2023-2024 Quality Improvement Plan
"Improvement Targets and Initiatives"

Aim		Measure						Change				
Issue	**Quality Dimension**	**Measure/ Indicator**	**Unit/ Population**	**Source/ Period**	**Current Performance**	**Target (2023/2024)**	**Target Justification**	**Planned Improvement Initiatives (Change Ideas)**		**Methods**	**Process Measures**	**Target for Process Measure**
Theme I: Timely and Efficient Transitions	**Timely**	Median Wait Time from Referral to Consult	Days /referred outpatients	Local data collection/ January – December 2023	NA	CB	New indicator	**Year 1 (2023)**	1) Develop a strategy to address data quality issues across CAMH (e.g. non-compliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times	Standardize mechanisms for measuring wait time data across CAMH (new clinic referrals)	1) General and local barriers identified to wait time data completion 2) General and local barriers identified to reduce wait times 3) % of Wait Time PowerForm completion rates across all programs	1) General and local barriers identified to wait time data completion by June 2023 (Y/N) 2) General and local barriers identified to reducing wait times (Y/N) 3) 50% of Wait Time PowerForms completed by December 2023
									2) Develop and pilot change initiatives to decrease wait times for outpatient services across the three clinical programs	Plan and initiate one pilot in each of the three clinical programs (CYEA, Acute and CCR) with high wait times. The pilots will have one MD and one non-MD level sponsor leader	1) MD and non-MD level sponsor leaders identified 2) Pilots designed and initiated	1) MD and non-MD level sponsor leaders identified by end of March 2023 2) Pilot designed by end of Q2 2023 and initiated by Q3 2023
								Year 2 (2024)	1) Strategy implemented to address data quality issues across CAMH (e.g. non-compliance with Wait Times PowerForm completion in I-CARE) to ensure every outpatient clinic is reporting accurate wait times	Analyse, validate and disseminate Wait Time data results (e.g. highest/lowest)	1) % of Wait Time PowerForm completion rates across all programs 2) Wait times in key priority dashboard will be monitored by outpatient clinical services	1) 80% of Wait Time PowerForms completed by March 2024 2) Wait times in key priority dashboard monitored by outpatient clinical services weekly
									2) Begin evaluation process of the pilots, modify, and adapt pilots as needed	Evaluate the three pilots and month-to-month reductions in wait times (CYEA, Acute and CCR)	1) Evaluation of the three pilots 2) Wait time reduction in all three pilot areas	1) Evaluation of the three pilots completed by Q3 2024 2) 30- 50% of wait times reduced in all three pilot areas
									3) Set the conditions for scale and spread of the pilot projects to other outpatient clinics within each program	Identify additional areas in other outpatient clinics within CYEA, Acute and CCR. Each clinic will have one MD and one non-MD level sponsor leader who are jointly accountable for each pilot	1) Additional areas identified in other outpatient clinics within CYEA, Acute and CCR 2) MD and non-MD level sponsor leader identified in each clinic	1) Additional areas identified in other outpatient clinics within CYEA, Acute and CCR by January 2024 2) MD and non-MD level sponsor leader identified in each clinic (Y/N)
								Year 3 (2025)	1) Long-term evaluation related to Emergency Department volumes, inpatient admissions related to outpatient wait times controlling for key confounding variables and develop sustainability plan	By year end, begin to determine whether reductions across clinics in wait times are being achieved	1) Wait time reductions systematically occurring and progressing positively across all clinical programs 2) Sustainability plan developed	1) Wait time reductions systematically occurring and progressing positively across all clinical programs by September 2025 2) Sustainability plan developed (Y/N)
									2) Scale and spread wait time reduction approach across larger number of clinics cutting across all major outpatient services at CAMH	Launch wait time reduction approach across larger number of clinics cutting across all major outpatient services at CAMH	Wait time reduction across all major outpatient services	30-50% of wait times reduced across all major outpatient services
									3) Develop a plan to support other components of access (e.g. on discharge and with community partners, or across the health system, for instance, our role in Early Psychosis Intervention (EPI) wait times across the province)	Begin planning for access 2.0 initiative (e.g. peer clinics in the system)	1) Factors related to access to care beyond year 3 at CAMH and across the health system are identified 2) Begin planning to support other components of access	1) Factors related to access to care beyond year 3 at CAMH and across the health system identified by (target: TBD) 2) Plan developed (target: TBD)

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Theme II: Efficient	**Efficient**	**Vacancy Rate**	Percentage/workers	Local data collection/ January – December 2023	NA	CB	New Indicator	**Year 1 (2023)**	1) Collect reliable data on drivers that positively enhance retention and recruitment. Develop and pilot improvement initiatives in relation to manager, physician and nurse retention across all clinical programs	1) Conduct stay interviews with permanent managers and physicians to identify drivers for retention	1) Establish process and communication for leaders on conducting manager and physician stay interviews 2) % of permanent managers who have a stay interview conducted by their direct supervisor 3) % of full time physicians who have received a stay interview	1) Process and communications developed and implemented by early Q2 2) 20% of all permanent managers have received a stay interview 3) 20% of all full time physicians have received a stay interview
		Voluntary Turnover	Percentage/workers	Local data collection/ January – December 2023	9.8% (FY 2022 Q2)	8.8%	Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence limit). The target is comparable to pre-pandemic averages			2) Conduct exit interviews for all permanent full-time and part-time nurses (RNs and RPNs) who leave CAMH within 2 years of their start date and for all physicians who leave CAMH to identify drivers of retention	1) Develop and implement a communication plan for managers and leadership to ensure that exiting staff are asked to participate in exit interviews 2) % of exit interviews completed with permanent full-time and part-time nurses (RNs and RPNs) 3) % of physicians who leave CAMH who participate in an exit interview	1) Communication plan developed and implemented by early Q2 2) 50% of permanent full-time and part-time nurses (RNs and RPNs) with voluntary turnover (with 2 or less years service) invited to participate in an exit interview 3) 50% of physicians who leave CAMH voluntarily to be invited to participate in an exit interview
										3) Continue Nursing Referral Program (NRP) with incentive payment for staff who make a referral that leads to a successful external nurse hire	1) Number of referrals made that lead to hire and who have passed the probation period 2) Number of new hires through the NRP who are still employed at CAMH six months following the end of their probationary period	1) Number of new nurse hires who have completed their probationary period (CB) 2) Number of new hires through NRP who are still employed at CAMH six months following the end of probationary period (CB)
									2) Nursing informatics Engagement Strategy aimed as sustaining and retaining nursing workforce by enhancing nursing engagement and leadership in informatics decision-making; improving experiences with technology; leveraging data to identify opportunities to further streamline documentation and enhancing and optimizing informatics education/training and communication strategies	Engage nurses in workflow and system process improvements	1) Number of Nursing and Health Disciplines Think Tanks held 2) Number of clinical IDEAS submitted on nursing-related topics 3) Number of clinical IDEAS implemented in I-CARE on nursing related topics 4) Number of nurses engaged in informatics/ digital health governance and related committees	1) 10 Nursing and Health Disciplines Think Tanks held (approximately every 4-5 weeks) by the end of December 2023 2) 10 clinical IDEAS submitted on nursing-related topics over the course of 2023 3) 10 clinical IDEAS implemented in I-CARE on nursing related topics over the course of 2023 4) 20 number of nurses engaged in informatics/digital health governance and related committees
									3) Identify and track measures relating to staff and physician wellness	1) Identify and track measures relating to CAMH staff and physician wellness [e.g., Wellness Centre usage numbers, Employee and Family Assistance Program [EFAP] utilization rates, Sunlife Financial (SLF) Lumino online tool usage, lost time (sick, WSIB, STD, LTD) and overtime data]	1) Number of all Wellness Centre classes offered per quarter (staff and physician usage) 2) % of staff who use EFAP and SLF Lumino online tool by category of service 3) Number of hours paid due to WSIB, STD, LTD, and leaves (excluding vacation) compared to FTE staff count per inpatient unit (of inpatient staff) 4) % of physician attendance at physician-specific wellness initiatives	1) Number of all Wellness Centre classes offered per quarter (staff and physician usage) (CB) 2) % of staff who use EFAP and SLF Lumino online tool by category of service (CB) 3) Number of hours paid due to WSIB, STD, LTD, and leaves (excluding vacation) compared to FTE staff count per inpatient unit (CB) 4) 20% of physicians to engage with at least one wellness initiative by end of 2023

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										2) Lead the TAHSN Measurement Working Group (part of the TAHSN Physician Wellness Working Group) to review and identify measures of burnout and ways to evaluate wellness initiatives	1) Identification of metrics related to physician burnout/wellness 2) Develop implementation plan for tracking metrics related to physician burnout/wellness 3) % of physicians who indicate via the Leadership and Management Program for Physicians (LAMP) evaluation survey that this professional development program is relevant to their work	1) Identification of wellness indicators by Q2 2) Implementation plan for wellness measures completed by Q3 3) 60% of physicians indicate on the LAMP evaluation survey that this is relevant to their work
									4) Improve measurement and reporting to support recruitment and retention (development of data acquisition and measurement reporting)	1) Develop, support and receive approval for the implementation of a new Human Resources Information System (HRIS) as part of a larger Enterprise Resource Planning (ERP)	1) Business case approved	1) ELT approval obtained (Y/N) 2) Board approval obtained (Y/N)
										2) Build a reliable report framework for the current HRIS	1) Create a standardized report for vacancy and voluntary turnover rate and lost time data 2) Feedback obtained by clinical management	1) 4 reports (quarterly) 2) Obtain feedback from 50% clinical management on report by end of December 2023
									5) Enhance psychological health, safety, and wellness of staff and physicians	Continued implementation of the CAMH Workplace Mental Health Strategy	1) Develop content to embed psychological health and safety in new hire orientation 2) Number of organization-wide events where staff can talk about workplace mental health, anti-racism and psychological safety 3) Physician Engagement, Wellness & Excellence Committee (which includes divisional wellness leads, Peer Support lead, Mentorship lead, and LAMP lead) and conduct wellness forums for exploration of topics that impact physician engagement, wellness, and excellence 4) Number of enrollments in the automated text-based clinician mental health support, which aims to connect CAMH clinicians to mental health resources and discipline-specific resources and information	1) New hire orientation content developed by September 20, 2023 2) Host 2 organization-wide events 3) Physicians attend at least 1 quarterly wellness forum per year 4) # of enrollments (CB)
									6) Enhance diversity, equity and inclusion for staff and physicians	1) Provide tools and supports for staff and physicians to foster a Fair & just CAMH for all	1) % of managers who have completed the mandatory training on Foundational Knowledge on Anti-Black Racism 2) Number of training sessions developed and launched for managers on leading discussions to create an inclusive environment for everyone at CAMH 3) Number of staff who have completed the San'yas training for staff	1) 70% of management have completed the mandatory training by December 2023 2) 5 sessions for managers developed and launched by end of Q2 3) 375 CAMH staff trained by the end of December 2023
										2) Re-launch updated CAMH Diversity Survey	1) Design and launch campaign for participation in Diversity Survey 2) % increase in response rate	1) Develop campaign and communication plan by end of March 2023 and launch survey by April 2023 (Y/N) 2) Increase response rate by 10% by end of Q2

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camh
mental health is health

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Theme III: Safe and Effective Care	**Safe**	Workplace Violence Lost Time Injury Frequency (# of WPV incidents/100 FTEs)	Count per FTE / Worker	Local data collection / January - December 2023	0.28	0.29	Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence limit). The target is comparable to pre-pandemic averages	**Year 1 (2023)**	1) 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	90% of recommendations in-progress or completed
										3) Urgent TIDES consultations to high-acuity inpatient units	1) # of consultations 2) Time of referral to time of consult	1) # of consultations (CB) 2) Time of referral to time of consult <24 hours
									2) Plan and implement locally-driven change initiatives to ensure compliance with 1) This is Me; 2) Safety and Comfort Plan; and, 3) Client/Patient Debriefing (e.g. unit champions, utilizing team huddles, chart audits, education and awareness, sharing compliance rates)	Inpatient unit leadership teams: 1) To review workplace violence incident data and mitigation strategies, as well as training requirements, with teams 2) In collaboration with Professional Practice and TIDES, develop and implement local-level strategies based on best practices to increase completion of This is Me, Safety and Comfort Plan and Client/Patient Debriefing in compliance with CAMH documentation standards and policy	1) % of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) % of Safety and Comfort Plans completed within 72 hours of admission 3) % of Client/Patient Debriefs completed within 72 hours of the restraint event	1) 40% completion rate of This is Me within 7 days of admission by the end of 2023 2) 58% completion rate of Safety and Comfort Plans within 72 hours of admission by the end of 2023 3) 44% completion rate of Client/Patient Debriefs within 72 hours of the restraint event by the end of 2023
									3) Plan, design and implement a simulation training on mitigating bad news, which is a TIDES practice enhancement. The goal of mitigating bad news is to ensure the care team works together to deliver bad news empathically, and provide support to the patient afterwards. Practice enhancements are aligned with interventions shown to reduce conflict and containment in inpatient mental health settings. The simulation will provide an opportunity for staff in the clinical areas to learn and practice delivering bad news as a care team emphatically	1) Understand gaps in knowledge, skills and attitudes related to the TIDES practice enhancement through staff feedback, and review evidence-based practices in the literature to design a simulation training on mitigating bad news 2) Identify a working group to lead the design and implementation of the simulation training (e.g. develop the simulation scenario and curriculum, assist with training faculty to facilitate the simulation etc.)	1) Needs assessment and literature review completed 2) Convene curriculum committee and draft learning objectives 3) Scenario developed and faculty trained 4) Number of staff who completed the simulation training	1) Needs assessment and literature review completed by March 2023 2) Curriculum committee convened and learning objectives drafted by June 2023 3) Scenario developed and faculty trained by August 2023 4) 10 staff will complete the simulation training by December 2023
Theme III: Safe and Effective Care	**Safe**	% of patients physically restrained during inpatient stay	% / All inpatients	Hospital collected data / Q4 22-23 through Q3 23-24	5.4%	4.8%	Target is set as a significant improvement compared to the average of the past 8 quarters (lower 99% confidence limit). The target is comparable to pre-pandemic averages	**Year 1 (2023)**	1) Plan and implement locally-driven change initiatives to ensure compliance with 1) This is Me; 2) Safety and Comfort Plan; and 3) Client/Patient Debriefing (e.g. unit champions, utilizing team huddles, chart audits, education and awareness, sharing compliance rates)	Inpatient unit leadership teams, in collaboration with Professional Practice and TIDES, to develop and implement local-level strategies based on best practices to increase completion of This is Me, Safety and Comfort Plan and Client/Patient Debriefing in compliance with CAMH documentation standards and policy	1) % of new admissions with "This is Me" completed within 7 days of admission (in our EHR) 2) % of Safety and Comfort Plans completed within 72 hours of admission 3) % of Client/Patient Debriefs completed within 72 hours of the restraint event	1) 40% completion rate of This is Me within 7 days of admission by the end of 2023 2) 58% completion rate of Safety and Comfort Plans within 72 hours of admission by the end of 2023 3) 44% completion rate of Client/Patient Debriefs within 72 hours of the restraint event by the end of 2023
									2) Advance 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,	1) Offer train-the-trainer sessions to inpatient and outpatient 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 and outpatient clinical staff trained as POCFs	20% increase of inpatient and outpatient POCFs by December 2023

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								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			
								3) Implement the Registered Nurses' Association of Ontario (RNAO) Best Practice Guideline: Promoting Safety: Alternative approaches to the use of Restraints. This guideline assists staff to focus on evidence-based best practices for assessment, prevention and use of alternative practices (including de-escalation and crisis management techniques) to prevent the use of restraint.	1) Review and update the Emergency Use of Chemical Restraint, Seclusion and Mechanical Restraint Policy, and other associated policies, to ensure alignment with RNAO Best Practice Guidelines (BPG) 2) Review, update, align and implement documentation standards related to restraint use, de-escalation, and crisis management in alignment with RNAO BPG 3) Review, update, and implement decision-making algorithms and assessment tools; prevention and safety strategies to ensure alignment with RNAO BPG (e.g. Mutual Action Plan behavior profile (MAP), alternative to restraints decision tree, behavior monitoring log, assessment of pre-disposing factors, patient and family education tools) 4) Conduct documentation audits to establish baseline to identify gaps in the use of assessment and prevention strategies, alternative approaches, and assessment strategies for physical restraints and provide focused education to address identified gaps 5) Work with Reporting and Analytics to monitor CAMH-wide physical restraint use	1) **%** of policies reviewed and updated to align with RNAO BPG 2) **%** of clinical documentation standards reviewed, updated and implemented to align with RNAO BPG 3) # of decision-making algorithms and assessment tools; prevention and safety strategies reviewed, updated and implemented to align with RNAO BPG (e.g. Mutual Action Plan behavior profile, (MAP), alternative to restraints decision tree, behavior monitoring log, patient and family education) 4) % of documented evidence of the use of assessment and prevention strategies, alternative strategies to physical restraints use 5) % of physical restraints used across CAMH	1) 75% of policies reviewed and updated by December 2023 2) 75% of clinical documentation standards related to restraint use, de-escalation and crisis management will be reviewed, updated and implemented by December 2023 3) # of decision making algorithms and assessment tools; prevention and safety strategies reviewed, updated and implemented by December 2023 (CB) 4) % documented evidence of the use of alternative strategies used prior to the use of physical restraints (CB) 5) % decrease in the use of physical restraints at CAMH (CB)
								4) Work with physicians to understand current state of pharmacotherapy order data including challenges with use	Identify a working group to develop and implement a strategy to address data quality issues across CAMH (chart audits and current state analysis)	Develop pharmacotherapy indicators associated with mechanical restraint reduction	Indicators developed by December 2023