Excellent Care For All.

# 2013/14

# Quality Improvement Plan for Ontario Hospitals

(Short Form)

camh

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

**March 28, 2013**

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

# Overview of Our Organization’s Quality Improvement Plan

## Overview of CAMH Quality Improvement Plan

CAMH is an organization dedicated to improving mental health and addictions care. Our purpose statement is “At CAMH, we Care, Discover, Learn, and Build to transform lives”. The fundamental values that guide the organization are respect, courage and excellence. In 2012, CAMH developed a new strategic plan with six directions: Enhancing recovery by improving access to integrated care and social support; earning a reputation for outstanding service, accountability and professional leadership; building environments that support healing and recovery; ignite discovery and innovation; revolutionize education and knowledge exchange and drive social change.

The organization has undergone large changes in the past year, both in clinical program structures as well as physical changes with new buildings for clients and staff in many areas. These changes are in-line with the strategic plan, as CAMH works towards building new environments, breaking down the stigma surrounding mental health, and improving care and excellence in the field of mental health and addictions. In 2013, we will be focusing on change management strategies and supporting staff at all levels to help implement the new changes occurring across the organization and continue to examine needs and best practices.

For 2013/2014, reducing restraint use continues to be our “priority 1” measure in the Quality Improvement Plan. In addition, we have added a second “priority 1” measure, which is to reduce the number of involuntary clients who leave the facility without an authorized pass. We believe that this is an important safety issue in the inpatient care of people who have been diagnosed with mental illness.

Priority 2 indicators include continuing to improve medication reconciliation at admission, ensuring low wait times to the Emergency Department, improving patient satisfaction, and improving integration so that patients are not spending unnecessary time in the hospital.

As a sector, mental health is challenged by a paucity of valid indicators for measuring quality. In 2011, the Mental Health and Addictions Quality Initiative (MHAQI) was launched, which is a partnership among the mental health and addictions hospitals in Ontario. Through this initiative, hospitals agreed to standardized performance indicators to measure key areas including client complexity, client outcomes, client access, client safety, staff safety, human resources and fiscal responsibility. Also in 2011, CAMH completed the Accreditation process and received Accreditation with Exemplary Standing which is the highest level of performance attainable. In 2013, we will continue to improve our processes, and accountability structures to strive for the best care for our clients and provide quality care.

## Focus of the CAMH Quality Improvement Plan

Safety

Patient safety is the most foundational dimension of quality, and as such, the majority of our identified objectives are in the safety domain this year as in previous years. Between 2008 and 2011 CAMH has had a focused initiative on prevention and reducing mechanical and chemical restraint and locked seclusion use.

These efforts and changes resulted in a considerable decrease in the use of mechanical restraints across all clinical areas. While we have achieved excellent results, we aim for continued improvements and to hold the gains in this area by focusing future efforts on examining and understanding system and process issues that contribute to restraint use through debriefing. We are also promoting medication safety by ensuring that medication reconciliation on admission continues to be completed for all clients across the organization. We will measure the percentage of medication reconciliation and also the quality of the best possible medication history through analysis of audit information. At present our ability to report on medication reconciliation is based on manual chart audit process. As we implement a new electronic health record in 2014, the ability to monitor and report on medication reconciliation will be greatly enhanced and expanded to medication reconciliation on transfer and discharge as well.

A key safety issue for mental health facilities is unauthorized leave for involuntary patients. This interruption in a patient's care and treatment can compromise safety for the client and also contributes to safety concerns for the public. Our goal is to reduce the number of involuntary clients who leave the hospital without an authorized pass, so we have included this as a new indicator on our QIP Plan for 2013/2014. There are no benchmarks for this measure, thus it is not possible to set a meaningful target. All incidents of such nature are reported and tracked through our incident management system and our intent is to better understand the factors that contribute to such incidents with a goal of reducing the overall number of involuntary clients who leave without a pass. In 2012 /13 we revised our policy on passes and privileges after much consultation. As we implement the new policy we will ensure targeted attention to high risk areas to ensure our processes are robust and followed consistently and closely monitor the outcome. We will also review all such incidents closely to better understand contributory factors in order to further strengthen our processes and practice.

Access to Care

The second ongoing crucial issue for CAMH and the mental health sector is access to care. Like other acute care hospitals, the majority of our admissions come through our Emergency Department (ED) and patient flow and wait times are important indicators of how well we are serving our communities. By increasing efficiency in these processes we can provide care to more patients and families. In the past year we have seen significant increases in the number of patients accessing our Emergency Department, as well as in complexity and acuity of presenting clients. In addition to monitoring wait times in the ED, we are also implementing a patient flow initiative that is streamlining intake and working with our system partners to ensure CAMH patients are discharged appropriately to services in the community.

Patient-Centered

In the fall of 2013, we will be conducting a client experience survey to measure improvements and identify areas that require continued attention and resources. Surveys of consumers of mental health services can provide complementary insights into the quality of care they are receiving. Often clients do not come to our care voluntarily. Creating genuine partnerships with our clients and families is critical to our vision of transforming

lives. Positive client response to the overall Client Experience Survey question of how they would rate their care is our indicator of patient centeredness. This survey also provides critical and detailed information about the content of care and manner in which it is delivered. Previous survey has identified areas for improvement including involvement in discharge planning thus our change initiative will target that area to enhance the overall experience.

Further overall benefits expected to be gained through the implementation of the QIP measures include: improvements in clinical practice and documentation, awareness of critical quality improvement issues, and the development of new quality improvement processes. CAMH will demonstrate its commitment to these objectives by making resources, such as training, tools, and time, available to staff and by providing support to data collection and analysis. We will ensure that our care and services are efficient by ensuring that all costs are within our budget and the total margin remains above zero.

## Alignment

The QIP is developed as a result of a systematic and regular operational planning, consistent with organizational strategy. It is in alignment with our HSAA Commitments. Medication reconciliation is a Required Organizational Practice (ROP) for Accreditation Canada.

The CAMH Balanced Scorecard (BSC), like other Academic Health Science Centres, outlines a range of indicators consistent with our mission of providing excellent care, conducting research across the spectrum of brain science to social and epidemiological research, providing education to health care professionals and scientists, and contributing to the healthcare system through our leadership role in the mental illness and addictions sector. Specifically, our BSC reflects our well developed Quality Improvement agenda and several measures on the BSC are replicated in the QIP. It is advantageous to draw on measures that have already been developed and tested as comparative data across periods over time exists to facilitate the development of understanding of results and meaningful responses. As noted earlier, mental health and addictions sector is limited in access to benchmarks and targets specific to our population. CAMH, together with other psychiatric facilities in Ontario, is undertaking the necessary steps to develop meaningful and reliable indicators and benchmarks. The collaboration and dialogue is critical to challenging assumptions and identifying best practices for the sector. Where possible, we have chosen measures that can be compared across mental health care hospitals and we deliberately share several measures with Ontario Shores, Waypoint and the Royal Ottawa hospital. In addition to the QIP, our comparative performance is also publicly available on our website.

## Integration and Continuity of Care

A major challenge for CAMH, like other mental health facilities is access and the ability to adequately meet the needs of the population we serve. There is considerable unmet need in the sector, thus it is imperative that we focus on access as well as transitions and discharge. Both inflow and outflow are priorities for the organization and a key aspect of the clinical program reorganization. Simply put, we need to effectively meet the demands of the population and this is being monitored through our access indictor on ED wait time. We are also looking at our long stay clients and working with community and housing partners to better transition, and where appropriate implement shared care models to reduce ALC days and thus increase capacity to care for more patients.

## Health System Funding reform (HSFR)

Not Applicable at this time

## Challenges and risks

There are a number of identified challenges and risks in the implementation of our QIP. These center around the following areas: lack of valid and reliable indicators, under-developed measurement systems and tools, absence of appropriate baseline or benchmark data and the significant transformation agenda as a result of the new strategic plan.

- We have recently embarked on a significant realignment of our clinical programs, including how clinical care services are clustered and aligned. While the ultimate aim is to improve quality through increased access and efficiency, the organization is in a state of considerable change and transition and this may complicate improvement efforts.

- By continuing to embark on a transformation agenda, CAMH has completed construction in many areas of the organization but still has more construction to be completed. In the upcoming year, the Emergency Department will be under construction to accommodate for the continued increase in patient volumes.

- We are implementing a new Clinical Information System. Work is currently being completed to develop the system and prepare for launch in 2014. During this time, we are continuing to work with sub-optimal information systems that may at times affect efficiency and productivity of staff. We are limited by our existing systems to be able to generate timely, meaningful reports to support data informed decision making and action. We are undertaking an enterprise reporting initiative that is focusing on priority reporting needs to ensure our quality initiatives are supported and sustained. Many staff are also involved in this initiative and this involvement further challenges their ability to meaningfully participate in other improvement projects.

- The use of results to identify problems and opportunities for improvement is limited by a lack of comparative data to interpret the measures. CAMH had partnered with other mental health and addictions hospitals to develop shared measures for mental health and addictions care and to report collectively on results. At this time, limited data, such as benchmarks are available to facilitate interpretation of measurement results.

## Link to performance-based compensation

At CAMH, the compensation plan for executive leadership team (ELT) members includes an Incentive Payment Target (or "at risk" pay) of up to 25% of base salary for the CEO and up to 15% for all other ELT members.

- It is recommended that 25% of the "at risk" pay be tied to the attainment of the ECFAA Quality Improvement Plan targets.
- Complete attainment of the target improvement will result in a full payment. Greater than 50% attainment but less than complete will result in 50% of the payment. Less than 50% attainment will result in zero payment. Level of attainment will be determined by the CEO.

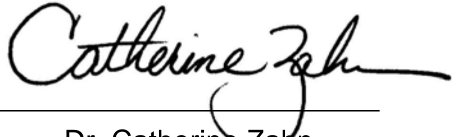
- This meets the EFCCA requirements and is compliant with the Public Sector Compensation Restraint act.
- This recommendation is consistent with the approach being taken by most other CAHO hospitals.

The specific relationship between attainment of the QIP targets and compensation are shown below.

| Quality Dimension | Objective | Weighting | CEO Compensation | ELT Compensation |
|---|---|---|---|---|
| Safety | Reduce use of physical restraints<br><br>Improve Medication Safety<br><br>Reduce involuntary patient missing events | 20% | 1.25 | 0.75 |
| Effectiveness | Improve organization financial health | 20% | 1.25 | 0.75 |
| Access | Reduce Emergency Department wait times | 20% | 1.25 | 0.75 |
| Patient-centred | Improve Patient Satisfaction | 20% | 1.25 | 0.75 |
| Integrated | Reduce unnecessary time spent as an inpatient in a psychiatric facility | 20% | 1.25 | 0.75 |
| | | | | |
| 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 | | | 25.0 | 15.0 |

## 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 | Pam Jolliffe | Dr. Catherine Zahn |
|---|---|---|
| *Board Chair* | *Quality Committee Chair* | *Chief Executive Officer* |

# Our Improvement Targets and Initiatives

| AIM | | MEASURE | | | | | CHANGE | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Quality dimension** | **Objective** | **Measure/Indicator** | **Current performance** | **Target for 2013/14** | | **Priority level** | **Planned improvement initiatives (Change Ideas)** | **Methods and process measures** | **Goal for change ideas (2013/14)** | **Comments** |
| Safety | Reduce use of physical restraints | **Physical Restraints:** The number of patients who are physically restrained on admission assessment divided by all cases with a full admission assessment. Q3 2012/13 to Q2 2013/14, OMHRS | 2.4% Q2 2012-13 YTD | < 4.0% Stay below the provincial average for physical restraint use on the admission assessment. Currently provincial average at 4.0% | Given increasing acuity of client populations, we aim to stay below the provincial average for mechanical restraint use and to maintain the progress that we have made in the prevention of restraint. Further reductions in restraint utilization are difficult to achieve without changes in the physical environment, a contributing factor that will not be addressed in the upcoming year. | 1 | 1. Redesign restraint debriefing process<br>2. Develop standardized processes, including specified frequency, or sharing restraint data on unit, program and org. levels | 1. % of units that use restraints with weekly regular debriefing<br>2. Staff satisfaction with the debriefing process<br>3. Reconsider frequency and format of staff debriefing as well as required participants<br>4. Revise weekly restraint debriefing form<br>5 Develop appropriate report templates and reminder systems for teams and management. | Restraint debriefings that produce changes in conditions which contributed to restraint use.<br>Restraint data is used at all levels of the organization and on a specified basis to monitor progress. | |
| | Increase medication reconciliation on admission | **Medication reconciliation on admission:** % of medication reconciliation on admission completed in a sample of 100 patient records. YTD 2013-14. | 97% YTD 2012-13 | 98% | We are aiming to continue to improve towards attainment of the theoretical maximum (100 %) | 2 | 1. Continue to conduct quarterly chart audit for completion of med rec..<br>2. Analyze previously collected data on the quality of the BPMH (best possible medication history)<br>3. Target 1-2 identified problem areas related to the quality of the BPMH | 1. % of charts with med rec completed on admission<br>2. % of BPMH with quality related issues<br>3. Frequency of identified issues related to quality in the BPMH | Full compliance with medication reconciliation on admission with high quality BPMH | |
| | Reduce involuntary missing client events | **Missing involuntary client events:** Count of missing involuntary client events. Q1 2013/2014 to Q3 2013/14. From electronic incident reporting system. | 96 missing involuntary pts Q3 YTD | Reduce number of report involuntary missing patient events | We are unaware of any benchmarks on which to base improvement in this area and are looking to reduce the number of incidents from the same period a year earlier. | 1 | Implement revised Passes and Privileges policy which prohibits unaccompanied passes for involuntary pts unless in exceptional circumstances approved by Medical Director. Targeted education in areas with high incidence of AWOL | Examine incidents that are reported through the electronic reporting system to determine adherence to the policy and whether we need to update the procedure.<br>Develop process to serve as recognition and feedback. | Reduce the number of involuntary missing clients | |
| Effectiveness | Improve organizational financial health | **Total Margin (consolidated):** Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2012/13, OHRS | 1.98% Q3 2012-13 | Above 0 | We are aiming to stay above 0 to ensure ongoing financial stability for the organization | 3 | Continued Monitoring | Corporate financial reporting | 0% financial margin | |
| Access | Emergency department wait time | **ER Wait Times:** 90th percentile ER length of stay for admitted patients. Q1 2013/14 to Q3 2013/14, NACRS/CIHI database | 3.43 hours 90th percentile for Q2 YTD | 3.43 hours | Target is to maintain current performance. We continue to experience increased volumes in the emergency department (ED). We have adjusted staffing accordingly. However, the physical space challenges require renovations that are expected to begin later in 2013. | 2 | Given the anticipated challenges of maintaining full and safe operations during a major renovation of the ED, the goal is to maintain quality. LOS will be monitored regularly, including on a shift by shift basis, and staffing will be adjusted accordingly. | Analysis of wait times, data to be provided by Decision Support Department | Maintain or improve wait time in the ED in order to optimize access to services | |
| Patient-centred | Improve patient satisfaction | **From In House Survey:** "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good") | 2012:<br>Inpt: 72.4%<br>Outpt: 91.1% | Maintenance of inpatient levels of satisfaction from the 2012 survey. | Our goal is to continue to maintain or increase our patient satisfaction results for the inpatients in particular however we are also aiming to maintain our outpatient satisfaction of 91.1% from 2012. It is however, not possible to identify a target as there are no benchmarks for our patient population. Furthermore, the patient satisfaction survey is census based which means that often patients are responding in the very early stages of their admission when they may be in considerable distress. Thus it may not be possible to further increase levels of satisfaction. We believe that 2012 levels of overall satisfaction are a reasonable target for 2013-14. | 2 | Focused attention in the area of discharge planning that was evident as an improvement area in 2012 survey:<br>- Implementation of revised policy for discharge planning that identifies explicit expectations re: care planning and documentation<br>-Use of a checklist for providers<br>- Patient information booklet for discharge, patient sign off on discharge information form, and providing patients with a copy of the discharge instructions | Increase % of Inpatients who reported that staff had talked to them about their discharge in the 2013 administration of the Client Experience Survey<br><br>Chart audit for required documentation re: discharge planning | Improved organizational responsiveness to Client Experience Survey results. | |
| Integrated | Reduce unnecessary time spent as a inpatient in a psychiatric facility | Reduce number of non-forensic Long stay clients (greater than 1 year) | December 31 2012 - 43 non forensic long stay clients | Continued decrease in Long Stay patients | There are no benchmarks in the sector on this. Discharge options are limited but we have had considerable success in working with community housing partners and these efforts will be continued. | 2 | Continued leadership efforts to transition CAMH ALC patients to supportive housing units in the community and monitor utilization .<br>CAMH is participating in the Transitional Discharge Model pilot through CAHO ARTIC project.<br>Implementation of LOCUS (Level of Care Utilization System) tool across the organization allows for objective assessment of level of care needed for clients. This will allow us to ensure that ALC designation occurs in a timely manner and alternative options for discharge can be explored | Develop system to monitor the application of LOCUS tool to ensure clients who do not need inpatient services are appropriately discharged or designated as ALC | Successful discharge of long stay clients to community housing and appropriate utilization of inpatient services | We are not reporting on % of ALC days as the current organizational processes do not capture all ALC clients |