construction of Clinical RedCap 2. Engage patients to complete measures using Clinical RedCap 1. Refresh training material for assessment 2. Use clinical dashboard to monitor assessment administration and report to teams	1. Clinical RedCap established by the end of May 2022 1. 75% of patients who have provided their email addresses will receive the link to Clinical RedCap to complete measures 2. 30% of patients who have received the Clinical RedCap link through email will complete the measures 1. Training materials refreshed by September 2022 2. 50% of clinicians and physicians will complete one minimum dataset assessment within a month of first visits for 50% of patients with recurrent encounters by Dec 2022
									3) Development and implementation of a data quality dashboard in the Ontario Structured Psychotherapy (OSP) Program to support/improve MBC	% of validated indicators on the data quality dashboard	65% of metrics completed