Quality Improvement Plan (QIP): 2020/2021 Progress Report

Centre for Addiction and Mental Health, 1001 Queen Street West

Measure/ Indicator from 2020/21	Current Performance as stated on QIP 2020/21	Target as stated on the QIP 2020/21	Current Performance 2021	Change Ideas from Last Year's QIP (2020/21)	Methods	Was the change idea implemented as intended Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
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 given quarter (% / All inpatients; Hospital collected data/ Q4 19-20 through Q3 20-21)	4.2%	4.2%	4.5%	Ensure that information relevant to the care of the patient is communicated effectively during care transitions by ensuring compliance with: 1) PODS as standard discharge practice across inpatient areas	Audits/feedback mechanism for compliance rates and targeted initiatives for areas identified from audits as needing improvement/support	Y	Patient-Oriented Discharge Summaries (PODS) are being completed in inpatient areas and targets have been met quarterly. PODS completion is being monitored through the Key Priorities Dashboard and Inpatient Dashboard.
				2) ED Multidisciplinary Assessment for External Providers as standard discharge practice from the Emergency Department	Identify challenges associated with form completion, use evidence to inform potential solutions and conduct improvement cycles to test ideas to enhance uptake	N	This Quality Improvement project work was paused due to the COVID-19 pandemic.
				3) Discharge summaries completed within 48 hours of discharge and sent from hospital to the community care provider	Review key performance indicators with physicians during their annual re-appointment evaluations and engage in practice improvements to improve performance targets	Y	Performance on these metrics is being measured and discussions to identify areas for quality improvement are in progress. We are exploring opportunities to collaborate with the College of Physicians and Surgeons of Ontario (CPSO) and to align our QI priorities related to medical practice with CPSO peer review activities. It has been noted that backend transcription can sometimes cause a delay.
				4) Physician consultation notes completed and sent	Review key performance indicators with physicians during their annual re-appointment evaluations and engage in practice improvements to improve performance targets	Y	Performance on these metrics is being measured and discussions to identify areas for quality improvement are in progress. We are exploring opportunities to collaborate with the College of Physicians and Surgeons of Ontario (CPSO) and align our QI priorities related to medical practice with CPSO peer review activities. The methodology for physician consultation note completion is still under development and Reporting & Analytics continues to work with physician leaders to improve this indicator. It has also been noted that backend transcription can sometimes cause a delay.

Measure/ Indicator from 2020/21	Current Performance as stated on QIP 2020/21	Target as stated on the QIP 2020/21	Current Performance 2021	Change Ideas from Last Year's QIP (QIP 2020/21)	Methods	Was this change idea implemented as intended? (Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
90th percentile ED/EOU LOS (Emergency department wait time for inpatient bed) (Hours / ED patients; Hospital NACRS / Q4 19-20 through Q3 20-21 (TYD)	50.2 (updated methodology, ED & EOU combined)	CB	50.1 hours	1) Move Emergency Department (ED) to new building as part of Phase 1C and monitor the impact of the new space on ED Length of Stay (LOS). Expand on the Emergency Department Optimization work after transition is complete	1) Move Emergency Department to new physical location and implement refined processes (July - September, 2020)	Y	The move of the Emergency Department to the new physical location was completed, but delayed due to the COVID-19 pandemic.
					2) Gather current state data on triage process in new physical location, monitor performance against target, and conduct improvement initiatives where appropriate (October - December, 2020)	N	The move of the Emergency Department to the new location was delayed due to the COVID-19 pandemic. As such, we were unable to complete this change idea as per the specified timeline.
				2) 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 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. We will continue our 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 the Ministry of Health and Long Term Care 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	Y	Of the eight housing proposals CAMH submitted (in partnership with six partners), one has been accepted – the Step-Up Housing Program at O'Connor. Five patients will be housed through our Letter of Agreement with LOFT, which is currently underway. In November 2020, CAMH submitted three proposals to support ALC patients transitioning to the community and supported six proposals in collaboration with high support housing providers. Through these efforts, various patient populations were considered, including, but not limited to, dual diagnoses, forensic, and ethno-cultural specific inpatients, designated as ALC. We continue to develop housing proposals to support our complex ALC patients.
					2) Continued collaboration with Ontario Health/the Local Health Integration Network (LHIN) to participate in the Service Resolution Table to obtain supports for those patients that require additional resources to aid with discharge	N	The TC-LHIN has not been facilitating the Service Resolution Table (SRT) since the spring of 2020 and discussions have been limited since the COVID-19 pandemic began. To date, seven of the ten patients have been discharged. Two patients will be discharged to DSO housing and a third patient is waiting for LTC placement. We continue to monitor the three patients who are awaiting discharge.

Measure/ Indicator from 2020/21	Current Performance as stated on QIP 2020/21	Target as stated on the QIP 2020/21	Current Performance 2021	Change Ideas from Last Year's QIP (2020/21)	Methods	Was this change idea implemented as intended? (Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
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 19-20 through Q3 20-21)	2019: 35% (Top Box)	35%	38.5%	1) Continue implementation of the three-year Corporate Patient and Family Engagement Roadmap in partnership with patients/families. At CAMH, we know that involving patients and families in quality improvement and listening to their feedback helps us provide care that is better informed, more responsive to their needs, collaborative and more likely to achieve better outcomes and experience	Continue development of the Patient and Family Partners Program (PFP Program), which is designed to recruit and match patient and family partners (PFP) to advisory groups, committees, working groups and special projects across CAMH. PFP will be involved in partnerships, co-design initiatives, and improvements that impact quality and patient safety	Y	The Patient and Family Partners Program database has been completed. A Committee was established to oversee key operational decisions across clinical/corporate, research and youth integration. The goal is to create increased alignment across the hospital toward clinical and research integration for the Patient and Family Partners Program. The launch and subsequent recruitment, matching, and evaluation were postponed until Q4 due to COVID-19. Orientation is currently being developed for the Q4 launch. Application (patient-facing) and registration (staff facing) forms were developed. The Public and Patient Engagement Evaluation tool (PPEET) was approved and is ready for use.
				2) Development of structured therapeutic programs and activities which will be centrally facilitated in the Therapeutic Neighbourhood. The Therapeutic Neighbourhood will provide 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	1) Development of innovative evidence-based program curriculum/content 2) Development of a program schedule 3) Provision of staff training of structured treatment modalities 4) Development of an implementation and evaluation plan 5) Increase the hours of therapeutic programming offered	Y	1) The Therapeutic Neighbourhood (TN) opened and implemented new programming content as of November 30, 2020. A literature review was completed and curriculum was developed for all programs offered. 2) TN schedule was finalized and implemented. However, the schedule requires ongoing modification due to COVID-19 restrictions and new information received around the availability of external partners. 3) Staff have received training on group facilitation, CBT skills and introductory DBT skills. Staff are provided with ongoing opportunities for weekly support and skill building. Additional training, specifically for CAT, is scheduled for February 2021. 4) An implementation and evaluation plan and logic model has been completed in collaboration with Reporting & Analytics. Further steps to move our evaluation processes to electronic format will require additional staff training and review from appropriate governance structures. 5) The initial goal of programming for the TN was twenty+ hours of programming per day. However, this was adjusted due to funding restrictions and stakeholder engagement. The initial TN schedule will now offer a total of six groups per day, totalling approximately ten to twelve hours of daily programming. This is still a significant increase, as ENCORE was previously offering five hours of daily programming. With the move into the TN, previous limits on attendance has been removed. In addition, the groups will be run concurrently thereby increasing patient access to the groups. However, with the ongoing mandated restrictions related to COVID-19, we have had to place limits on the number of patients that can attend in-person groups, and to ensure patients' attend groups in their own cohorts and maintain physical distancing. The TN is compensating by offering virtual options for patients to attend programming as much as possible. The schedule and programing offered will be evaluated six month's post-occupancy and reviewed again six month's post-pandemic restrictions. Amendments will be made based on the evaluations.

Measure/ Indicator from 2020/21	Current Performance as stated on QIP 2020/21	Target as stated on the QIP 2020/21	Current Performance 2021	Change Ideas from Last Year's QIP (2020/21)	Methods	Was the change idea implemented as intended Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count / Worker; Local data collection / January – December 2020)	YTD: 521 incidents	521	628	Expand and enhance implementation of Safe & Well CAMH program, and Workplace Violence Prevention Committee recommendations and annual work plan	1) Optimization of in- and outpatient huddles through six-month fidelity checks with targeted training/recommendations for areas identified as needing support	Y	For the inpatient and outpatient team huddles, 100% compliance was reached for the six-month fidelity checks on both sides.
					2) Implement revised Supervisor Competency Training	N	Due to the COVID-19 pandemic, this revised training has been put on hold. The revised content is now being translated/adapted to be delivered virtually. A virtual training pilot was launched in January 2021.
					3) Continue implementation and adoption of the recommendations from the risk assessments completed on high-acuity units	Y	We continue to track the risk assessment recommendation work and provide regular updates to the Workplace Violence Prevention committee.
					4) Continue roll out of staff education/training for Trauma-Informed De-Escalation Education for Safety and Self-Protection (TIDES) training in outpatient programs	N	Due to the COVID-19 pandemic, Outpatient TIDES has been put on hold. New hires, including Outpatient staff, have received TIDES training as part of their orientation to the organization.
% of patients physically restrained during inpatient stay (% / All inpatients; Q4 19-20 through Q3 20-21)	4.4%	4.4%	6.2%	1) Continuation of Trauma-Informed De-Escalation Education for Safety and Self-Protection (TIDES) training implementation and sustainability and utilization of practice enhancements of TIDES. The Vision for TIDES is to build a foundation to ensure the safety and wellness of everyone at CAMH. This is achieved through these three 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) Continue TIDES implementation through various training modalities (e.g. Simulation, Inpatient/Outpatient, Hospital Orientation, and Program Specific)	Y	Inpatient TIDES completed its initial roll-out in Q3 2019. Inpatient departments continue to receive support, including on-unit training, and their completion rates have been maintained through new hires receiving TIDES as part of Orientation.
					2) Continue work with clinical units to implement practice enhancements and PDSA cycles for improvement	Y	A Quality Improvement project was launched in August 2020 with the aim of increasing "This is Me" completion rates. The project work is underway however identifying PDSA partner areas and the subsequent implementation of change ideas and PDSA cycles was delayed due to COVID-19.
				2) Implementation of the Canadian Patient Safety Institute (CPSI) Teamwork and Communication Safety Improvement Project. The goal of this initiative is to empower direct-care teams to actively solve local-level teamwork and communication issues that are impacting patient safety outcomes	Optimize an evidence-based tool (e.g. SBAR) to continuously improve care team communication that reduces the number of restraint events on a pilot unit (Geriatric Admissions Unit – B)	Y	At the direction of CPSI, the Restraint Minimization Project was closed on September 30, 2020 due to the COVID-19 pandemic. The Project Team presented the results and lessons learned at the virtual CPSI Congress on October 28, 2020. While the Project has closed, the Project Team had intended to support the GAU-B care team and leadership with on-going education and training on the SBAR tool. However, due to COVID-19, this was not possible.

Measure/ Indicator from 2020/21	Current Performance as stated on QIP 2020/21	Target as stated on the QIP 2020/21	Current Performance 2021	Change Ideas from Last Year's QIP (2020/21)	Methods	Was the change idea implemented as intended Y/N)	Comments The following questions were considered: • What is the status of the proposed change idea? • Has the proposed change idea(s) been implemented? If no, why? • If implemented, to what degree (e.g. is the change idea(s) on track for completion)?
Percent positive response to the OPOC Survey question, "Staff were sensitive to my cultural needs (e.g. religion, language, ethnic background, race)" (% / All inpatients who completed the survey; Validated Ontario Perception of Care Tool for Mental Health and Addictions (OPOC) survey tool / Q4 19-20 through Q3 20-21)	2019: 55% (Top Box)	CB	39%	1) Implementation of a training program, under Fair & Just CAMH, that examines unconscious bias, anti-Black racism, and other root causes of racial disparities in health outcomes to increase staff and leadership knowledge, awareness and capacity. Fair & Just CAMH is a CAMH-wide initiative to advance equity, diversity and inclusion. Key milestones will be in data sharing, health outcomes, training and other supports	Implement equity-based trainings for CCR Forensics program staff (pilot)	Y	The pilot project is complete. Due to COVID-19, the training was offered virtually and the numbers adjusted accordingly. Three management training sessions and three additional direct care staff training sessions (2 days each) were held.
				2) Expansion and enhancement of Interpretation Services (IS). CAMH provides interpretation services free of cost to our patients. We offer over 45 languages and receive over 3000 requests annually. Access to IS at CAMH is underutilized. An internal review shows that the use of IS for inpatients is inconsistent. We are conducting a multipronged study to increase awareness and utilization of IS across CAMH	1) Add Indigenous languages to languages offered by IS at CAMH 2) Conduct focus groups with inpatient CAMH staff to increase IS awareness and identify barriers to use 3) Host CAMH-wide event to increase staff awareness of IS	Y	An Indigenous language will now be sourced through our partnership with Shkaabe Makwa and as needed as part of Interpretation Services at CAMH. Focus groups were conducted with inpatient CAMH staff to increase IS awareness and identify barriers to use. Promotional materials (including mousepads, postcards, posters and lanyard cards) were also developed and distributed to units, using a rolling distribution strategy to monitor consistent use of IS. An in-person event was not possible due to COVID-10 however, a "how to use an interpreter" course was developed for Insite as an additional promotional items in lieu.